Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Runciman (Chair), Brooks, Cannon and Craghill

Sharon Stoltz	Director of Public Health, City of York Council
Martin Farran	Director of Adult Social Care, City of York Council
Jon Stonehouse	Director of Children's Services, Education and Skills, City of York Council
Patrick Crowley	Chief Executive, York Teaching Hospital NHS Foundation Trust
Colin Martin	Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust
Dr Mark Hayes	Chief Clinical Officer, NHS Vale of York Clinical Commissioning Group (CCG)
Rachel Potts	Chief Operating Officer, NHS Vale of York Clinical Commissioning Group (CCG)
Sarah Armstrong	Chief Executive York CVS
Julie Warren	Locality Director (North) NHS England
Tim Madgwick	Acting Chief Constable, North Yorkshire Police
Mike Padgham	Chair of Independent Care Group
Siân Balsom	Manager, Healthwatch York

Date: Wednesday, 20 July 2016

Time: 4.30 pm

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

A G E N D A

1. Introductions

2. Declarations of Interest (Pages 3 - 4)

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. A list of general personal interests previously declared is attached.

3. Minutes (Pages 5 - 14)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 18 May 2016.

4. Public Participation

It is at this point in the meeting that members of the public who have registered their wish to speak can do so. The deadline for registering is by **Tuesday 19 July 2016** at **5.00 pm**

To register please contact the Democracy Officer for the meeting, on the details at the foot of this agenda.

Filming, Recording or Webcasting Meetings

Please note this meeting will be filmed and webcast and that includes any registered public speakers, who have given their permission. This broadcast can be viewed at http://www.york.gov.uk/webcasts.

Residents are welcome to photograph, film or record Councillors and Officers at all meetings open to the press and public. This includes the use of social media reporting, i.e. tweeting. Anyone wishing to film, record or take photos at any public meeting should contact the Democracy Officer (whose contact details are at the foot of this agenda) in advance of the meeting.

The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at: https://www.york.gov.uk/downloads/file/6453/protocol_for_webcasting_filming_and_recording_council_meetingspdf

GOVERNANCE

5. **Appointments to York's Health and Wellbeing Board** (Pages 15 - 18)
This report asks the Board to confirm a number of appointments to its membership. It also asks them to appoint a Vice Chair for the Committee.

THEMED MEETING-OLDER PEOPLE

6. **Presentation from the Independent Care Group- Social Care in 2016** (Pages 19 - 44)
This report asks Health and Wellbeing Board Members to receive a presentation from the Chair of the Independent Care Group (ICG) about Social Care in 2016.

7. **Older People's Survey** (Pages 45 - 52)
This report asks the Board to consider revising and repeating the older people's survey that was last held in 2008. They are asked to consider whether there is value in repeating this survey and whether there are any specific themes they would wish to be included should a new survey be undertaken.

8. **Update on Service Delivery for Dementia Care in York and Selby** (Pages 53 - 60)
This report updates the Health and Wellbeing Board on service delivery for Dementia/Cognitive Impairment in York.

CORE BUSINESS

9. **Annual Report-Safeguarding Adults Board**
(Pages 61 - 146)
This report provides information on the work of the Safeguarding Adults Board over the course of 2015/16. Kevin McAleese CBE, the Independent Chair of the Safeguarding Adults Board will be in attendance at the meeting to present the report.

10. **Monitoring and Managing Performance** (Pages 147 - 156)
This report sets out some thoughts in relation to strengthening performance management to improve outcomes and the effectiveness of the health and social care system.

11. **Sustainability and Transformation Plans** (Pages 157 - 174)
This report is to update the Board on the latest arrangements for the development of Sustainability and Transformation Plans in the NHS for the Vale of York area.

12. **Healthwatch York Report- Access to GP Services** (Pages 175 - 258)
This report asks Board Members to receive a new report from Healthwatch York entitled 'Access to GP Services'.

13. **Progress in York with implementation of the Care Act 2014** (Pages 259 - 266)
This report aims to update the Health and Wellbeing Board on York's implementation of the Care Act 2014 it describes areas where progress is being made as well as areas where further work is required. It also notes the principal changes that have occurred nationally since April 2015.

14. **Better Care Fund Submission 2016/17** (Pages 267 - 274)
The purpose of the report is to update the Health and Wellbeing Board (HWBB) on progress to finalise a submission for the Better Care Fund (BCF) in 2016/17 and beyond.

15. **Forward Plan** (Pages 275 - 276)
To consider the Board's Forward Plan.

16. **Urgent Business**
Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Name- Judith Betts
Telephone No. – 01904 551078
E-mail- judith.betts@york.gov.uk

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

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

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

☎ **(01904) 551550**

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Agenda Annex

Extract from the
Terms of Reference of the Health and Wellbeing Board

Remit

York Health and Wellbeing Board will:

- Provide joint leadership across the city to create a more effective and efficient health and wellbeing system through integrated working and joint commissioning;
- Take responsibility for the quality of all commissioning arrangements;
- Work effectively with and through partnership bodies, with clear lines of accountability and communication;
- Share expertise and intelligence and use this synergy to provide creative solutions to complex issues;
- Agree the strategic health and wellbeing priorities for the city, as a Board and with NHS Vale of York Clinical Commissioning Group, respecting the fact that this Group covers a wider geographic area;
- Collaborate as appropriate with the Health and Wellbeing Boards for North Yorkshire and the East Riding;
- Make a positive difference, improving the outcomes for all our communities and those who use our services.

York Health and Wellbeing Board will not:

- Manage work programmes or oversee specific pieces of work – acknowledging that operational management needs to be given the freedom to manage.
- Be focused on the delivery of specific health and wellbeing services – the Board will concentrate on the “big picture”.
- Scrutinise the detailed performance of services or working groups – respecting the distinct role of the Health Overview and Scrutiny Committee.
- Take responsibility for the outputs and outcomes of specific services – these are best monitored at the level of the specific organisations responsible for them.
- Be the main vehicle for patient voice – this will be the responsibility of Health Watch. The Board will however regularly listen to and respect the views of residents, both individuals and communities.

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Agenda Item 2

Health & Wellbeing Board
Declarations of Interest

Patrick Crowley, Chief Executive of York Hospital
None to declare

Rachel Potts, Chief Operating Officer, Vale of York Clinical Commissioning Group)
None to declare

Dr Mark Hayes, Chief Clinical Officer, Vale of York Clinical Commissioning Group
None to declare

Mike Padgham, Chair Council of Independent Care Group

- Managing Director of St Cecilia's Care Services Ltd.
- Chair of Independent Care Group
- Chair of United Kingdom Home Care Association
- Commercial Director of Spirit Care Ltd.
- Director of Care Comm LLP

Siân Balsom, Manager Healthwatch York

- Chair of Scarborough and Ryedale Carer's Resource
- Shareholder in the Golden Ball Community Co-operative Pub

Councillor Douglas

- Member of Mental Health and Learning Disabilities Partnership Board
- Governor of Leeds and York Partnership NHS Foundation Trust
- Governor of Tees, Esk and Wear Valleys NHS Foundation Trust

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City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	18 May 2016
	Councillors Runciman (Chair), Brooks, and Looker (Substitute for Councillor Cannon) Marion Gibbon (Assistant Director, Consultant in Public Health, City of York Council) (Substitute for Sharon Stoltz) Jon Stonehouse, (Director of Children's Services, Education and Skills, City of York Council) Sarah Armstrong (Chief Executive, York CVS) Siân Balsom (Manager, Healthwatch York), Michael Melvin (Assistant Director, Adult Social Care, City of York Council) (Substitute for Martin Farran), Ruth Hill (Director of Operations, York and Selby, Tees, Esk and Wear Valleys NHS Foundation Trust) (Substitute for Colin Martin), Michelle Carrington (Chief Nurse, NHS Vale of York Clinical Commissioning Group) (Substitute for Mark Hayes), Keren Wilson (Chief Executive, Independent Care Group (Substitute for Mike Padgham), Richard Anderson (Superintendent, North Yorkshire Police) (Substitute for Tim Madgwick)
Apologies	Councillor Cannon, Sharon Stoltz, Patrick Crowley, Rachel Potts, Colin Martin, Mike Padgham, Mark Hayes, Martin Farran and

67. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests, that they had in relation to the business on the agenda.

No other interests were declared.

68. Minutes

Resolved: That the minutes of the Health and Wellbeing Board held on 20 April 2016 be approved as a correct record and then signed by the Chair.

69. Public Participation

It was reported that there had been one registration to speak at the meeting under the Council's Public Participation Scheme.

John Yates shared comments with the Board on Agenda Item 8 (Alcohol Strategy). He felt that the document was not clear enough to be understood by those who had a problem with alcohol and because it was, in his opinion, poorly expressed, it could impact detrimentally impact on the main objectives of the strategy. He added that the language used in general public consultation documents had not been clear enough and asked that this be reviewed.

70. Appointment to York's Health and Wellbeing Board

The Board received a report which asked them to confirm a new appointment to its membership.

That;

- Helen Hirst, Interim Accountable Officer, NHS Vale of York Clinical Commissioning Group (CCG) be appointed as a second substitute for Dr Mark Hayes, Chief Clinical Officer, NHS Vale of York CCG.

