AGENDA SUPPLEMENT

Health and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Cullwick (Vice-Chair), Hook, Norman, Perrett, Waudby and K Taylor

Date: Tuesday, 10 November 2020

Time: 5.30 pm

Venue: Remote Meeting

The Agenda for the above meeting was published on 2 November 2020. The attached additional documents are now available for the following agenda item:

6. Winter Care Plans (Pages 1 - 46)

Members will receive the Winter Plan for the City of York Council, developed in response to the Government policy paper *Adult social care: our COVID-19 winter plan 2020 to 2021,* published in September. This plan has been prepared with the support of partners across the health and social care system.

This agenda supplement was published on 3 November 2020.

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Agenda Item 6

Health and Adult Social Care Policy and Scrutiny Committee

10 November 2020

City of York Council Adult Social Care Winter Plan 2020

Summary

This report is for information.

The Government published its Adult Social Care Winter Plan in September 2020:
https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021

The Adult Social Care Task Force also published its report making 50 recommendations, many of which were for the Government and the NHS as well as some for councils:

https://www.gov.uk/government/publications/social-care-sector-covid-19-support-taskforce-report-on-first-phase-of-covid-19-pandemic/social-care-sector-covid-19-support-taskforce-final-report-advice-and-recommendations

All Councils were required to confirm in writing to DHSC by 31st October 2020 that they have a Winter Plan in place. These papers constitute City of York Council's Adult Social Care Winter Plan return.

Contact Details

Author's name:
Pippa Corner

Title: Assistant Director Joint Commissioning (CYC and VOYCCG)

Chief Officer:
Amanda Hatton
Corporate Director for People

Report Approved √ **Date** 03/11/20

Wards Affected: *List wards or tick box to indicate all* **All** x

For further information please contact the author of the report

Background Papers:

York ASC Winter Plan 2020

Annexes

1 York COVID Three Month Social Impact Report

2 York CVS – What we did during the COVID-19 lockdown. 09.2020

City of York Council
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FAO winterplanteam@dhsc.gov.uk

30th October 2020

Dear DHSC Winter Plan Team,

City of York Council Adult Social Care COVID-19 Winter Plan 2020 to 2021

I am pleased to confirm City of York Council has developed its Winter Plan, in response to the Government policy paper *Adult social care: our COVID-19 winter plan 2020 to 2021,* published in September. This plan has been prepared with the support of partners across the health and social care system.

Our plan addresses each area identified by DHSC and the *Social Care Sector COVID-19 Support Taskforce: final report, advice and recommendations.*

It builds on our Care Home Support Plan, published in May 2020:

https://www.york.gov.uk/downloads/download/923/york-care-market-plan-documents

It is aligned to our Outbreak Control Plan:

https://www.york.gov.uk/downloads/file/5805/york-covid-19-outbreak-control-plan-draft

It complements our approach to business continuity and resilience, and emergency planning, which includes the council winter maintenance plan and extreme weather policy.

It complements our EU Transition planning. Our latest advice and information is available through this site:

https://www.york.gov.uk/BrexitTransition

Preventing and controlling the spread of infection in care settings

Guidance on infection prevention and outbreak management

We continue to implement relevant guidance and circulate and promote guidance to adult social care providers in our area, including for visitors. We provide regular bulletins to all providers (including those supporting people with learning disabilities and autism), which include alerts about new guidance, links to the detailed documents as well as an overview of the content. Providers have given us positive

feedback on the role of the adults commissioning team, which has built on our strong relationships and ensured open channels of communication. Our system daily Care Homes Gold Resilience meeting with North Yorkshire engages colleagues from all the relevant partners across health and social care, including representation from the Independent Care Group.

City of York Council works with relevant partners to identify and control local outbreaks. The Director of Public Health has established the Outbreak Control Plan (see link above) and Health Protection Board to support this process, providing support and advice, and where necessary, interventions to prevent and manage the transmission of infection. Support is in place for the NHS test and trace system through the provision of a local Contact Tracing programme. The public health team supports the multi-agency Team Around the Home, as set out in our Care Home Support Plan.

We work with Vale of York CCG to support care homes to carry out learning reviews after each outbreak to identify and share any lessons learned at local, regional and national levels. Since the initial surge in cases in April and May, there have been no major outbreaks in the care sector in York. Our proactive approach to testing of staff and residents in May enabled us to identify individual staff members with asymptomatic infection, and subsequent whole site testing has reassured us that infection control is being extremely well managed across the sector, as these have not gone on to develop as outbreaks. We are not complacent, and we recognise that this may change with the rise in community infections during the autumn and winter.

Managing staff movement

We have distributed the Infection Control Fund (round 1), in line with the grant conditions, have submitted returns on how the funding has been used by local providers. We have made the necessary arrangements to distribute the Infection Control Fund (round 2) by 30th October 2020, as required. Our providers have been informed of the schedule of reports to account for the way in which the money has been used.

The Bringing Back Staff campaign has yielded very little staff for out of hospital (we were offered one who then couldn't be accommodated due to lack of experience in primary care) and discussions continue with NHSE/I on how the BBS campaign can be better utilised. The CCG were agile in offering staff to the system if there was anyone with capacity, for example the CCG staffed and ran the COVID-19 testing centre in Easingwold with council staff and some CCG staff worked in the discharge hub at YHFT.

We maintain regular direct contact with our providers, and monitor the Capacity Tracker daily, which enables us to discuss any issues relating to the workforce, including staffing pressures, avoiding movement between settings, staff sickness and training needs. Where necessary we have been able to target financial support to providers. We have followed up all cases of staff infection, and worked with providers to identify how these occurred, and are confident that staff movement has been minimised as far as practically possible. York providers have achieved 100%

compliance with the requirement to adopt and update the Capacity Tracker, resulting in York being identified as a national exemplar.

Our commissioning team provides a very regular bulletin to all social care providers and partners, which has ensured clear communication about the importance of COVID-19 workforce measures, and enables easy access to the latest guidance on all matters.

Personal Protective Equipment (PPE)

Our Care Home Support Plan, published in May, describes the arrangements for ensuring the reliable supply of PPE to our providers, as well as the concomitant training in its use, provided by the IPC team at the CCG. These arrangements remain in place. The suppression of the infection in care homes and home care is evidence that this work has been successful. Promotion of the guidance, use of the portal and our local supply to ineligible providers, as well as informal carers where needed, all combine to support the safety of individuals and care givers. These will remain in place throughout the winter.

All providers have been informed about the availability of PPE free of charge until March 2021 as set out in the ASC Winter Plan, and PPE issues are monitored through the Capacity Tracker and daily calls to partners. We have not been affected by shortages of PPE since the early stages of the pandemic, but we have mechanisms in place to manage the risk of shortages, including a local stockpile for immediate distribution if needed, and alerting the LRF. We work closely at a local level with CQC to ensure a timely response to any staff members in services who raise concerns about the supply of PPE in their workplace.

COVID-19 testing

York has taken a proactive approach to testing throughout the crisis. Initially this meant the daily prioritisation of available testing capacity for homes where we had been informed of suspected cases. This was initially managed through the North Yorkshire and York Care Homes Gold Resilience Group but we now have a daily - Testing Priorities Decision Meeting which involves colleagues from ASC, PH and the CCG. We have previously benefited from access to spare testing capacity through the Bradford Route, which enabled us to undertake a programme of proactive testing for all homes since May 2020. York was successful in bidding for a satellite site, which has been in operation since mid-July 2020. This supports testing through the national portal programme and where cases have come to light through this process (almost all have been single staff members who were asymptomatic), the CCG input into the “Team around the Home” has provided infection prevention control support to the provider to review practice and ensure all risks are being mitigated.

All homes are compliant with the testing programme, and the outcomes are monitored daily through the Gold Resilience Group.

Seasonal Flu vaccines

Our Public Health team provides leadership for the city on the national and local seasonal Flu campaign, aligned with our enhanced communications to service providers and local people, including family carers, stressing the importance of flu vaccination for staff working in ASC for themselves and the residents they care for, and the wider community. Public Health provided an article for bulletins circulated via the CCG and CYC ASC commissioning for circulation to all Older People's Care providers. This included information and links to PHE campaign materials specifically for use in the ASC environment. Access to flu vaccination for the wider workforce has also been promoted through our bulletin.

The City York Council staff flu vaccination programme is underway for all eligible staff (role related) to receive free flu vaccination provided by CYC. Regular communication is issued to council staff via the Chief Executive's bulletin to staff regarding the offer of vaccination, and how and where to access it.

We have worked with primary care networks in the city and provided infrastructure to establish the mass vaccination site, and have provided some support through the Better Care Fund to resource upskilling of clinical workforce to expand whole system capacity.