Reason: In order to make this appointment to the Board.

71. Sustainability and Transformation Plans

Board Members received a report which updated them on the latest arrangements for the development of Sustainability and Transformation Plans (STP) in the NHS for the Vale of York area.

It was reported that it had been confirmed that York would be part of a large overarching Humber, Coast and Vale STP footprint based on patient flow. It would also be part of a mini York and Scarborough STP.

An event held for stakeholders about STPs had been attended by some Board Members. Some conclusions from this event were reported as being;

- The Integration and Transformation Board (ITB) would be based on the local footprint.
- The regional STP did not yet seem to make a priority of children and young people.
- Communicating in plain English would be challenging
- Co-production of STPs was key

It was felt that there had been no opportunity to debate the footprint itself. In addition, the paperwork regarding STPs was not publicly available and so those who wished to communicate were disadvantaged. Some Board Members asked whether the new STP was looking for savings and asking for people to travel out of area for treatment. It was reported that the idea behind the STP was transformation, providing better healthcare, and not savings.

The Chair requested that the Board receive a brief update on STPs at a future meeting.

Resolved: (i) That the report be noted.

(ii) That an update report on STPs be received at a future meeting.

Reason: To keep the Health and Wellbeing Board informed of progress against the development of STPs.

72. Verbal Update on Better Care Fund

The Board received a verbal update on the Better Care Fund (BCF). Financial information on the CCG and CYC led schemes within the Better Care Fund was circulated at the meeting amongst Board Members.

Officers informed the Board that following the previous meeting held to consider the BCF they had continued to engage and explore arbitration with a number of agencies including NHS England, the Local Government Association, the Social Care Institute for Excellence (SCIE) and Association for Directors of Adult Social Services (ADASS). Discussions continued over full scale system transformation, but issues still to be resolved included a single commissioning strategy and streamlined governance. It was noted that the new deadline for the BCF was 3 June and that if not reached then external intervention could be brought in and a decision over the spending plan could be handed to an independent expert, or alternatively funding could be withdrawn for a period.

The Board were advised of continuing issues, such as the underperformance of last year's plan and the financial consequences of this which had directly impacted the Hospital and the CCG. It was reported that the CCG wished to see 1/3 of the plan monies spent on dealing with this underperformance, but this would mean consequential reductions in spending in other areas. However, if a particular scheme had been identified which could generate an equivalent return on the investment put in, then the Board were informed that the CCG may decide to make money available for this scheme.

The ambition of the plan was to look at health and adult social care services in York overall, but certain areas in which there needed to be a system focused approach had been specifically identified such as Continuing Health Care, Reablement, Early Discharges, and Equipment Hire.

Progress on whether an agreement between the Council and CCG was likely to be reached by the deadline was discussed.

Officers reported that current negotiations suggested that there was a determination to reach an agreement. In terms of lessons learnt for the future, it was felt that there ought to be greater involvement of local people at an earlier stage.
Further discussion took place during which the following comments were made;

- The BCF was originally conceived to protect adult social care, but was premised on generating efficiencies.
- The only way forward for health and adult social care was integration and transformation

It was acknowledged by Officers that consultations that had taken place could be revisited and the demand encountered was due to the way that the system was designed. It was also noted that the CCG was examining long term schemes.

Resolved: (i) That the verbal update be noted.

(ii) That a further update be received in July.

Reason: To ensure that the Board are kept aware of the progress of the Better Care Fund.

73. Alcohol Strategy

Board Members considered a report which asked them to agree approve a draft alcohol strategy for public consultation.

Officers advised the Board that the consultation questions would be published on the Council website, to accompany the strategy once approved. In that regard, the comments of the public speaker would be taken on board. To help wider understanding, consideration would be given to an Easy Read summary being produced.

A full discussion ensued on various factors including;

- The only data that was available to show if people were drinking alcohol responsibly was self reported data.
- It would be helpful to include information about empty calories in alcohol in the consultation questions.

- There was a necessity to make sure that appropriate relationships were in place with the Safer York Partnership Board.
- There were measurable aspects such as alcohol related crime and A & E attendance as well as awareness programmes, which could show whether the strategy had made an impact on individual choices.
- The Police welcomed the link with the strategy and the link with the Safer York Partnership but felt that the measures needed to be more robust.
- As Children and Young People commented they felt alcohol made York a less safe place to be, they needed to be consulted as part of the strategy.
- The strategy did not look at the licensing or economic aspects of alcohol such as minimum pricing.
- That alcohol had a significant impact on all types of health intervention.

The following Options were considered by Board Members:

Option 1: Agree that the draft alcohol strategy (Annex A) can go forward to public consultation using the proposed or slightly amended consultation questions (Annex B) and that the final sign-off of the strategy following any amendments post-consultation is delegated to the Chair of the Health & Wellbeing Board.

Option 2: Agree that the draft alcohol strategy (Annex A) can go forward to public consultation using the proposed or slightly amended consultation questions (Annex B) and that the final sign-off of the strategy following any amendments post-consultation is returned to the Health & Wellbeing Board for ratification.

Option 3: Delay public consultation pending further amendments to the draft strategy or consultation process.

In light of their comments, Board Members wished to reconsider the draft Strategy for ratification at a future meeting.

Resolved: That Option 2 be approved- to return the draft strategy for final ratification to the Health and Wellbeing Board following amendments post consultation.

Reason: This will allow for further work to be undertaken to develop the draft local strategy to provide clear direction and focus to reduce local alcohol harm ahead of the public consultation and allow the strategy to be reviewed by the Health and Wellbeing Board before its ratification.

74. Update on the York, Easingwold and Selby Integration and Transformation Board

The Board received a report which provided them with information on the York, Easingwold and Selby Integration and Transformation Board (YESITB).

It was noted that discussions were ongoing as to how the YESITB linked with the geographical STP footprint. Board Members were also told that the Terms of Reference for the YESITB were different from other partnership boards in that they referred to the expectations of the attendees.

Discussion took place around the recommendations of the report. It was suggested in order to better involve patients, service users and citizens in the formulations of YESITB's Plans, there needed to be single points of engagement and shared communication. It was suggested that collective communication be adopted. There also needed to be reports of how people would help deliver the health system needed, as sometimes by treating people for one matter hospitals left people with other long term health conditions, such as mobility problems.

It was felt that the main risks that the YESITB needed to consider whilst developing its plans were financial, in that proposals needed to be evaluated properly before funding was allocated. In addition, with the STP footprint being wider than just the Vale of York area, partnership work could inevitably be territorial. They also felt there needed to be a workforce strategy to shape and breakdown professional boundaries.

Resolved: (i) That the report be noted.

(ii) That a quarterly report be received on the work of the YESITB at future Health and Wellbeing Board meetings.

(iii) That the YESITB Terms of Reference and proposed governance and reporting arrangements be agreed.

(iv) That when YESITB involve patients, service users and citizens in the formulations of its Plans collective communication be adopted.

Reason: To keep the Health and Wellbeing Board up to date with the progress made by the recently established YESITB.

75. Building The Right Support Across York and North Yorkshire

Board Members received a report which informed them of the Building the Right Support (BTRS) agenda.

The Board were informed that the Building the Right Support Plan had be signed off by the Board and submitted to NHS England (NHSE) by 24 June.

The Board raised the following points on the report;

- The plan was not without risk and the health and social care market needed to be ready. As a consequence, the NHS may find more beds blocked with people who should not be there.
- That it was not always the cheapest option to have people with complex needs cared for in the community.
- Parents were worried about the wellbeing of children, as they themselves were getting older. There were particular concerns around the transitions from one age group to another.
- If case studies were shown about the closure of inpatient provision this would provide a positive opportunity to explain what action had been taken.

It was understood that there were plans to use the STP footprint for specialist services.

Board Members were encouraged to share the Building Right Support Across York and North Yorkshire Draft Plan and provide feedback.

Resolved: (i) That the plan's visionary principles, underlying ethos and main objectives be supported.

(ii) That the associated challenges and risks associated with BTRS delivery.

(iii) That NHSE's requirement for the Transforming Care Partnership's plan to be approved (via local governance arrangements) and finalised by 24 June be noted.

(iv) That the Chair of HWBB and the Chair of the Mental Health and Learning Disabilities Partnership Board be nominated to approve the plan outside of the formal HWBB schedule- the final plan to achieve the NHSE 24 June deadline.

Reason: To meet the NHS England guidelines in relation to the Building the Right Support Programme.

76. Forward Plan

Board Members were asked to consider the Board's Forward Plan.

The Chair reported that as part of Health and Wellbeing Board's governance review she would be meeting a number of non Executive Directors these were;

- Keith Ramsay, Lay Chair Vale of York CCG
- Sue Symington, Chair of York Teaching NHS Foundation Trust
- Lesley Bessant, Chair Tees, Esk and Wear Valleys NHS Foundation Trust

Resolved: That the Forward Plan be approved subject to the following amendments;

- An update report on STPs
- A further update on the BCF

- An update on the draft alcohol strategy

Reason: To ensure that the Board have a planned programme of work in place.

Councillor C Runciman, Chair
[The meeting started at 4.30 pm and finished at 6.45 pm].

Health and Wellbeing Board **20 July 2016**

Report of the Assistant Director, Governance and ICT

Appointments to York's Health and Wellbeing Board

Summary

1. This report asks the Board to confirm a number of appointments to its membership. It also asks them to appoint a Vice Chair for the Committee.

Background

2. The Council makes appointments at its Annual Meeting, to Committees for the coming year. However, the Health and Wellbeing Board is able to appoint its membership separate of Full Council. Therefore, the following appointments have been put forward for the Board's approval:

Vice Chair of Health and Wellbeing Board

- To note the appointment of Keith Ramsay, lay Chair of NHS Vale of York Clinical Commissioning Group as both a Board Member and to appoint Mr Ramsay as Vice Chair.

Substitutes

- To appoint Sheenagh Powell, Lay Member and Audit Committee Chair of NHS Vale of York Clinical Commissioning Group (CCG) as a first substitute for Keith Ramsay
- To appoint David Booker, Lay Member and Chair of the Quality and Finance Committee of NHS Vale of York Clinical Commissioning Group (CCG) as a second substitute for Keith Ramsay.
- To appoint Brian Coupe, Head of Service, Mental Health Services for Older People (York and Selby), Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust as a second substitute for Colin Martin,Chief Executive, Tees, Esk and Wear Valleys, NHS Foundation Trust.

3. All of these appointments have been brought to the Health and Wellbeing Board to allow for their confirmation.

4. As the appointment of the Vice Chair for the Health and Wellbeing Board will always be the lay Chair of NHS Vale of York Clinical Commissioning Group (CCG) and as this is an addition to the Board's current membership, this report also seeks approval from Full Council to agree to this change and appointment.

Consultation

5. Normal processes to consult the organisations have been applied to ensure that they nominate the candidates of their choice.

Options

6. There are no alternative options available to the Board as this is simply for the organisations concerned to nominate appropriate candidates concerned

Council Plan 2015-19

7. Maintaining an appropriate decision making structure, together with appropriate nominees to that, contribute to the Council delivering its core priorities set out in the current Council Plan, effectively. In particular, these appointments to the Health and Wellbeing Board ensure that partnership working is central to the Council working for the benefit to improve the overall wellbeing of the city.

Implications

8. There are no known implications in relation to the following in terms of dealing with the specific matters before Board Members:

- Financial
- Human Resources (HR)
- Equalities
- Crime and Disorder
- Property
- Other

Legal Implications

9. Statutorily the CCG is responsible for appointing members to represent it on the Board. The Board's terms of reference make provision for substitutes. In the case of the CCG that is particularly important since the Board's quorum of seven must include at least one representative of the CCG. The appointment of other members, including substitutes, is within the remit of the Board.

Risk Management

10. In compliance with the Council's risk management strategy, the only risk associated with the recommendations in the report is by Board Members not approving them that a Vice Chair will not be appointed and additional substitutes for key organisations on the Board will not be provided.

Recommendations

11. The Health and Wellbeing Board are asked to approve;

- The appointment of Sheenagh Powell, Lay Member and Audit Committee Chair of NHS Vale of York Clinical Commissioning Group (CCG) as a first substitute for Keith Ramsay
- The appointment of David Booker, Lay Member and Chair of the Quality and Finance Committee of the Vale of York Clinical Commissioning Group (CCG) as a second substitute for Keith Ramsay.
- The appointment of Brian Coupe, Head of Service, Mental Health Services for Older People (York and Selby), Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust as a second substitute for Colin Martin.

To recommend to Council:

- The appointment of Keith Ramsay, lay Chair of NHS Vale of York Clinical Commissioning Group as Vice Chair of the Health and Wellbeing Board

Reason: In order to make these appointments to the Health and Wellbeing Board.

Author:

Judith Betts
Democracy Officer
Telephone: 01904 551078

Chief Officer Responsible for the report:

Andy Docherty
Assistant Director, Governance and ICT

Report Approved √ **Date** 11 July 2016

Specialist Implications Officers
Not applicable

Wards Affected: **All** ✔

For further information please contact the author of the report

Background Papers
None

Annexes
None

Abbreviations used in the Report

CCG- Clinical Commissioning Group

HR- Human Resources

TEWV- Tees, Esk and Wear Valleys NHS Trust

Health and Wellbeing Board 20 July 2016

Report of the Chairman of the Independent Care Group (York & North Yorkshire)

Presentation from the Independent Care Group Social Care in 2016

Summary

1. This report asks Health and Wellbeing Board members to receive a presentation from the Chair of the Independent Care Group (ICG) about Social Care in 2016.

Background

2. The Independent Care Group was set up to establish a voice for the local sector. It is a not for profit company with a strong and growing membership. It represents almost 100% of the region's care homes and many of the homecare providers.

Main/Key Issues to be Considered

3. The presentation highlights a number of key issues within the care sector both nationally and locally; including numbers of York residents in residential/nursing care; numbers receiving community based services and numbers receiving homecare.

4. It also highlights the ageing population and their increasing complexity of need which in turn increases demand on services and pressures on budgets.

5. In addition to this it highlights some of the challenges for the future.

Consultation

6. No consultation was needed to produce this accompanying report to the presentation.

The presentation references a survey undertaken by the Independent Care Group about independent businesses who supply care services.

Options

7. This report is for information only and as such there are no specific options for members of the Board to consider. However Health and Wellbeing Board members should consider what, if any further steps need to be taken in relation to the information received today.

Analysis

8. Further steps could include considering how any new Joint Health and Wellbeing Strategy could address some of the concerns raised in the presentation from ICG particularly those around making a significant shift from reliability on services to self management and prevention could be achieved.

Strategic/Operational Plans

9. Older people and people with long term conditions is a key theme in the current Joint Health and Wellbeing Strategy for the city. This strategy is currently being renewed and the older population are very likely to be a key focus in this.

Implications

10. There are no implications associated with the recommendations set out within this accompanying report. However there may be significant implications for health and social care organisations in the future if the Independent Care Sector cannot provide the level of service required.

Risk Management

11. There are no known risks associated with the recommendations in this report other than those highlighted in the paragraph above.

Recommendations

12. Health and Wellbeing Board are asked to receive the presentation and discuss its implications for the city.

Reason: To keep members of the Board up to date regarding the Independent Care Sector.

Contact Details

Author:

Tracy Wallis
Health and Wellbeing Partnerships Co-ordinator
Tel: 01904 551714

Chief Officer Responsible for the report:

Martin Farran
Director of Adult Social Services

Report Approved ✓ **Date** 05.07.2016

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex 1 – Presentation slides from the Independent Care Group

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Glossary

CQC – Care Quality Commission

ICG – Independent Care Group

LGA – Local Government Association

NHS – National Health Service

NLW – National Living Wage

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Social care in 2016

Independent Care Group

(York and North Yorkshire)

presentation to

York Health and Wellbeing Board

Wednesday, 20th July 2016

Mike Padgham, Chair

Independent Care Group

(York and North Yorkshire)

Independent Care Group

Introducing the ICG

- Set up to establish a local sector voice
- A non-profit company limited by guarantee
- Volunteer Board of Directors
- Paid Chief Executive
- Strong and growing membership…

Independent Care Group

Introducing the ICG

- Represent almost 100% of region's care homes …
- … and majority of homecare providers
- Works with commissioners, particularly negotiating care fees – with some success!
- Promotes the local care sector through publicity and lobbying
- Holds regular meetings and seminars to share information

Independent Care Group

Introducing the ICG

- Produces a quarterly newsletter to disseminate information
- Sends out a regular email information bulletins
- Annual Conference - 9th November - on Recruitment and Retention (a key issue in York and elsewhere).

Independent Care Group

Our collective duty

'Promoting diversity and quality in provision of services' places a duty on local authorities to promote a diverse and high quality market of care and support services.

- The Care Bill 2013.