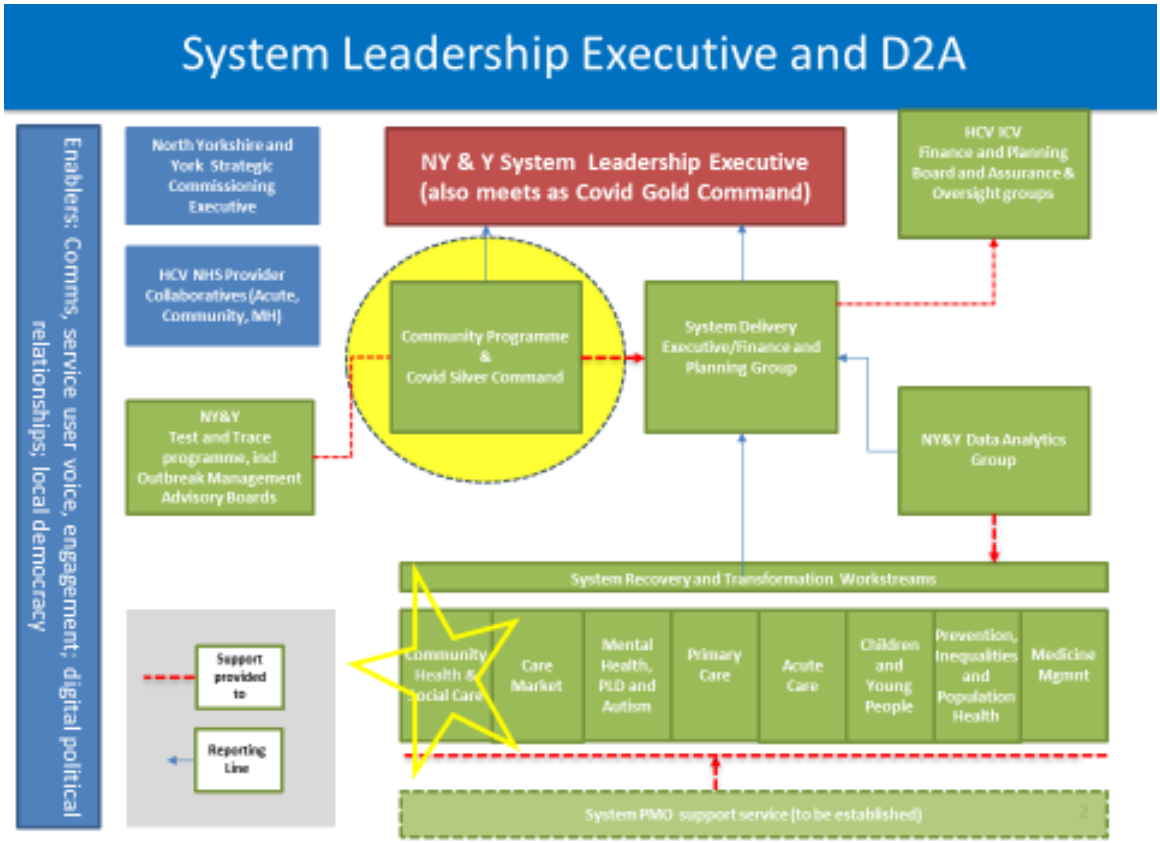
The Public Health team has offered staff to support the mass vaccination site. Council eligible staff are accessing this service.

Collaboration across health and care services

Safe discharge from NHS settings and preventing avoidable admissions

We have a number of multi-agency groups supporting the safe discharge from NHS settings and prevention of avoidable admissions. These are at both the North Yorkshire and York ICP level, under the Humber Coast and Vale ICS, and also at the Place level for York. The COVID-19 Discharge Steering Group has led the establishment of the Discharge Command Centre, reporting to the Health and Care Resilience Board (A&EDB).

The Hospital Discharge Service: Policy and Operating Model published on 21st August requires us with partners to designate a System Executive Lead for Discharge and a System Coordinator with specific responsibility for escalation. Through this structure and in conjunction with our partners we have nominated our Executive Lead and System Coordinators. In conjunction with partners we have assessed our compliance with the relevant sections of the Policy and this has informed our plan.



Refreshed Operational Delivery Groups: Health & Care Resilience Group (A&EDB)

NHS Scarborough and Ryedale and Vale of York Clinical Commissioning Groups
York Teaching Hospital NHS Foundation Trust

NORTH YORKSHIRE & YORK SYSTEMS LEADERS EXECUTIVE

Health & Care Resilience Board (A&EDB)

CLINICAL REFERENCE GROUP

SYSTEM RESILIENCE GROUP

- ✓ Refresh/ recalibrate OPEL escalation framework and process for refreshing after each OPEL escalation
- ✓ Business continuity plans – single, aligned and consistent expectations and response from all organisations based on the work in the delivery groups below
- ✓ Winter resilience planning requirements and escalation reporting to HCV and NHSE/I

PRE HOSPITAL

Default is no attendance or admission to hospital

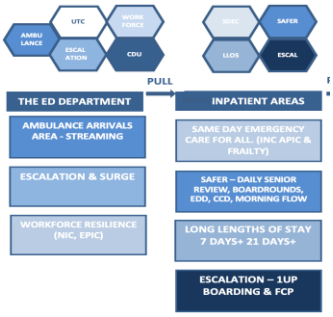
The work of this delivery group will be to:
- confirm all first contact services in each locality and understand resilience issues and patient demand
- optimise these services to ensure non-conveyance to hospital
- work to develop the integrated out of hospital prevention and care model ('anticipatory care') with PCNs/ localities
- work to develop the integrated urgent care model (including UTCs and link to emerging primary care hubs)

SRO: Phil Mettam, CO, VoY CCG

IN HOSPITAL

Default of delays in care in acute setting

The work of this delivery group will be to:
- do today's work today



SRO: Wendy Scott, COO, YTHFT

INTERFACE

Default is home first

The work of this delivery group will be to:
- enable Home First at every opportunity for every patients
- Transform the joint dual assessment processes
- Home visits
- Define the at risk groups
- Trusted assessor framework
- Community bed state
- Single choice policy for the system
- Assistive technology
- Family communications

SRO: Sharon Houlden, Corporate Director for Health, Housing & Adult Social Care, CYC

We have collaborated to jointly manage placements and packages of care, and to commission a range of alternative resources to enable discharge to assess and to prevent admission. These include expanding reablement and voluntary sector services as well as the rapid response home care service for people who have tested positive for COVID-19, and Peppermill Court, short term residential care setting for people leaving hospital recovering from COVID-19. The latter is our designated alternative accommodation for people with residential care needs. We have worked with our providers to identify the potential for zoning and cohorting within care homes for COVID-19 positive admissions, however this is feasible in only a small number of homes.

We have a weekly finance working group between the CCG and council to support shared understanding of the funding streams and the relevant guidance, and to provide oversight and governance for the process of claiming against the COVID-19 grant. This forum has supported us to plan and monitor the reintroduction of CHC assessments and the implementation of the discharge guidance, to identify the staff resource required to manage the deferred assessments, and to enhance transparency across the system.

Enhanced health in care homes

NHS Vale of York CCG has confirmed that all care homes have been aligned to a PCN by 1 October 2020. The CCG members of the Team Around the Home has worked with care home providers to support home oximetry, and identified where there was a need for oximeters in our area.

PCNs have nominated a clinical lead and informed homes about this and the support available, including oximetry. PCNS are delivering the EHCH service requirements. Personalised care approaches are embedded through the work of the PCNs, with our well established social prescribing service supporting this, as well as other partnership work, such as health trainers and volunteer health champions.

Technology and digital support

As identified by the Social Care Taskforce, Recommendation 29, we have worked across our local system to enable remote consultations between care providers and GPs and primary care. Early in the pandemic IT equipment was distributed to homes for use in consultations and to enable families to maintain contact with their loved ones.

Technology and digital support - Social prescribing

Our Ways to Wellbeing social prescribing service, run by the York Centre for Voluntary Service and working with GP surgeries, has been embedded in primary care from its inception. With the welcome developments set out in the NHS LTP we have been able to expand and deepen this model. Ongoing support has been available during lockdown and afterwards to carers, and people with learning disabilities and autism through our Local Area Co-ordination, strengthened by the significant numbers of volunteers who came forward in York. All our teams have the capability to work remotely, and to offer ‘socially distanced’ support in the

community. The SPLWs have been central to the development of a Primary Care Hub for York. Our service has been so well received by local GPs that they submitted a case study to the national NHS project to capture examples of beneficial COVID-19 related innovations in working practice.

[See the two attached interim reviews of Ways to Wellbeing and York CVS APPENDIX 1 and 2].