Independent Care Group

National picture

- Adult social care employs more than 1.5m (NHS 1.35m)
- Contributes more than £20bn directly in to the economy
- 640,000 people receive home-based care in the UK
- Domiciliary care market worth £5.5bn per year in England
- 426,000 elderly and disabled people in residential care
- Estimated 5,153 nursing homes and 12,525 residential homes in the UK
- By 2026 an extra 1.7m adults will have a care need …

Independent Care Group

Current challenges

- Health Foundation estimates £6n funding gap by 2020
- LGA estimates NLW will add £1 billion to that
- £5bn cut from the adult social care budgets since 2009-10
- 3,000 care homes closed in six month to Sept 2015
- Large providers predicts 9,000 care homes could close
- CQC fee increase will add thousands to care home costs
- Closure of care homes to cost NHS £3bn
- Bed-blocking and strain on NHS services

Independent Care Group

Local picture

- In York 1,155 people are in residential/nursing care
- 6,000 receive community-based services
- 1,200 receive homecare
- 11 homecare providers supplying 6,000 hrs a week
- These are changing and challenging times
- City of York Council talks of 're-wiring Public Services'

- 2012-13 City of York Council figures

Independent Care Group

The local care landscape

- **Population is ageing**
- **Needs are becoming more complex**
- **Demands on services are becoming greater**
- **Increased pressure on budgets**
- *(City of York £7m savings target for 2014/5 to 17/18)*
- **Quality & value for money are paramount**
- **Need for integrated services with person-centred outcomes**

Independent Care Group

The local care landscape

- **Population is ageing, older people more frail**
- **York has high proportion of people over 80**
- **Needs are becoming more complex, esp dementia**
- **Demands on services are becoming greater**
- **Increased pressure on budgets**
- *(City of York £7m savings target for 2014/5 to 17/18)*
- **Quality & value for money are paramount**
- **Need for integrated services with person-centred outcomes**

Independent Care Group

Current challenges

- A quarter of the 20,000 care homes in the UK (5,000) are in danger of going bust within three
- Huge staff cost rise due to National Living Wage
- Homes are closing their doors to new local authority clients because it is no longer economically viable
- Housing stock is old (85% more than 50 years old) and there is no money to invest, meaning more and more will become unsuitable

ICY survey results:

- **An Independent Care Group survey found that 40%-43% expected their businesses to decline in the coming three years**
- **Up to 10% expected their businesses to close within three years**
- **57% believed that they would accept fewer publicly-funded places in the future.**

Independent Care Group

The future

- By 2026, an additional 1.7 million adults in England will have care and support needs
- The number of people with dementia in the UK will increase from 750,000 to over 1 million people by 2025
- The number of people with a learning disability needing care or support will increase by 50% by 2018.

Independent Care Group

The future:

- Rapidly increasing demand for social care
- Plentiful supply of entrepreneurial providers
- But the future is fragile and challenging!

Independent Care Group

The future

- We have to work together
- We must utilise the independent sector
- Greater merging of health and social care budgets and provision
- Accent on prevention rather than cure
- Keep up the pressure on funding…

Independent Care Group

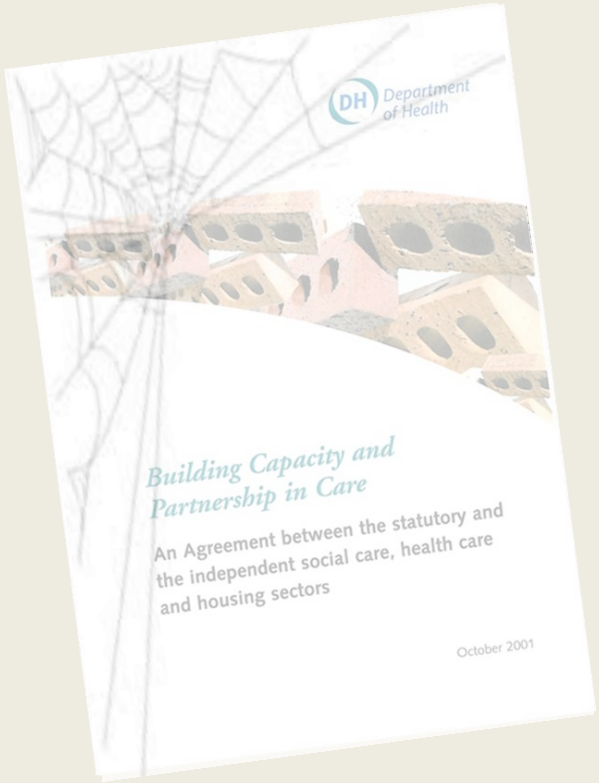
We need partnership

- In my 30 years partnership is:
- a ‘Holy Grail’
- Aspired to
- Desirable
- Rarely achieved ...

Independent Care Group

No more talk!

- No more commissions
- No more studies
- No more documents
- We need action…



Independent Care Group

“Coming together is a beginning; keeping together is progress; working together is success.”

- Henry Ford

Independent Care Group

Thank you

Mike Padgham, Chair

Independent Care Group (York and North Yorkshire)

Health and Wellbeing Board 20 July 2016
Report of the Director of Adult Social Care

Older People's Survey

Summary

1. This report asks Health and Wellbeing Board to consider revising and repeating the older people's survey that was last held in 2008.

2. They are asked to consider whether there is value in repeating this survey and whether there are any specific themes they would wish to be included should a new survey be undertaken.

Background

3. In January 2007 a Long Term Commissioning Strategy for Older People was agreed by City of York Council. This Strategy identified that the needs of older people were changing and that the number of older people in the city was increasing. At this time a wide consultation process was undertaken to explore the views of older people on some of the challenging options that needed to be addressed, given the demographic pressures of a growing older population and the changing aspirations of that particular part of York's population.

4. As part of this consultation process a survey of the over 50s in the city was undertaken for a four week period. This was made available on-line through the Council's website and was also posted to around 3,000 people who were on the mailing lists of the following organisations:

- York Older People's Assembly
- Age Concern York (now Age UK York)
- Alzheimer's Society
- York Blind and Partially Sighted Society
- OCAY (Older Citizens Advocacy York)

5. The postal surveys were undertaken with the help of all of these organisations and were co-ordinated by the York Older People's Assembly using their databases – this allowed for the survey to be sent to people that might not be in receipt of services or known to the Council.

6. The response rate in 2008 was good with 725 people responding to the consultation. 638 by postal survey and 87 online. Advice from Marketing and Communications at the time was that this represented a very good response rate of 24%, and that based on an estimated over 50s population of 62,000, the results were accurate to within a +/-3.6% at a 95% level of confidence. Just under two thirds of respondents to the consultation were aged over 70 years, half had a disability, two thirds were female and respondents lived in all areas of York. 93.7% of respondent belonged to the White British ethnic group.

7. The responses received to the 2008 survey led to a re-commissioning of services that are still in existence.

8. The 2008 survey covered a number of areas:

   - Using care services/providing care for older people
   - Helping older people to live independently
   - Residential care
   - Using our resources more effectively

9. The survey in 2008 was led by the marketing and communications team at the City of York Council who sought information and ideas for relevant questions from the voluntary sector. Whilst much of the co-ordination was done by the voluntary sector the costs were covered by City of York Council.

Main/Key Issues to be Considered

10. As the older population continues to increase and with the current absence of an older people's partnership board it is important that the voice of this sector of York's residents is heard and taken into consideration when commissioning future services.

11. Discussions with representatives from York Older People's Assembly have indicated that whilst many of the survey questions from 2008 could be re-used there would be a need to revisit them all to ensure they were still meaningful.

In addition the representatives have suggested the following themes be included if the survey is repeated:

- Older people living in poverty (impact and consequences)
- Social isolation and loneliness
- Older people living in their own homes (are their homes too large, are housing needs catered for)

12. The recent needs assessment around frail/elderly [undertaken as part of the Joint Strategic Needs Assessment (JSNA)] would also make a good reference point for questions. Additionally the survey results could be used to inform further ongoing work on the JSNA.

13. Purpose/Aim of Survey – routine sources of information provide a good indication of mortality and morbidity in the local older population at present however there is a lack of robust local information on wider factors which impact upon an older person's health and wellbeing. It is therefore suggested that the two main aims of any repeated survey should be:

    - To gather information on the factors that impact on the wellbeing of older people

    - To fill gaps in knowledge in order to aid health and social care services in meeting the specific needs of the older population in York.

14. Value added – repeating a revised version of the 2008 older people's survey has the potential to be an excellent piece of partnership working between different departments within the local authority, health colleagues the voluntary sector and all partners represented on the York Health and Wellbeing Board. It would be an opportunity to receive feedback from local residents to help all partners understand the needs around health and wellbeing, lifestyle and vulnerability of older people.

15. With growing numbers of older people with more complex needs the implications of this demographic change for those delivering health and social care services is vast. Whilst the outlook overall is very positive in York, we know that the city has some older residents who are in poor health, feel vulnerable and are socially isolated. Keeping older people active, independent and engaged for longer will become increasingly important.

16. As well as referencing some of the original questions asked in 2008 and reflecting the views from the discussions with the representatives from the York Older People's Assembly; this would be an opportunity to drill down and understand better some of the information we have already collected. It could also include questions around smoking, alcohol, carers, contact with health services, home life, anti-social behaviour and vulnerabilities thus reflecting the Health and Wellbeing Board's ambition to be focused on the wider determinants of health and wellbeing.

17. The survey and subsequent analysis and report will be made available to commissioners and policy makers and all those involved in delivering services to older people in York to aid the integration of health and social care process. It will assist in ensuring there is an evidence based approach to prevention, early intervention and reducing ill health and wellbeing and in meeting the needs of the local older population.

Consultation

18. To date no formal consultation has taken place as this would be the role of any new survey undertaken. Informal conversations between the Director of Adult Social Care and representatives from York Older People's Assembly and the VCS Older People's Forum have happened which have led to this report being produced.

Options

19. Health and Wellbeing Board Members can choose to:

Option 1 – support a refreshed survey taking place and indicate the timescale in which they would like this to happen

Option 2 – request that no further action be taken in relation to a survey of older people for the time being

Analysis

20. Option 1 would allow for views to be gathered from a wide range of older people who may not be known to the Council and ensure that the voice of older people is heard. Whilst the sub-structures of the Health and Wellbeing Board are being reviewed, and may include an older person's board in the future, currently there is no formal route in to the Health and Wellbeing Board for older residents.

21. If the Health and Wellbeing Board choose to support a refreshed survey this will give all partners the opportunity to have input and use the responses to help re-commission services for older people. NHS Vale of York Clinical Commissioning Group has indicated that there would be benefits to making this a joint health and social care survey sponsored by the Health and Wellbeing Board.

22. In addition the Joint Health and Wellbeing Strategy for York is currently being renewed and this is likely to follow a life course approach with one of the themes being Ageing Well. Any engagement with older people will help inform this piece of work.

23. There will be a number of ways of conducting this survey and these will need to be worked through should agreement be given to proceed.

24. Consideration could be given to the merits of commissioning an external party to undertake the survey so that it would be truly independent. However, this could come with significant cost implications. Health and Wellbeing Board may feel that with the involvement of the voluntary sector this would be a peer led survey anyway and would be considered both good practice and the most cost effective way to provide the survey.

Strategic/Operational Plans

25. Ensuring that resources are used to best effect to meet the needs of a growing older population could be better achieved by gathering information on the factors that impact on the wellbeing of older people.

Implications

26. **Financial** – if the survey were to be undertaken in-house with the support of the York Older People's Assembly there would be a small cost involved and a budget would need to be found for this. Based on posting to 3,500 people using second class postage this would equate to approximately £2,000.

27. **Human Resources (HR)** - consideration needs to be given to resources available to put this survey together. The Marketing and Communications Team have indicated that they will be able to help pull the survey together but further capacity may be needed to analyse the survey responses.

28. There are no other known implications associated with the recommendations within this report.

Risk Management

29. There are no known risks associated with the recommendation in the report. However it would be difficult to make fully informed commissioning decisions and potentially decisions around disinvestment and investment without robust and up to date information around the needs of the older population.

Recommendations

30. It is recommended that Health and Wellbeing Board approve Option 1

Reason: To ensure that the needs of the older population are fully understood when re-commissioning services

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator 01904 551714	Martin Farran Director of Adult Social Care

Report Approved ✓ **Date** 05.07.2016

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

2008 Report and Survey Results – Outcome of the Consultation on the Future Challenges for Social Care

Annexes

None

Glossary

JSNA – Joint Strategic Needs Assessment
OCAY – Older Citizen's Advocacy York

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Health and Wellbeing Board 20 July 2016

Report of Brian Coupe, Head of Service Mental Health Services for Older People (MHSOP)

Update on service delivery for Dementia care in York and Selby

Summary

1. This report updates the Health and Wellbeing Board on service delivery for Dementia/Cognitive Impairment in York.

Background

2. Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) took responsibility for all mental health and learning disability services across the Vale of York from 1 October 2015.

3. The service transition has been complicated by business continuity arrangements which have been in place since the decision by the Care Quality Commission (CQC) not to register services at Bootham Park Hospital (BPH).

4. TEWV have put in place a number of operational plans to minimise the disruption to patients and carers. The Trust has reinstated services in a number of areas including Bootham for outpatients.

5. As part of the redesign of Mental Health Services in York and Selby it was planned to reduce inpatient beds within mental health services for older people (MHSOP). This is to support the delivery of care within the community and to prevent unnecessary admissions to hospital. This reduction in beds will allow care delivery in the least restrictive environment by offering increased support from community services in both service users' own homes and via in-reach into residential / nursing home settings. This will support us in our aim to provide high quality care to service users in the most appropriate environment to meet their needs.

6. A comprehensive review of MHSOP inpatient services is ongoing to establish required bed base to ensure appropriate service delivery for MHSOP service users. This is anticipated to include further transfer of services within the locality to ensure care delivery in the most appropriate environment and to provide male and female dementia services within York.

7. Work is progressing to develop a new mental health hospital in the York and Selby Locality by 2019.

Main/Key Issues to be highlighted / Current Service Configuration

8. Cherry Tree House (CTH) now provides 18 mixed gender functional MHSOP inpatient beds to the York and Selby Locality.

9. Peppermill Court which was previously a male dementia unit has now closed and total refurbishment works are currently underway. This refurbishment will allow the delivery of Adult Mental Health inpatients services in York and Selby.

10. TEWV now have two gender specific Dementia care assessment and treatment inpatient services within the locality, Worsley Court in Selby a 14 bed male unit and Meadowfields in York which is a 14 bed female unit.

11. The mid-term plan is to relocate the male unit currently at Worsley Court into the vacant Acomb Gables unit in Acomb. This unit is also been refurbished and should be operational by November 2016. The programme of estate works will deliver environments that are fit for purpose in terms of safe, effective, and dementia friendly care delivery for the client group. The redesign is evidence based to ensure we provide an environment conducive to the delivery high quality dementia care including enhancing existing safety aspects of the wards including new staff attack alarm systems and improvements to controlled access and egress.

12. The Purposeful In-Patient Admissions (PIPA) model of care delivery across the inpatient wards has now commenced at Cherry Tree House. This model provides a clear structure to support care delivery and identify clear purpose for admission and underpins a more collaborative approach to care delivery.

Daily report processes have been introduced involving all members of the multi-disciplinary team (MDT) to ensure timely, collaborative decisions are made around patient care. The MDT approach supports teams in a positive risk taking approach and also ensures timely and proactive care delivery to our service users. Implementation in other areas within the Trust has demonstrated significant improvement in patient outcomes and experience. Furthermore, areas have seen significantly reduced violent and aggressive incidents and improved staff well-being. We are now planning to roll the PIPA model out across the other inpatient units.

13. 20 nursing staff across the inpatient units have been trained in the use of dementia care mapping (DCM) which is based on the philosophy of person centred care , which promotes a holistic approach to care that upholds personhood of the person with dementia.

14. TEWV Challenging behaviour pathway is being implemented across services as a strategy for enhancing the quality of life of services users and reducing the behavioural challenges resulting in an enhanced service user experience improved quality of life, happiness and wellbeing. Staff will then be better equipped to support people whose behaviours may be described as challenging.

15. Plans are now in place to expand the Care Home Liaison team. This team offer in-reach into care homes offering an alternative to in patient admission to hospital and also support the discharge process to appropriately identified placements. It is planned to expand the team by 6 WTE staff allowing for an extension of hours during the day and also providing weekend cover. We hope to have these arrangements in place by Autumn 2016.

16. The team plan to continue to build relationships with care home providers within the locality so that our partners fully understand the role of the team and the support they can offer. The team will also deliver support and training to our colleagues with the care homes services as/when required. The team already have some excellent examples of how this partnership working with care homes has supported the successful discharge of service users.

17. TEWV have worked closely with Local Authorities and commissioners to reduce delays in discharge from hospital.

This multi-agency commitment was evident during the closure of Peppermill Court. All agencies are keen to further develop our partnership working and an engagement event is planned to allow for sharing of learning and also allow us to work together to streamline our processes.

18. Strong Voluntary Sector services have already been established within community services and TEWV are keen to build on this partnership working. Dementia Forward (DF) is commissioned by TEWV to provide dementia support advice, from pre diagnosis onwards. The service provides practical and emotional support and ensures the right individual support at the right time. The range of support is varied from planning of legal and financial matters through to the support needed for family carers. The aim is always to avoid unnecessary crisis and create a 'place to turn', it is designed to bridge the clinical and social needs, ensuring that people feel supported. An important aspect is the strong relationships between TEWV and DF at all levels, so that from the perspective of the patient it is one 'virtual' team and there is no wrong door.

19. Across TEWV we are promoting the work of volunteers and peer support workers. York and Selby already have a number of volunteers. This work will be rolled out across the locality to promote the recruitment of volunteers and to highlight the benefits of the work that they do.

20. TEWV are in the process of establishing speciality specific Community services for MHSOP for service users in York and Selby. York and Selby locality will be part of a TEWV trust wide initiative around community services productivity.

21. The Memory Management Service aims to give the people of York and Selby access to good quality assessment and diagnosis and treatment of dementia. The sooner service users are diagnosed the quicker they can access the support they need. We are committed to reducing waiting times for assessment by this service and have therefore temporarily redeployed staff to this service. A nurse within the service has also commenced the Non-medical prescribers training which once complete will also support timely access to this service.

22. Acute hospital liaison has received some additional staffing resource which has allowed us to extend the hours we provide a service within York district hospital. This will have wider impact across partners around admission avoidance and capacity to support patients who may have complex care needs.

23. TEWV are actively involved in the ongoing work around the discharge to assess model and are committed to supporting the implementation of this model that will see all agencies provide a timely response to mobilising service around service users when discharge from the acute hospitals.

Consultation

24. Not applicable as this is a written update

Options

25. Not applicable as this is a written update

Analysis

26. Not applicable as this is a written update.

Strategic/Operational Plans

27. The longer term strategic plan for Dementia services within the locality is to reduce the bed base to 30 with a ward for organic illness and a ward for functional illness. Each ward will have 15 mixed gender beds all with en suite facilities in a purpose built new hospital. The reduction in the bed base will be supported by enhancing community based services to provide additional support to people within their own homes or other establishments to avoid unnecessary admission into hospital, addressing length of stay within units and facilitating appropriate discharge.