Supporting people who receive social care, the workforce, and carers

Supporting independence and quality of life - Visiting guidance

We have a process in place, supported by advice from the Director of Public Health, for regularly reviewing the local risks relating to visiting care homes. These arrangements take account of the steps which will be required if York becomes an 'area of intervention'. The considerations are updated as new information becomes available, and guidance is communicated to providers and families of people living in care homes.

We have shared good practice examples among providers, for example in relation to people who are at the end of their life.

Direct Payments

We are aware that a number of the services which support people receiving Direct Payments in York, have changed or reduced the support available, due to the lockdown initially and later the requirement for social distance. Some of our day support services shifted to telephone contact and online sessions. We continued to make the Direct Payments to ensure services remained viable for the future. However, we are aware that during the winter, when it is harder for people to get out and about, we will need to ensure Direct Payment recipients or their nominees are supported to develop alternative uses for the money. We will reinforce the message that flexibility and innovation is encouraged, and we are on the process of engaging individuals to find out what would help them in their situations, such as new forms of support and respite for carers.

Support for unpaid carers

Information and advice for unpaid carers is available through our LiveWellYork website.

https://www.livewellyork.co.uk/s4s/WhereILive/Council?pageId=5223

We are working with York Carers' Centre, which has seen a significant increase in new contacts over the pandemic period. We will be investing BCF to develop additional support for carers during the winter 2020-21, following feedback from individuals and groups about the experiences so far and their concerns for the coming months as the second surge has been seen.

We are aware that services have been obliged to close during the pandemic, or have shifted to telephone and online support. Where possible these have been bolstered by the additional of volunteers making welfare calls. However, further work is required to maximise the support and respite available to carers.

Assessment and review processes have been ongoing throughout the pandemic-we have continued to conduct these virtually and in COVID-secure face to face visits where required. We have established mechanisms for carers and people in need of care to contact us should their circumstances change; and we have proactively contacted those people for whom we have assessed the pandemic to pose a significant risk.

End of Life Care

The CCG identified a GP to lead on Advance Care Planning with primary care, hospice and hospital colleagues to increase the number of conversations with people and resulting in a nearly nine fold increase in the number of ACPs in the community from 175 to 1704.

The CCG also commissioned extended end of life care by using the local adult hospice to provide end of life care in care homes and in people's own homes and this included bereavement support for any staff.

Care Act easements

City of York council has not implemented Care Act easements, and has no plans to do so at this stage, or during the winter.

As outlined earlier in this letter, we have strong arrangements in place to ensure the discharge to assess pathway is well managed between the CCG and council. We have a shared trajectory to manage the backlog of deferred assessments for CHC and long term care, and have prioritised those who need to move from a care setting to return to their own home with appropriate support.

Supporting the workforce – staff training

We use our regular bulletins to providers to raise awareness of the free induction training offer and encourage them to make use of it.

As set out earlier in this letter, since the start of the pandemic providers have received a regular provider bulletin summarising the latest guidance from DHSC, alongside any local implications.

Supporting the wellbeing of the workforce

The council has augmented a wide range of measures to support its staff through the pandemic, building on existing good employment practice. This has included daily emails through our staff communications channel 'Buzz', accompanied by emails from the Chief Executive to all staff, providing regular reminders of the support available, and tips for self-care and mutual support.

All our provider bulletins that go out include links to staff welfare resources as a standing items. Providers are offering a range of welfare support including the promotion of the resources in the bulletins. Examples include access to counselling, enhanced supervisions, support and advice programmes from 'head office'. Smaller providers are promoting open door ‘time to talk’ cultures, encouraging informal (virtual) mutual support networks. Areas of good practice include compassion fatigue training (which is receiving very positive feedback), mental health first aiders on site, a wellness adviser who will connect through zoom calls to staff members who are away from work, offering them strategies to maintain or rebuild their wellbeing.

Providers are paying staff while they are isolating, they are covering the cost of travelling to work by taxi, and some providers are over recruiting against their usual establishment or retaining bank teams.

We will use our communication with providers to check what arrangements they continue to have in place as we go into the winter, to ensure staff are well supported, including access to occupational health services where appropriate.

The CCG instigated a wide range of well-being support to staff and this included regular videos from executive and other staff, well-being conversations with each member of staff, regular team meetings, well-being resources, continuation of our Staff Engagement Group (SEG), funding for equipment to allow home working, risk assessments of all staff, development of action plan on the NHS People’s Plan and an occupational health offer which includes well-being support for staff and their families.

Workforce capacity

This is covered in earlier passages of this letter, relating to prevention and collaboration. As described, we have regular contact with providers and discuss minimum staffing levels, any mutual aid or support required and maximising the opportunity for the voluntary and community sector to contribute to individual wellbeing of residents.

Shielding and people who are clinically extremely vulnerable

We have a well-established network within the council covering the range of relevant roles for managing the reintroduction of shielding, should this be needed. We have attended meetings and webinars with the regional team, and have completed the surveys as requested. We have maintained our flexible approach to people needing support from volunteers, community hubs and neighbourhood groups.

There is currently no expectation that shielding will be reintroduced in York, but this situation will be monitored and responded to as required.

Social work and other professional leadership

We have an established strength-based framework for social work and occupational therapy practice in York-with a number of facets already in place pre-COVID (strength based paperwork, a model of community led support, strength based supervision, and

practice forums). We have continued to develop this framework during the pandemic, embedding 'Being Strength Based' as a key objective in our Recovery Plan. As part of this we have introduced a programme of strength based audit to ensure we have the appropriate governance oversight arrangements to continue to deliver high quality social work practice in the face of the pandemic.

Staff are aware of their duties under the Care Act, Mental Capacity Act, Mental Health Act and Human Rights Act, and our Principle Social Worker has been circulating regular updates in relation to how these duties should be met during the pandemic. Our staff advocate the principles of these Acts in all meetings with Health partners, and are cognisant of the need to promote the best possible outcomes for individuals and their families, both in individual case discussion and on the wider service development level (e.g., use of the ASC Ethical Framework when determining how we will operate the York Discharge to Assess process). We are in the process of embedding the ASC Ethical Framework into our Recovery transition plans for the next 12 months.

Working alongside our colleagues in Public Health we have identified that York has a higher than average proportion of shielding 70+yr olds and that our predominant risk factor in relation to Covid-19 is 'age'. We are working to support local community organizations and mutual aid groups who support our older population-particularly those who are reporting sustainability pressures. We operate Talking Points in York, which are a preventative asset-based offer, enabling quick and local access to social care advice and information. During lockdown, we moved Talking Points to a virtual offer, and we are now reopening physical Talking Points in areas of significant deprivation and/or where we have higher numbers of older people who my struggle to access a digital platform.

Our Head of Safeguarding and Safeguarding Adults Manager have closely monitored the safeguarding concerns being raised during the pandemic. They have ensured that we continue to operate a person-centred and outcomes focused approach to safeguarding, and have introduced a link worker system between key providers and specialist safeguarding workers, providing a 'critical friend' to regularly monitor and support with practice issues. We are also trialing use of a decision support tool for providers, so that they determine whether specific issues require referral to the local authority, enabling autonomy and supporting readiness for likely winter pressures.

Supporting the system

<u>Funding</u>

City of York Council has complied with the requirements of the Infection Control Fund, round 1, and we are in the process of delivering on the requirements for round 2, which coincide with the timing of this letter. We have devised a schedule for providing information returns to DHSC in line with the grant conditions.

Details of the council's financial support to the local social care market are published on the council website.

Care market sustainability

We have described the very regular contact between the council adults commissioning team and our care providers throughout this letter. We have well-established relationships with providers on an individual basis and with the Independent Care Group. We have completed the Care Market Sustainability self-assessment questionnaire, and have shared this with partners and the ICG, although timescales prevented us from co-producing the response.

We have promoted the financial support available through the IPC and are in ongoing discussions with the sector about other considerations, such as fees, practical support and advice, PPE and testing. The market in York has traditionally been buoyant with high levels of occupancy, and therefore may have greater financial resilience than some parts of the country. The council's financial position does not allow for significant additional financial aid to providers.

We are in the process of refreshing our Market Position Statement, which was put on hold due to the impact of the pandemic.

CQC emergency support

We have well-established relationships with local and regional officers of CQC, and work closely together, sharing information to ensure robust intelligence is available concerning individual providers or settings, and to support the mitigation of risks as they arise. We promote the role of CQC in monitoring services and supporting improvement.

Local, regional and national oversight and support

This letter confirms the action taken by City of York council to put in place a winter plan, in partnership with the NHS, local providers and the voluntary and community sector. A central part of our approach is the continuation of our care Home Support Plan, published in May and reviewed in preparation for winter. York has been recognised as an exemplar for providers' compliance with the Capacity Tracker.