Implications

28. This implications section is not applicable as this written update does not require any decision.

Risk Management

29. This section is not applicable as this is a written update as opposed to a report.

Recommendations

30. Health and Wellbeing Board are asked to note and comment on the report.

    Reason: To keep the Board up to date in relation to mental health services for older people.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Brian Coupe Head of Service Mental Health Services for Older People (MHSOP) York & Selby Tees, Esk and Wear Valleys NHS Foundation Trust 01904 294614	Ruth Hill Director of Operations – York & Selby Tees, Esk and Wear Valleys NHS Foundation Trust 01904 294623
Report Approved ✓	**Date** 04 July 2016

Specialist Implications Officers - None

Wards Affected **All** ✓

For further information please contact the author of the report

Background Papers
None

Annexes
None

Glossary

BPH – Bootham Park Hospital

CQC – Care Quality Commission

CTH – Cherry Tree House

DCM – Dementia Care Mapping

DF – Dementia Forward

MDT – Multi-Disciplinary Team

MHSOP – Mental Health Services for Older People

PIPA – Purposeful In Patient Admissions

TEWV – Tees, Esk & Wear Valleys NHS Foundation Trust

WTE – Whole Time Equivalent

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Health and Wellbeing Board **20 July 2016**
Report of the Director of Adult Social Care

Annual Report – Safeguarding Adults Board

Summary

1. This report provides information on the work of the Safeguarding Adults Board over the course of 2015/16. A summary of the report can be found at Annex A of this report and the full annual report at Annex B.

2. Kevin McAleese CBE, the Independent Chair of the Safeguarding Adults Board will be in attendance at the meeting to present the report.

Background

3. The Safeguarding Adults Board is a multi-agency board whose role is to plan strategically and ensure the safety of vulnerable adults within the City of York Council's geographical area.

Main/Key Issues to be Considered

4. The Annual Report is for information only but clearly sets out the work the Board carried out over the course of 2015/16.

Consultation

5. This report is for information only.

Options

6. There are no options for the Health and Wellbeing Board to consider; this report is for information only.

Analysis

7. This section is not applicable to this report.

Strategic/Operational Plans

8. The Safeguarding Adults Board has a statutory duty to produce an annual report.

Implications

9. There are no implications associated with the recommendations set out in this report; the Annual Report is for information only.

Risk Management

10. There are no risks associated with the recommendations in this report.

Recommendations

11. The Board are asked to note the Safeguarding Adults Board's Annual Report.

12. Reason: To keep the Board appraised of the work of the Safeguarding Adults Board

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator Public Health Team Tel: 01904 551714	Martin Farran Director of Adult Social Care
	Report Approved ☐ **Date**

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A – Summary of Safeguarding Adult's Board Annual Report
Annex B – Safeguarding Adults Board's Annual Report
Annex C – Presentation Slides

Glossary

CCG – Clinical Commissioning Group

CPN – Community Psychiatric Nurse

CVS – Centre for Voluntary Service

NHS – National Health Service

MSP – Making Safeguarding Personal

SAB – Safeguarding Adults Board

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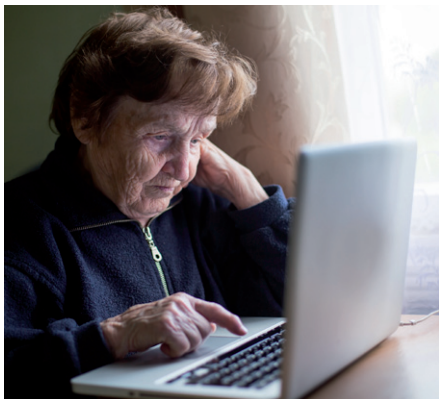
ANNEX A

Safeguarding Adults Board

Annual Report 2015/16

Executive Summary



City of York Safeguarding Adults

CITY OF YORK COUNCIL

Foreword

by Kevin McAleese CBE, Independent Chair

Kevin McAleese CBE
Independent Chair, City of York Safeguarding Adults Board

This is my third annual report as Independent Chair of the City of York Safeguarding Adults Board (CoYSAB) and covers the year ending 31 March 2016.

The work of the Board is driven by its vision: "We aim to ensure that agencies supporting adults who are at risk or in vulnerable situations, and the wider community, can by successfully working together:

- Establish that Safeguarding is Everybody's Business
- Develop a culture that does not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does unfortunately happen, support and safeguard the rights of people who are harmed to:
  - stop the abuse happening
  - access services they need, including advocacy and post-abuse support
  - have improved access to justice
  - have the outcome which is right for them and their circumstances."

York is a great place to live and work and our job as the Safeguarding Adults Board is to help protect every adult's right to live there in safety, free from abuse and neglect. It is above all is about people and organisations working together to prevent and to stop both the risks and experience of abuse and neglect, whilst at the same time making sure that the adult's wellbeing is promoted, including having regard to their views, wishes, feelings and beliefs in deciding on any action. Whilst in a city of over 200,000 people we can never eliminate risk entirely, the Board is satisfied that in 2015/16 the arrangements in place for safeguarding adults across a range of organisations were broadly effective and appropriate.

Introduction

The Report's pages contain a wealth of information about adult safeguarding activity across the City of York and the contributions made by partner agencies.

The work of the Board includes the safety of individuals in local health services, local care and support services and prisons and approved premises. The Care Act 2014 has made Safeguarding Adults Boards statutory bodies like Children's Boards, with legal obligations to produce both an Annual Report and an on-going Strategic Plan which must both be published. The Act also clarifies that the local authority, the clinical commissioning group covering York and the local police force must be represented on SABs. In fact, there are twelve local organisations who have full membership.

This Executive Summary sets out brief details about our work and actions during the year. There is a great deal of further detail in our full Annual Report, which will be available on our website at www.safeguardingadultsyork.org.uk.

Some facts and figures

During 2015/16, the Council's safeguarding team received a total of 1,108 safeguarding concerns (formerly known as alerts) concerning 863 different individuals. This was an increase of nearly 5% from 1,058 the previous year. Where the Council was unable to resolve the concerns at the initial stage, a safeguarding referral was made for further investigation. There were a total of 468 cases which progressed to formal enquiries. Some 75% of adults at risk were already known to the Council's Social Services, the majority having physical support needs. In line with the national picture, 61% of safeguarding concerns raised related to women with care and support needs and 98% of the concerns raised related to people of white ethnic origin, which reflected York's overall demographic pattern.

Neglect accounted for 31% of the concerns investigated, followed by psychological abuse (22%) and physical abuse (19%). Financial or material abuse accounted for 17% of the concerns raised. This trend in York has been consistent in all quarterly reports to the SAB, and reflects the national picture.

The 18-64 age group, which is some 64% of the total York population, was represented in just 38% of safeguarding adult referrals made during 2015/16. By contrast, the over 65 age group, which is just under 18% of York's total population, was represented in 62% of safeguarding adult referrals made. This is unsurprising and in line with national trends, which confirm that people 65 and over will have increasingly higher care and support needs and are more likely to need both hospital, home support and residential care services. People aged 85-94 were the most over-represented group in safeguarding concerns.

The data sets also indicate that the source of safeguarding risk has most frequently been people known to the adult with care and support needs (as per last year) and this has most frequently been located within their own home. In 2015/16, vulnerable adults were most at risk in their own homes, followed by care homes and then by being in hospital.

Finally, action was successfully taken to reduce or remove the safeguarding risk in the majority of cases. In 59% of all completed enquiries, the risk was noted to have reduced, and in 29% to have been removed. In only 4% of cases did the risk remain. This was a significant improvement in the outcomes for adults with care and support needs on previous years, as in 2014-15, 22% of cases resulted in no action being taken and in 67% of cases the risk remained.

How are we doing?

Between October 2015 and January 2016 the Association of Directors of Adult Social Services (ADASS) in Yorkshire & Humberside conducted a regional "mystery shopping" focussing on access to services. The method adopted was based on the Care Quality Commission 'access to service' toolkit and a range of scenarios which have been developed through the regional Standards and Performance network. The assessment was conducted by real customers testing how easy it is to access services over the telephone, face to face, and on the internet. The feedback that was then taken from their captured observations and experience.

Face to face, telephone and internet scenarios were used, with City of York staff by calling at West Offices, including the following questions:

- Can you tell me who I need to contact to report suspected abuse, as I have concerns about a neighbour and don't know who to contact?
- I am not sure if this is an emergency or not but my Mum/Dad is in residential care and recently their money has been going missing.
- I am not sure what to do as my Mum says that staff sometimes shout at her and so doesn't want me to say anything.
- How do I report a safeguarding concern?
- How do I report suspected abuse?

Each of the outcomes were rated **Excellent** (Lots of useful information, helpful staff, very satisfied with the service received, enquiry dealt with promptly), **Good** (some information given, knowledgeable staff, satisfied with the service given, enquiry deal with in a timely manner), **Fair** (limited information given, fairly satisfied with the service, enquiry deal with in a reasonably timely manner and Unsatisfactory (no information given, poor customer experience, didn't feel valued, unhelpful staff, very dissatisfied with the service).