We will now adapt our very regular bulletins to providers to include a weekly joint communication from the Director of Adult Social Services, Amanda Hatton, and the Director of Public Health, Sharon Stoltz.

Care home support plans

Care homes in York have successfully implemented infection prevention and control measures, as demonstrated by the very low infection rate in homes since the initial height of the pandemic. This is supported by the regular input from the CCG through the "Team around the home", who investigate cases with providers where required to identify any issues and share learning. We have been proactively testing all residents and staff since Mary 2020, including precautionary testing where individuals move to a new setting, or where an individual shows symptoms, and is isolating. Almost all cases detected have been individual staff members who are asymptomatic, and have not infected residents, which indicates effective use of the infection control measures, such as PPE and hygiene.

The Social Care Taskforce has recommended (R25) there should be a single dashboard which can be used by each region for the social care sector based on the national dashboard, and used to identify risk and support improvement. Our local arrangements would complement this, and we would be keen to understand the work being undertaken regionally to bring these together.

Conclusion

I hope you will find this to be a comprehensive response to your request. Please do not hesitate to contact me if there is anything you wish to discuss linked to this letter.

Yours sincerely

Ian Floyd
Chief Operating Officer
City of York Council

APPENDIX 1 and 2

APPENDIX 1

Three Month Social Prescribing Impact Report from York CVS

June 2020

1

*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

Introduction

A collaboration between York CVS and the newly formed Primary Care Network's in York began in January 2020. This collaboration was the first steps in ensuring that Social Prescribing was consistently available within Primary Care, as outlined in NHS Long Term Plan. This one year pilot has set out to explore how by working together with the voluntary sector we can improve wellbeing outcomes for patients registered with GP Practices in York. Our model of work reflects a holistic person centred approach to working with people, we have the time and opportunity to explore not what is the matter with people but what matters to them. The aim of Social Prescribing is to empower individuals to take more responsibility for their own health and wellbeing and to identify support networks within their community and to reduce the number of patients attending the GP's with non-medical conditions that may well have a social solution.

However, before this work was able to take off Covid-19 arrived. This report has been compiled to provide a snap shot of the work that has been carried out by the Social Prescribing teams during the three months March 2020 – June 2020, at the height of the Covid-19 Pandemic. When we went into lockdown York CVS offered a hotline number to all the PCN's that could go into their call menu. This number was staffed by the Social Prescribing Link Workers (SPLWs) and the team at York CVS and provided social and emotional and wellbeing support. We quickly became aware that a number of people were experiencing significant isolation and loneliness and began making weekly welfare calls, alongside a team of volunteers, to a number of patients across the City. We also made calls to lists of people who were coded as frail, shielding, Carers and patients living with a Dementia diagnosis.

In May York CVS was contacted by Andrew Lee at the CCG and asked to work alongside Nimbus Care Ltd. As part of the Covid-19 Monitoring Hub. This was set up to ensure that individuals who were symptomatic for Covid-19 were contacted on day 1, day 3 and then every day from day 7 to 14. This was identified as a need when it was recognised that on days 7 to 10 the symptoms of Covid-19 could worsen and it was necessary to ensure individuals had access to the medical support they needed.

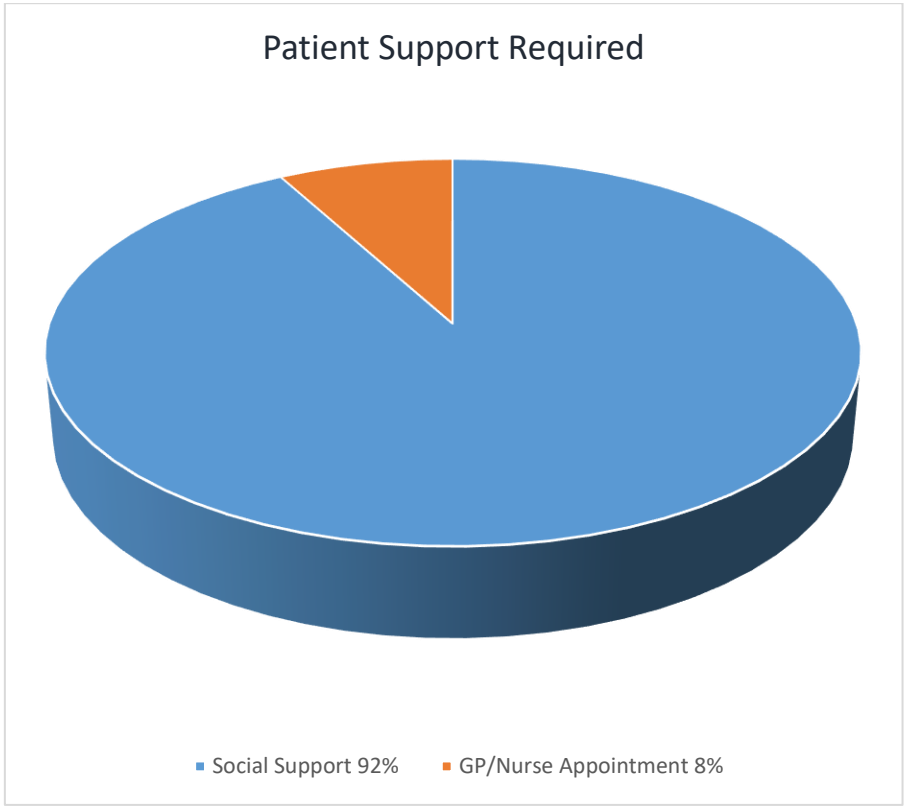
Moving forward: SPLWs are part of both the general practice and community response to Covid-19, working to ease some of the pressure on primary care. They are currently carrying their own caseloads, as well as supporting shielded and other vulnerable groups. It is predicted that the pandemic will have an impact on health and wellbeing beyond the immediate crisis, and the hope is that SPLWs will be integral to primary care's effective response. Alongside this SPLWs are well placed to contribute to addressing health inequalities which have been highlighted during the pandemic.

*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

What We Did

1,759 people supported

Saving Primary Care of £56,525



IMPACT

- Over the last 3 months we have supported 1,759 people
- Of the number of patients that were referred to the Social Prescribing team or contacted the Social Prescribing number only 8% required an appointment with a GP or Practice Nurse
- This equates to saving Primary Care £56,525*

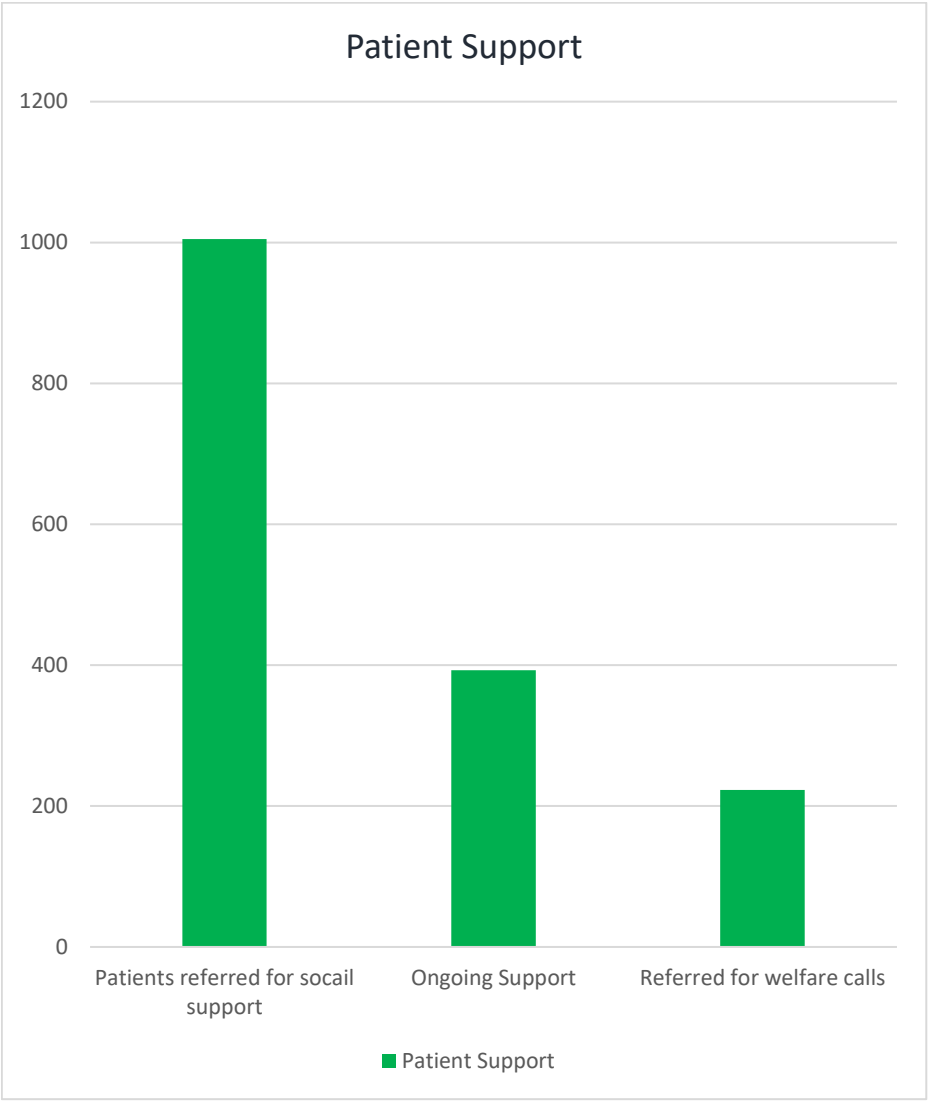
3

*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

- 1,005 PATIENTS REFERRED FOR SOCIAL SUPPORT
- 393 PATIENTS CONTINUE TO RECEIVE SUPPORT FROM THE LINK WORKER TEAM OR WELFARE CALLS
- 223 PATIENTS WERE REFERRED TO THE WELFARE CALL VOLUNTEERS
- 876 WELFARE CALLS MADE
- THIS EQUATES TO SAVING PRIMARY CARE £30,660

876 welfare calls made

Savings to Primary Care of £30,660



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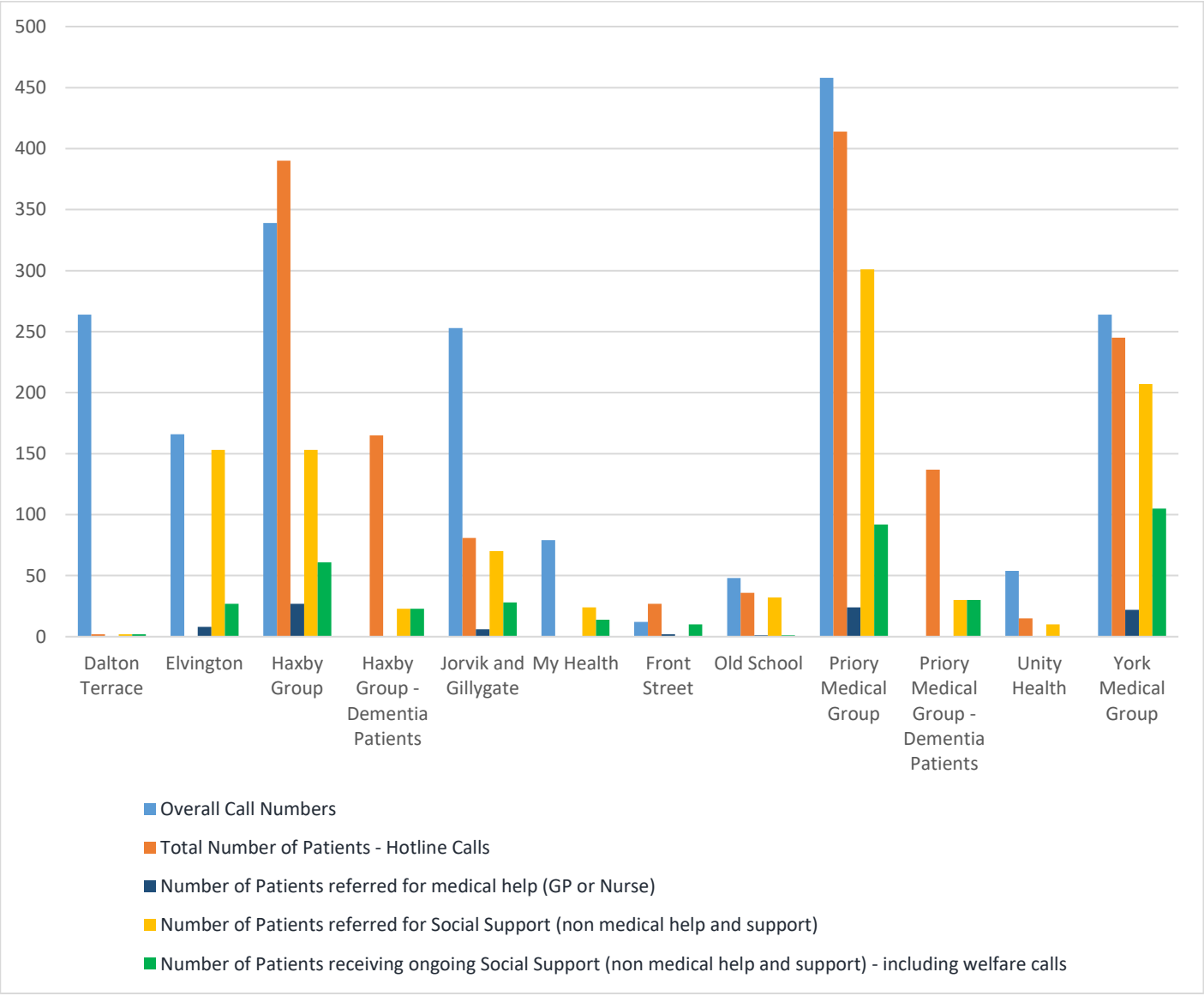
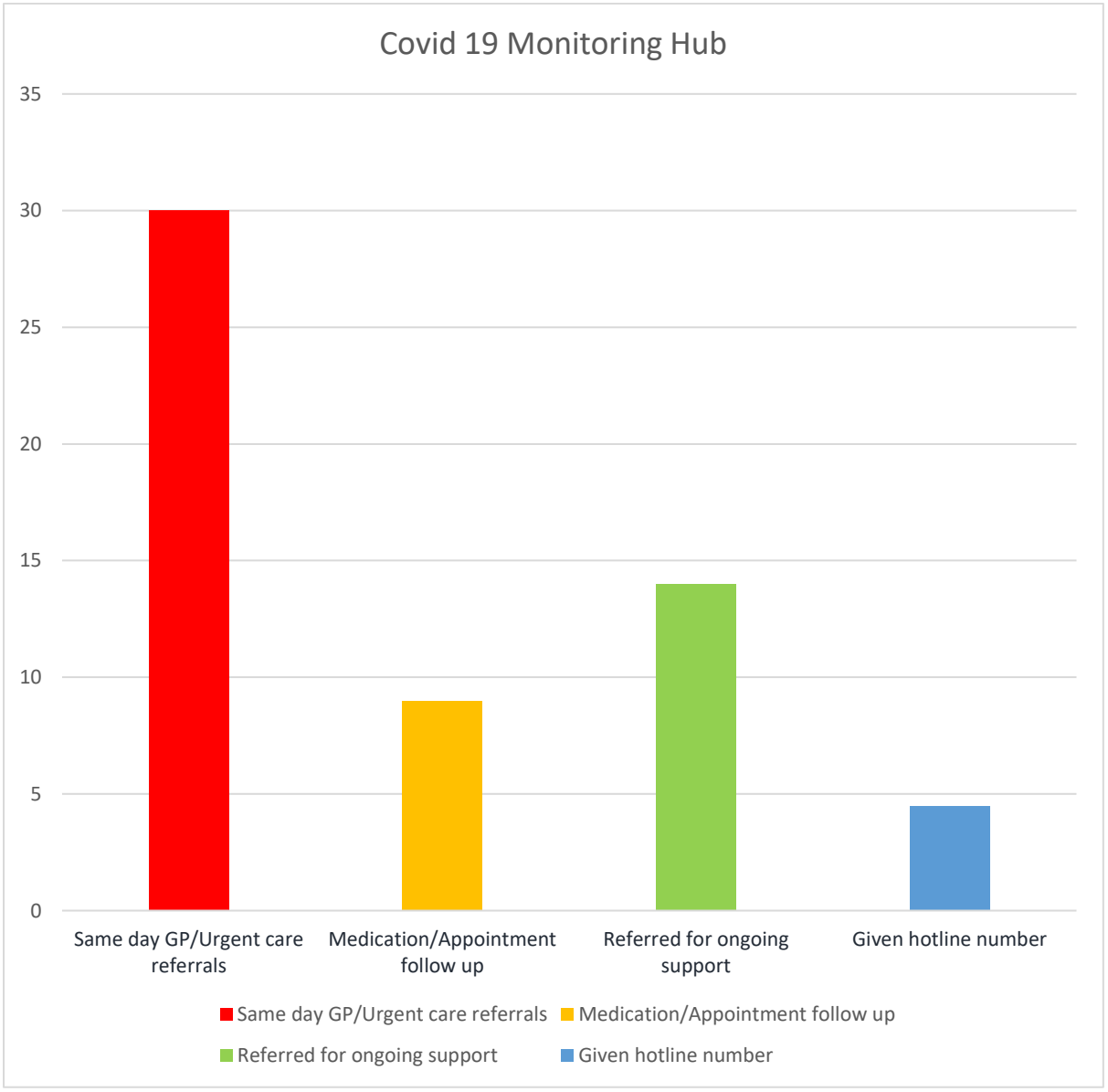
*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

The data below shows the impact the Social Prescribing team had within specific practices, the data provided includes all calls received, referrals received and proactive calls made to vulnerable and shielding patients.