These are the results for City of York Council, with comparisons back to 2012:

Scenario	2015/16 Rating	2014 Rating	2013 Rating	2012 Rating
Telephone	EXCELLENT	GOOD	GOOD	FAIR
Website	EXCELLENT	GOOD	FAIR	GOOD
Face to Face	GOOD	GOOD	GOOD	FAIR
Reception	GOOD	GOOD	EXCELLENT	UNSATISFACTORY
Out of Hours	EXCELLENT	GOOD	UNSATISFACTORY	GOOD
Safeguarding Access	EXCELLENT	GOOD	GOOD	

The SAB was delighted to see such progress demonstrated over the past four years.

Formal audits and reviews

We are pleased to report that there have been no cases during 2015/16 which merited a Safeguarding Adults Review under the Care Act 2014, just as there were not in 2014/15. However, there were two suicide cases during 2014/15 which required investigation for Lessons Learned, and details of both are in the full Annual Report.

The Board invited each partner organisation to complete an up to date assessment of their state of readiness for safeguarding, using a standard self-assessment tool. The results were that all organisations were at least Good across virtually all measures. The next stage is for each organisation to invite another one to peer review its results, which will then be discussed at Board level.

Training and development

The full Annual Report shows the extensive training programme which is established for staff from partner organisations and the very high levels of positive evaluations received. A total of 417 staff attended Safeguarding Levels and Mental Capacity Act Levels 1 to 4 training during 2015/16, of whom 65% were from organisations other than City of York Council. Such training at Level 1 only was provided free, with a fee for non-attendance at any course.

The Board is pleased to report that an Impact Assessment tool for use by managers with staff attending training has been developed by the Workforce Development Unit. This has been designed to support managers in checking on the transfer of learning from the classroom to their day to day roles. This is due to piloted on a small number of courses during May/June 2016 and if successful, it will be rolled out to all safeguarding courses during 2016/17. The safeguarding training offer is currently being reviewed for 2016/17. The current levels 1-4 will no longer form part of the offer and a new range of courses is being developed based on Making Safeguarding Personal.

A skills analysis of Board members was conducted in the Summer of 2015. The responses to the needs analysis were varied and demonstrated the breadth of experience of members on the Board. In response two full-day development sessions were held in January and April 2016 which were very well attended by Board members on behalf of their organisations.

Achievements during 2015/16 and Priorities and challenges for 2016/17

The full Annual Report confirms that planned changes set out in the Strategic Plan for 2015/16 were delivered, including:

- Safeguarding as a priority to be addressed featured in the published plans of all SAB partners
- A Safeguarding Systems Leadership Group covering North Yorkshire Police and both North Yorkshire and York Councils was successfully established
- Development Days for the full Board were successfully held during 2015/16
- All SAB partners presented a safeguarding report to their relevant governing bodies
- All SAB partners were signed up to the revised West and North Yorkshire and York multi-agency safeguarding policies and procedures, with appropriate training organised
- The Making Safeguarding Personal agenda was highlighted and is being implemented across SAB partners
- The City of York Safeguarding adults website was totally rewritten and is accessible at www.safeguardingadultsyork.org.uk.
- The "user voice" was captured with Healthwatch York becoming a full SAB member and also conducting public involvement in the next Strategic Plan

For 2016/17, the new Strategic Plan will include plans to:

- Roll out a new Communications Strategy and launch it in the community
- Add more publicly accessible information on the website about abuse and neglect
- Agree a Quality Assurance framework across all partners
- Commission Healthwatch York to undertake a public consultation on adult safeguarding
- Publish a Preventative Strategy
- Include information on how to keep safe on the public part of the website
- Use public feedback on the website to review and update safeguarding arrangements
- Monitor and report on the use of advocates for people who lack mental capacity
- Develop local operational guidance on safeguarding for all SAB partners, underpinned by new training arrangements
- Plan and host an annual Safeguarding week, in conjunction with West and North Yorkshire Councils
- Publicise and present the SAB Annual Report to any community group requesting it
- Develop and maintain an annual risk register

Contacts

City of York Council, West Offices, Station Rise, York YP1 6GA

To report a safeguarding concern:

- contact adult social care, tel: **01904 555111** (office hours) or fax **01904 554055**
- hearing impaired customers can use the text facility **07534 437804** and generic fax number **01904 554017**
- out of hours, tel: **01609 534527**

If you're not sure what to do, our adult social care team can give you advice.

To report a crime:

- in an emergency, contact the police: 999
- if the person is not in immediate danger, contact the police: 101

If you would like this information in an accessible format (for example in large print, in Braille, on CD or by email) please call **(01904) 551550**

This information can be provided in your own language.

Informacje te mogą być przekazywane w języku ojczystym.
Polish

Bu bilgi kendi dilinizde almaniz mümkündür.
Turkish

此信息可以在您自己的语言。
Chinese (Simplified)

此資訊可以提供您自己的語言。
Chinese (Traditional)

01904 551550

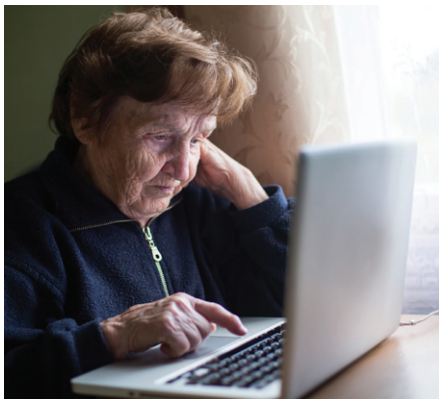
City of York Safeguarding Adults

CITY OF YORK COUNCIL

ANNEX B

Safeguarding Adults Board

Annual Report 2015/16



City of York Safeguarding Adults

CITY OF YORK COUNCIL

Contents

Introduction
by the Chair of the Safeguarding Adults Board (SAB)

Kevin McAleese CBE
Independent Chair, City of York Safeguarding Adults Board

I am very pleased to introduce the SAB Annual Report for 2015/16, having first taken up my appointment as Chair on 1 April 2013. As readers may know, the City of York SAB became a full statutory body under the Care Act 2015 on 1 April 2015, so we are just completing our first year with those new responsibilities. There are some 500 pages of statutory guidance on implementation of the Act, though the SAB has only had to concentrate on the fifty pages in Chapter 14. I am as certain as I can be as Chair that all which should be in place is, or is in the process of being finalised. The current Board members are drawn from twelve key organisations operating in the City of York. Three of them are "statutory partners" as required by the Care Act: the City Council, the "NHS" and the Police. The full list can be seen in Annex 2.

One of the requirements of the Care Act is that the SAB Annual Report must contain details of any Safeguarding Adults Reviews (SARs) which have been conducted when an adult has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect them. The findings of any SARs must be included, as must actions taken or intended in relation to those findings. I can confirm that, like 2014/15, there have been no SARs during 2015/16. However, there were two deaths during 2014/15 which were reported on last year in outline, where a lesser level of enquiry known as Lessons Learned had been started, and there are some details of those cases on pages 19-21 of this Report. They do illustrate the challenging nature of safeguarding work and the complexities of supporting individuals in particular circumstances.

The SAB does have a website, and I am delighted to say that it has been totally rewritten to make it more accessible for both members of the public and professional staff. The address remains www.safeguardingadultsyork.org.uk. The website can also be accessed by the safeguarding team to monitor how much usage is made of it via the internet, and we are confident that it will increase over previous years. It also contains minutes of our quarterly meetings, which are not open to public attendance because of the sensitive and confidential nature of much of our work.

I hope that you will be interested, informed and also reassured by the contents of this Report on our work for 2015/16. Thank you for taking the time to read it.

Kevin McAleese CBE
Independent Chair, City of York Safeguarding Adults Board

The Board's Work and its Vision

York Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city in order that all agencies contribute effectively to the prevention of abuse or neglect of vulnerable people. It has been in existence since November 2008 and has a strong focus on partnership working. The work of the Board includes the safety of patients in local health services, the quality of local care and support services, and the effectiveness of prisons and approved premises in safeguarding offenders.

Our Vision, stated in our new Strategic Plan (see Section 7 below) is that we aim to ensure that agencies supporting adults who are at risk or in vulnerable situations, and the wider community, can by successfully working together:

- Establish that Safeguarding is Everybody's Business
- Develop a culture that does not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does unfortunately happen, support and safeguard the rights of people who are harmed to:
  - stop the abuse happening
  - access services they need, including advocacy and post-abuse support
  - have improved access to justice
  - have the outcome which is right for them and their circumstances.

Work Undertaken in 2015/16

Making Safeguarding Personal (MSP)

A key part of the Care Act is MSP and the establishment of a person-centred approach to safeguarding adults across all agencies. The City of York took part in a national MSP pilot programme which came to an end a year ago. The SAB has begun trying to encourage the development of an MSP approach across all agencies in the city.

This is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and need assistance to do so. The two real case studies below illustrate how this has worked:

Case Study 1

Annie has a number of physical health conditions. She has historically declined to engage with services including declining medical treatment and it has been unclear why.

Annie came to the attention of the Safeguarding Adults Team as she was being financially exploited by people she knew. Through an MSP approach, Annie was spoken with about this concern and asked how services could support her to stop this harm from continuing.

Annie identified that she would like to move to another property so that the people no longer targeted her; and with steady support from the team, identified that moving closer to family may be of benefit to her wider welfare, as it would mean that family members could support her to attend medical appointments.