- Supported a number of vulnerable individuals identified by their GP to successfully amend prescriptions and arrange delivery or collection of medicines.
- Provided support for people with learning difficulties to understand the importance of staying home and how to access support.
- Put plans in place for individuals living with Dementia to receive a daily welfare call.
- Supported individuals in crisis to access same day appointments with their GP and/or made referrals to Adult Social Care and the crisis team.
- Arranged patient transport for individuals who otherwise would not have been able to attend their appointments.
- Arranged for emergency food parcels to be delivered to those most in need, when this has been the only option. When there has been no other option we have delivered it ourselves!
- We have worked closely with staff in the surgeries to ensure that those individuals who need medical support have received it.

*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)



7th May 2020 - 30th June 2020

350 PATIENTS RECEIVED MONITORING CALLS

- 30 PATIENTS REQUIRED SAME DAY GP/URGENT CARE REFERRALS
- 9 PATIENTS REQUIRED MEDICATION/APPOINTMENT FOLLOW UP
- 14 PATIENTS WERE REFERRED TO RECEIVE ONGOING SUPPORT FROM THE LINK WORKER TEAM OR WELFARE CALLS
- 13 PATIENTS WERE GIVEN THE HOTLINE NUMBER FOR SUPPORT

350 patients called

*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

The Impact (stories)

We supported an Elderly lady who was living with her daughter and grandchildren. Her Daughter was hospitalised with Covid-19 which meant there was limited income coming into the house and this was impacting their ability to shop for food and other essentials. The lady was extremely distressed and unsure of her options for support. The Social Prescribing Link Worker initially ensured prescriptions and food were being delivered, then liaised with Adult Social Care, alerting them to the current situation. Adult Social Care are now monitoring the situation and carers are going in to the home. We will continue to make welfare calls to this lady and work alongside Adult Social Care.

An existing GP referral for a very isolated lady has meant that she has benefitted from our continued support over the phone instead of face to face appointments. She lives with her cat and, other than a member of our team, wasn't speaking to anyone else. Through rapid changes to the service we've been able to arrange for a volunteer to call her once a week for a social call. She said speaking to another human over the phone makes such a difference. A social prescriber talked to her about practical ways to manage her mental health at home. We searched online for community based alternatives and she has now started watching the National Theatre at Home plays online each week. Crucially, this is also enables her to chat with others who are online. We also explored ways to stay physically active at home and manage anxiety with online yoga. A referral to York Mind's adapted 1-1 emotional wellbeing support over the phone means she's getting more practical tips to manage her anxiety and mood. At the moment she's still picking up her prescriptions, but her anxiety meant she was very worried about what happened if she or her cat became unwell – now that a volunteer is checking in each week and she knows Move the Masses can bring out prescriptions and there are options for 'click and collect' food delivery her anxiety has lessened as she knows help is out there if she needs it.

IN SUMMARY

-THIS PIECE OF WORK IS A 12 MONTH PILOT; PART OF A BIGGER 5 YEAR CONTRACT IN -LINE WITH THE NHS LONG TERM PLAN.

-THIS IS THE FIRST ATTEMPT (SINCE STARTING THE PILOT IN FEBRUARY) TO QUANTIFY THE SOCIAL AND ECONOMIC VALUE OF SOCIAL PRESCRIBING IN PRIMARY CARE.

-THIS REPORT IS EVIDENCE OF THE YORK CVS RESPONSE TO COVID – 19. OUR NEXT STEP IS TO ENSURE THAT OUR SOCIAL PRESCRIBING OFFER IS FULLY ALIGNED WITH THE PLANS OF EACH PCN, MEETING THEIR NEEDS FOR THE FUTURE.

We appreciate and value your feedback please contact christinemarmion@yorckcvs.org.uk with any thoughts or feedback. Thank you.

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*Where the cost of each GP appointment is £35 (this does not take into account repeat appointments)

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APPENDIX 2

WHAT WE DID DURING THE COVID-19 LOCKDOWN MARCH – JUNE 2020

SEPTEMBER 2020

yorkcvs

Registered Charity (no. 225087)
Company Limited by Guarantee (no. 493550)

Contents

Introduction

On 30 January 2020 the COVID-19 outbreak was declared a Public Health Emergency of International Concern. In March, the UK government imposed a lockdown. All "non-essential" travel and contact with people outside one's home (including family and partners) was banned, shutting almost all schools, business, facilities, places of worship. People were told to keep apart in public. Those with symptoms, and their households, were told to self-isolate, while the most vulnerable (people in their 70s and people with certain illnesses) were told to shield themselves.

This report summarises the themes that emerged from the many conversations we had with local people we supported during this lock down.

Please note: *all names have been changed to preserve anonymity.*

Who's 'We'?

This report has been compiled to provide a snapshot of the work carried out by York CVS during three months, March to June 2020, at the height of the Covid-19 pandemic.

'We' refers to all York CVS staff working in collaboration throughout the period described. In normal times, those staff undertake a wide range of roles for York CVS across social prescribing projects Ways to Wellbeing and NHS Link Workers, Healthwatch York, Dementia Action Alliance and Safe Places. See appendix 1 for more information.

What did we do during Covid-19?

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

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

Staff and volunteers (supported and co-ordinated by the York CVS staff team) made weekly welfare calls to vulnerable people, to make sure they had food, medicines and any other essential help.

In May, the Vale of York Clinical Commissioning Group (VoYCCG) asked York CVS to run a Covid-19 Monitoring Hub. This was set up to make sure that individuals who were symptomatic for Covid-19 were contacted regularly. It was recognised that on days 7 to 10 the symptoms of Covid-19 could worsen, and VoYCCG wanted to make sure people had access to the medical support they needed.

Healthwatch York encouraged local York residents to share their Covid-19 experiences via an item in a City of York Council (CYC) leaflet that went to every household.

They also urged local employers to help protect their most vulnerable staff with an article in the York press - https://www.yorkpress.co.uk/news/18362063.coronavirus-vulnerable-put-risk-employers/

York CVS also published weekly updates for the Voluntary Sector within York, to help keep other organisations up to date with York's response to the pandemic. Sharing information and knowledge was key.

What we heard – in summary

This report covers the period from 23 March to 30 June 2020, so the statistics reflect this time period. This data does not include the support we gave through the COVID-19 Monitoring Hub.

During this time frame:

1759 people were supported through the GP Hot Line.

Out of the people supported, **92%** needed social support. Only **8%** needed a GP/Nurse appointment.

1,005 people referred for social support

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

876 Welfare calls were made, by the staff/volunteer welfare call team

The number of calls does not reflect the complex nature of many of the calls, and the high level of ongoing support and contact that some people needed.

Many of the calls that we received were questions about access to prescriptions and food, especially for shielding individuals who couldn't go out themselves, and for individuals who were struggling financially and were struggling to afford the necessities. York CVS staff took action to resolve peoples' problems and reduce anxiety.

Themes

Although every call was unique, clear themes emerged. Here, we explore those themes, with personal stories to illustrate them where possible. In these stories, all names have been changed, indicated by *.

Food and medicines

The Issue:

A large chunk of the calls that came through the hotline were about problems with accessing food and medicines. This also came up many times during the weekly welfare calls.

The reasons for people not being able to access food and medicines varied widely. Many of the callers were anxious about not having food and medicines.

Residents who were shielding weren't able to go into shops and chemists, or to GP practices and pharmacies to collect prescriptions. This meant a large number of people ran out of medicine, were afraid of running out of medicine and could not renew their prescriptions.

Digital exclusion was a significant barrier for many. Not being online or digitally confident meant that they were excluded from doing online food shops, online repeat prescription ordering and accessing online support groups (such as local Facebook support groups offering help).

We also spoke with many who were struggling financially. Some had been struggling before the lock down, and relied heavily on Food Banks and places like 'Pay as you feel cafes', that weren't open in their usual ways. Others had suffered financially due to Covid-19 which created serious problems and major anxiety for people and their families about accessing food and necessities.

How we worked to resolve this issue:

These issues were particularly challenging to deal with in the first few weeks of the pandemic and over bank holidays. Demand was high and there was widespread panic. Adequate help simply wasn't available at this point. As a result, York CVS staff delivered food and medicines to people who were really struggling, and had no other sources of help.

We worked collaboratively with Move the Masses, a charity that worked to deliver prescriptions to shielding people, or those who were self-isolating throughout the lock down. We sent many referrals through to Move the Masses, for their volunteers to deliver medicines, which was a very reliable service.

Once the CYC Food Hubs were established, we worked with them to get emergency food parcels to people and their families who were shielding, struggling to get to shops or who didn't have enough money for food.

Using the local food hubs meant that we could get food to people in need. We were able to depend on them in a way that was not possible with the Government food hubs.

Personal stories:

Michael was very unwell with Covid-19 symptoms and was unable to get food for his family due to feeling unwell and having to self-isolate. We provided support to the family and arranged for them to receive a food parcel. Michael told us that without our support he would have struggled to feed his family. He was very thankful.

Margaret is an older woman living alone. She registered with the Government scheme for food parcels and was hoping to get a priority slot for their online shop, but heard nothing back. She was already tearful and feeling anxious about Covid-19. We provided the number for Morrison's doorstep delivery in the interim while sorting them a food parcel. We then called back the following week for a chat and to make sure Margaret was doing ok.

Jacob's prescription was ready to be collected from their nominated pharmacy, but he was shielding. Jacob rang us as he was worried about how he would be able to collect it. We sent a referral to Move the Masses (MTM) and arranged for a volunteer to deliver the medication. Jacob was really happy with the help from both York CVS and the volunteers from MTM.

Access to routine care

Many of the calls we received highlighted the impact on individuals when routine care stops.

Dental Care

We received calls about the impact of lack of dental care due to dentists being closed. When people rang in need of urgent dental care, we signposted to NHS 111. Many people we spoke to found this process frustrating, confusing and not always resulting in appropriate care.

> *My COVID story is that from day 1 of the lockdown I have needed a tooth to be extracted, but all the dentist will do is give me more and more antibiotics. It aches and makes eating very difficult. All my food needs to be soft so that I don't need to chew anything. It gives me earache and the glands hurt. I'm not getting any information about when, if ever, I might be able to have the tooth extracted. I'm in my 70's.*

Further into lockdown, emergency dental hubs opened in York, but people found it very hard to access this service due to capacity and a lack of information about how to access. When people did manage to access the care from the hubs, they found them very efficient and helpful.

> *I contacted NHS 111 as I developed severe toothache and accessed care from a dental hub. I was quickly (less than 24 hours) diagnosed with an infection and antibiotics prescribed. I was very happy with the service provided.*

Toenail cutting

The closure of podiatry and nail cutting services in lockdown caused many issues for people who use these services. We received many calls from people who were in pain, struggling to walk and had balance problems. Their risk of falling increased. People were also anxious about when their next appointment would take place and were worried about other health conditions caused or worsened by their toe nails not being cut.

How we worked to resolve this issue:

We had a lot of communication with White Cross Podiatry Service (NHS) who were keeping in touch with their regular patients, checking in to see how they were managing. They were offering self-care packs, posting out equipment to patients and explaining how to use them over the phone. They were also offering emergency face to face appointments for patients who had broken skin, in-growing toenails or were in severe pain.

Some private podiatry services were offering face to face appointments for a fee. For people that called us who weren't struggling financially and were willing to pay for care, we signposted to these services.

Blood tests

We heard multiple examples of people getting confusing or incorrect information about blood tests. For example, getting sent to the wrong locations, not having the correct paperwork for the tests or not being in accessible locations (such as being suitable for people with mobility issues, and people with autism).

When people were given the correct information, the majority of people we spoke to found that Nuffield Hospital worked well as a location for blood tests.

Shielding and self-isolating

At the start of lockdown we heard from many people concerned about shielding, the most common worries being:

- needing to shield, but hadn't receiving a shielding letter
- receiving a shielding letter, but feeling they had no need to shield
- having to shield but then were not receiving any help with managing foods and medicines
- worries about what to do if one person in the household had to shield and the others didn't

We gave people classed as vulnerable and needing to shield the appropriate Government advice. We also arranged for people to speak to their GP's for medical advice when they had other concerns and confusions as to whether or not someone should be shielding. We also arranged for shielding letters to be sent to people who should have received one but hadn't.

Mental health and wellbeing

A large proportion of our calls were from people struggling to cope with poor mental health, often linked to being lonely and isolated in lockdown.

Many people were finding it very hard to manage high levels of anxiety. For example, people worried about catching the virus, and how life would be after lockdown. Many of these people had no previous experience of mental ill health before Covid-19.

We also heard from people with previous experience of mental health support, whose mental health was significantly deteriorating. They described the support networks and coping strategies they normally rely on being knocked due to services closing because of the pandemic.

We also had feedback from the Covid-19 Monitoring Hub highlighting an increasing number of people experiencing mental ill-health related to their experiences of contracting Covid-19.

How we supported people struggling with poor mental health

We offered weekly welfare calls to people who were struggling (most often this meant they were feeling lonely, anxious, depressed) and who would benefit from someone checking in on them.

We are particularly proud of our work here. Set up in rapid time shortly before lockdown started, our welfare call work was hugely successful in terms of uptake and efficacy.

- **223** people were referred to the welfare call volunteers

- **876** welfare calls made

We were able to keep an eye on those who seemed to be deteriorating (mentally and physically), or were otherwise giving cause for concern - offering extra support when needed, and also giving lots of practical support.

We signposted people to other organisations and charities; shared self-care tips, information on mindfulness and how to look after your wellbeing when stuck at home.

One Social Prescriber also set up a mindfulness group after lockdown began. The aim was to help people who were feeling lonely or anxious, and those interested in meditation. The group, called ‘Breathing Space’ is a weekly volunteer-led online mindfulness group. Members have a catch up, then are led through a meditation practice, followed by a further opportunity to talk and reflect. It has given the group members a safe space to chat and socialise, as well as an introduction to mindfulness and meditation. Several members of the group are hoping they might be able to meet up face to face one day soon.

Pat was a very isolated woman who was referred to us by her GP. Living alone with her cat, she spoke to nobody other than her York CVS welfare caller. As well as the support she got from the simple human contact of our weekly calls, we were also able to discuss practical ways to manage her mental health at home, introducing her to new coping techniques and resources. We searched online for community-based alternatives and she has now started watching the National Theatre at Home plays online each week. Crucially, this also enables her to chat with others who are online.

We also explored ways to stay physically active at home, and how to manage anxiety with online yoga. A referral to York Mind's adapted 1-1 emotional wellbeing support over the phone means she's getting more practical tips to manage her anxiety and mood.

Her anxiety caused her to be very worried about what would happen if she or her cat became unwell. Through our weekly calls, she was much reassured to discover that Move the Masses could deliver her prescriptions, and that she could order food delivery online.

She now has a whole suite of coping strategies to use, and a new online social community. Her anxiety has lessened because she knows help is out there if she needs it, and she knows how to get that help.

Dementia

We spoke to many people with dementia and to their families and carers, both via our hotline number and through the lists of vulnerable patients that GPs gave us. The loneliness and social isolation felt by many people with dementia has become even more apparent. There is also an understandable unease about returning to 'normal' life as lockdown restrictions slowly lift.

Concerns about loss of confidence, confusion about what 'rules' remain in place, and worries about loss of skills mean that many are even more fearful of the future.

Many people with dementia have seen a decline in their cognitive and physical health following lockdown. The loss of routine, and regular social interaction, has had a catastrophic effect on many, and those in relationships have experienced additional stresses from spending long periods of time together in the confines of their home without respite.

It is likely that York will follow national trends, in seeing a disproportionate amount of deaths of people living with dementia during COVID-19 - https://www.alzheimersresearchuk.org/fifth_deaths_covid_dementia/

Fred rang the GP hotline out of concern for Ellie, who was struggling with memory loss and confusion about lockdown rules to a worrying degree.

We found out that Ellie had been in the process of getting a dementia diagnosis, but due to the pandemic her appointments with the Memory Clinic had been cancelled.

We offered support to both Fred and Ellie. We made weekly welfare calls to them both, posted out information about dementia services in York, and arranged for weekly food parcels to be sent to Fred, who cooked meals for Ellie. We also organised a face to face GP appointment for Ellie, to rule out any medical issues potentially exacerbating her symptoms (such as a urinary tract infection).

Fred expressed deep thanks for our help, describing how reassured he felt now that he had somewhere to turn if needed.

Learning Difficulties

We took calls from a number of people with learning difficulties, both living alone and in supported accommodation. Many were shielding and lots felt very confused about the changes to their normal routines, sudden lack of support, activities and places to go.

We arranged food deliveries for many, made regular welfare calls and helped arrange practical support. We also sent craft packs to those who were struggling to occupy their days, and set up a letter-writing scheme using Healthwatch York's freepost address.

Carers

Many carers highlighted how the pandemic had cut them off from their usual sources of help and support. These could be formal, such as social care services and schools, or informal, through friends, family and peer networks.

We also heard multiple reports of people's mental health or behaviour deteriorating due to the impact of lockdown, increasing the challenges for the carers supporting them.

We spoke to many carers, sharing information and offering welfare call support where appropriate. We directed many to York Carers Centre, who were offering support online, over the phone and via Zoom.

Louisa is a parent of two: James, a teenager with autism and learning disabilities, and his sister Erin who has developmental issues. Louisa told us that the family normally feel well supported with informal support from family, the local community and James' school. For James, routine is very important, as is time outdoors. In lockdown, all of this stopped.

The direct impact of this was an escalation of challenging behaviours, especially when only able to leave the house once a day.

Both children became very anxious about leaving the house, and there was a lot of verbal abuse. Erin struggled a lot with the change in routine and James' worsening behaviours.

Louisa has mental health issues which are normally well managed with support from family and friends. However, once all this was removed she struggled to cope. She felt the children's schools provided little support at first, in terms of contact, school work or support. She felt they were just left to get on with it.

Eventually the family was referred to the school welfare worker who was very supportive and helped facilitate discussions to get James back into school part time.

Work and Money

During the first few weeks of lockdown, we heard from a large number of people worried about work. This included people (including key workers) who were unable or afraid to go to work for fear of putting a vulnerable loved-one at risk. We also heard from people who were self-employed, stressed and anxious about shielding, isolating, work and income. Some callers only needed information about how to access sick notes or get confirmation that they should be shielding.

The Government introduced Isolation Notes - a form of sick note for people with Covid-19 symptoms and who were isolating. GP's didn't need to sign off Isolation Notes, thus reducing pressure on surgeries struggling with the high number of people calling. We were able to complete Isolation Notes for people who were unable to access them online.

It became apparent that some employers were failing to fully understand their employees' circumstances, and the impact of shielding. This was resulting in workers having to decide between protecting their health (or the health of their families), or having an income.

Financial difficulties were a predominant issue throughout the pandemic. The food parcels were vital in helping people and families who were struggling (especially those who relied on free school meals).

One of the most frequent interventions we carried out was helping those struggling to afford or get hold of food. We referred a significant number of people to York Food Bank, local Pay as You Feel (PAYF) Cafes such as Planet Food, local mutual aid initiatives such as The Supper Collective, plus CYC food hubs.

Betty phoned us seeking financial help. She explained that she was retired and on a half pension, and had no food. Betty depended on her local weekly PAYF café and was struggling without it. We helped Betty speak to Citizens Advice York, who secured her more financial support. We signed Betty up for regular food parcels, and gave her information about Morison's Doorstop Delivery service, who could help her with any other necessities. We rang Betty weekly and she was very thankful for this support.

Technology

We supported a huge number of people to set up online prescription ordering, and provided information about how to register for online food delivery.

There was also much confusion about (and help needed to use) the NHS app for ordering prescriptions, choosing a nominated pharmacy, and making GP appointments.

We also sent lots of information by post (for example details of food delivery services). We did this as we didn't want digital exclusion to impact people's knowledge and to affect those needing to access services.

Technology came up as an issue for children and families in lockdown, especially those who were home schooling, as so much of this was expected to be done online. This put huge pressure on those families who couldn't afford the equipment or Wi-Fi, or had multiple children all needing to do school work.

Transport

We dealt with many calls from people unable to find transport to and from appointments. There seemed to be an assumption amongst health and care providers that everyone can travel easily.

People were unable to access transport for many reasons, such as shielding, not being able to access public transport, facing financial barriers and not being able to mix households.

We worked closely with Dial-A-Ride, who provided an excellent, reliable service. We could refer and arrange transport for people who needed to get to appointments. They used their mini-bus which meant that social distancing measures could apply for those that were shielding, and it meant that people who were struggling financially didn't have to worry about affording a taxi.

Peter had learning difficulties, was confused by the lockdown and needed transport for an urgent GP appointment. We worked with the surgery to change the time of the appointment so that Dial-a-Ride could do the pick-up and safely get Peter to and from his appointment. Peter was really happy with this service and felt reassured.

Complex situations which included many of the themes above

We heard from many people whose situation involved several of the themes above. There were particular challenges in living through the pandemic for people whose situations involved:

- Homelessness or rough sleeping
- Insecure and inadequate housing conditions
- Domestic violence and abusive households
- Being a single parent and juggling working from home and childcare
- Regular drug or alcohol misuse
- Safeguarding issues
- The sudden lack of care for those with Learning Difficulties
- Pre-existing health conditions
- Previous regular access to respite care

There was also a lack of guidance for agencies trying to support individuals. For example, it is dangerous for someone who drinks every day to stop drinking suddenly without support, but there was little information available about what support could be offered to someone who is reliant on alcohol.

We signposted people to the relevant services, in addition to providing telephone and practical support.

Reflection

Alison Semmence
Chief Executive, York CVS

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

Christine Marmion-Lennon
Social Prescribing Manager, Ways to Wellbeing

It is hard to summarise our response to Covid-19. From ensuring the delivery of food and prescriptions at the height of the Pandemic, delivering cards made by young people in the youth justice system to reduce feelings of isolation, to supporting those with the most complex and enduring health conditions to access the support they needed and everything in between. All done as a collaboration between the social prescribing team, Primary Care, Healthwatch York and fantastic local volunteers. By working together we were able to co-ordinate a joined up response to provide care and support to those who needed it most.

Sian Balsom
Healthwatch York Manager

Everyone pulled together to make sure no-one was left alone and in need, whether on the front line or behind the scenes. I could not be prouder of my team and my colleagues both in and outside York CVS.

Conclusion

York is a city where the relative affluence of the majority of its population masks the challenges faced by those with less. For us, supporting people during lockdown brought the ongoing issues faced by people with less advantage into sharp focus.

We are proud of many elements of our response to the pandemic:

- The speed of our response in the early stages
- How well staff worked together, adapting to rapidly changing circumstances with flexibility, initiative and drive
- The large number of people we supported across the city
- Our ability to swiftly identify gaps in provision and those in most need
- Our volunteers; the support they provided and the way we were able to support them
- Of how we were able to work in collaboration with the VCSE sector, pull together and put people in York at the heart of our response
- Our recognition of the risk of harm to people when intense support suddenly stops, and the measures we put in place to make sure nobody was left without support (for example, continued support from Social Prescribing Link Workers)

Next steps

We have learned a great deal from this experience and have had a rolling conversation to explore how the VCSE sector and CYC can work even better together, in the event of a second wave.

To this end, York CVS has organised and is hosting an online planning meeting at the end of September 2020. This event will bring the local VCSE sector together to discuss planning for a possible second wave and lockdown due to COVID-19. During the meeting we will explore any gaps in provision experienced during the first lockdown, what support organisations can offer if we go into a second lockdown, the sustainability or transition arrangements as we revert to ‘business as usual’ and messaging for volunteers in order to manage expectations.

Appendices

Appendix 1 – Glossary of abbreviations

CAY	Citizens Advice York
CYC	City of York Council
MTM	Move the Masses
VoYCCG	NHS Vale of York Clinical Commissioning Group
VCSE sector	Voluntary, Community and Social Enterprise sector

Appendix 2 – Organisation that are within York CVS and worked together throughout the pandemic

HWY provide information about local health and social care services. They also listen to your views and experiences about these services to make sure voices are heard and taken into account. They want to know what is working well and what is not working well. HWY can also signpost you to independent complaints advocacy if you need support to complain about a service.

Ways to Wellbeing is made up of a team of Social Prescribers. Social Prescribing aims to improve wellbeing by connecting people to activities, services and support networks in their community. We support individuals to identify what is important to them and work together to achieve the individual's goals.

Primary Care Link Workers are based in GP Surgeries across York. Often individuals access their GP for what is primarily a social issue; such as loneliness, isolation or financial problems. Social Prescribing provides an alternative to a medical intervention. The Primary Care Link Workers are well placed to address the root course of these difficulties and work together improve an individual's health and wellbeing.

DAA
York Dementia Action Alliance

York Dementia Action Alliance is a group of around 60 businesses and organisations for the public, private and voluntary sector who are committed to making York a better place to live, work and visit for people affected by dementia. YDAA is coming to an end in September 2020.

Safe Places are located in buildings in York, like libraries, shops, cafes and museums that are open to the public and are accessible. They have agreed to provide a safe and supportive place if someone who is vulnerable needs to ask for help while out and about.

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