Annie agreed to accepting support from an agency who were able to support her with applying for a housing transfer, and this relationship was facilitated by the team. Annie has now moved home, which has removed the risk of financial exploitation, and she continues to attend medical appointments, which has improved both her physical and mental wellbeing.

Case Study 2

Gerald has significant physical health problems, and is cared for in bed. He recently had a short break at a nursing home, and staff there were concerned about the way his informal carer interacted with him and the potential that he was suffering harm at home. Gerald's carer was known to have declined support on his behalf in the past.

Whilst Gerald was in the nursing home, a member of the safeguarding adults team visited him to discuss the staff's concerns. Gerald has limited communication so aids were used and Gerald was able to identify that he would like the team to speak with his carer, but that he would like to be present. Gerald was also very keen to return home and did not want this conversation to delay this.

As per Gerald's wishes, he was discharged home and on that day the safeguarding workers visited and outlined the concerns that had been raised. They spoke with Gerald and his carer together and separately to ensure that both had the opportunity to raise any individual concerns that they had.

As a result of this initial conversation, the carer allowed the workers to return and although she remained resistant to ongoing support from statutory services, Gerald reports that he is happy that the issue has been discussed and is out in the open.

Self-assessment

A key part of this year's work was the further development and implementation of a self-assessment framework for partners, to understand the progress their organisations are making in safeguarding adults. All partners completed this assessment and they were collated for the board.

Assurance on the ability of members to safeguard adults was good overall and areas for future work were highlighted. These areas included:

- Community engagement
- Improving delivery to minority groups
- Embedding the Mental Capacity Act
- Information sharing

A further round of self-assessment is being implemented during 2016/17, with each organisation having their own view of themselves validated and assessed by another one, beginning with City of York Council and the Vale of York Clinical Commissioning Group.

ADASS Mystery Shopping

Between October 15 and January 16 the Association of Directors of Adult Social Services (ADASS) in Yorkshire & Humberside conducted a regional "mystery shopping" exercise on behalf all the local authorities across the region focussing on access to services. The method adopted was based on the Care Quality Commission 'access to service' toolkit and a range of scenarios which have been developed through the regional Standards and Performance network. The assessment was conducted by real customers testing how easy it is to access services over the telephone, face to face, and on the internet. The feedback that was then taken from their captured observations and experience.

Face to face scenarios were used with City of York staff by calling at West Offices:

- My sister is struggling with washing and taking care of herself but has funds available. What help is on offer?
- My brother has a learning disability and I am his main carer. I a struggling to cope: what help can I get?
- Can you tell me who I need to contact to report suspected abuse, as I have concerns about a neighbour and don't know who to contact?

Telephone scenarios were used by ringing York City Council:

- My brother has a learning disability and I am his main carer. I a struggling to cope: what help can I get?
- My sister is struggling with washing and taking care of herself but has funds available. What help is on offer?
- I am not sure if this is an emergency or not but my Mum/Dad is in residential care and recently their money has been going missing. I am not sure what to do as my Mum says that staff sometimes shout at her and so doesn't want me to say anything.

Internet scenarios were asked using the City of York website:

- Is there any support for me as a carer?
- My sister is struggling with washing and taking care of herself but has funds available. What help is on offer?
- How do I report a safeguarding concern?
- How do I report suspected abuse?

Each of the scenarios was rated **Excellent** (Lots of useful information, helpful staff, very satisfied with the service received, enquiry dealt with promptly), **Good** (some information given, knowledgeable staff, satisfied with the service given, enquiry deal with in a timely manner), **Fair** (limited information given, fairly satisfied with the service, enquiry deal with in a reasonably timely manner and Unsatisfactory (no information given, poor customer experience, didn't feel valued, unhelpful staff, very dissatisfied with the service).

These are the results for City of York Council, with comparisons back to 2012:

Scenario	2015/16 Rating	2014 Rating	2013 Rating	2012 Rating
Telephone	EXCELLENT	GOOD	GOOD	FAIR
Website	EXCELLENT	GOOD	FAIR	GOOD
Face to Face	GOOD	GOOD	GOOD	FAIR
Reception	GOOD	GOOD	EXCELLENT	UNSATISFACTORY
Out of Hours	EXCELLENT	GOOD	UNSATISFACTORY	GOOD
Safeguarding Access	EXCELLENT	GOOD	GOOD	

The SAB was delighted to see such progress demonstrated over the past four years.

Care Act Implementation

Policies and Procedures

In preparation for the introduction of the Care Act 2014, the City of York SAB developed a constitution, memorandum of understanding and register of interests for its members. These documents give clarity and underpin the important statutory work of the Board. The SAB has also developed local policies for undertaking Safeguarding Adults Reviews (SARs) and Lessons Learned. These policies have helped to ensure that that the SAB has a robust process in place for carrying out a review where an adult with care and support needs has suffered serious neglect or abuse and there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard that adult.

The SAB took the decision in the Summer of 2015 to harmonise the City of York multi-agency policies and procedures for adult safeguarding with those for the whole of West and North Yorkshire, to ensure that different agencies were not using different arrangements in different parts of the same geographical region. That work is now virtually complete and the relevant information is available to staff on the SAB website. Workshops were run in February and March 2016 for community groups, the voluntary sector and independent providers, helping those working with adults at risk in the community to understand their roles and the support they can expect from City of York Council and the SAB.

Winterbourne Concordat

City of York Council and Vale of York Clinical Commissioning Group have continued to work together to identify vulnerable people from York who are placed out of the city area for whom a move back to the York area may be the best way to enable then to be safe and enjoy the highest quality of life possible. These arrangements are reported to the SAB twice yearly. During 2016/17 the SAB will also begin to receive assurance about vulnerable individuals placed in the City of York from other parts of the country.

Performance and activity information

The Safeguarding Adults Collection 2015-16

The Health and Social Care Information Centre (HSCIC) take national responsibility for compiling an annual Safeguarding Adults Collection (SAC), which records details about safeguarding activity for adults aged 18 and over in England. Each local authority (referred to by HSCIC as Councils with Adult Social Services Responsibilities-CASSRs), has a statutory obligation to contribute towards this Collection, and the data outlined in the Annex and described below represents the significant areas of the City of York's contribution.

The collection includes demographic information about the adults at risk and details of the incidents that have been alleged.

The SAC is an updated version of the Safeguarding Adults Return (SAR) which collected safeguarding data for the 2013-14 and 2014-15 reporting periods. Some of the categories collected have remained the same but there are also some significant differences and these are discussed in the following section. As a result of some of these differences, it is difficult to compare data across the collections in all areas.

Changes to the Collection between 2014-15 and 2015-16

Between December 2014 and February 2015 the HSCIC ran a public consultation about what changes needed to be made to the safeguarding return as a result of the Care Act. Key changes included changing the name of the Collection (so as not to cause confusion with the newly named Safeguarding Adults Reviews- SARs); removing words such as 'referrals' and 'completed referrals', and replacing these with 'concerns' and 'completed enquiries'; and adding in voluntary collections around 'other enquiries' (enquiries where an adult does not meet all of the section 42 criteria but the council considers it necessary and proportionate to have a safeguarding enquiry).

Certain areas of data collection were ceased, including collecting information about whether individuals were already known to the council, and importantly, collecting information regarding whether or not allegations were substantiated or not.

Certain areas remain the same, including the collections around the location of abuse or neglect, the number of SARs held; and the actions, result, and source of risk categories. The HSCIC are notably working on a different format for collection of the latter 3 areas for next year (2016-17).

Under the 'categories of abuse or neglect' four new categories were added; and two new MSP tables have been added to the SAC for voluntary collection (these are not currently within the scope of this report). NB. The consultation had asked whether it would be useful to collect a table about the type of actions taken and the HSCIC are working with stakeholders to develop this for implementation in 2016-17.

Concerns and Enquiries during the year April 2015 – March 2016:

Concerns

For data collection purposes, a Safeguarding Concern is 'a sign of suspected abuse or neglect that is reported to the council or identified by the council'.

During 2015-16, City of York Council received a total of 1108 Safeguarding Concerns (relating to 863 individuals). This figure is an increase from 1058 alerts in the previous year.

All Concerns raised with City of York Council are scrutinised to see if they meet the Care Act's conditions for a section 42 enquiry, and to consider our duties under the Wellbeing Principle (section 1 of the Care Act) to offer support, advice and information to reduce the risk for the person in question and prevent further harm.

Where the council is unable to resolve the concerns at this stage, further enquiries may take place, either under the auspices of S42 or using 'other' enquiry mechanisms as appropriate.

Section 42 and 'Other' Enquiries commenced during 2015-16

Of the 1108 Safeguarding Concerns raised with City of York Council in 2015-16, 636 were taken through an initial enquiry process which led to signposting and advice, and 4 'other enquiries'. 468 of these concerns were progressed through initial enquiry to formal S42 Enquiry (for 431 people). Please see table 1 for counts of concerns raised and referrals for further enquiries.

Table 1

Counts of Safeguarding Activity	Count
Total Number of Safeguarding Concerns	1108
Total Number of Section 42 Safeguarding Enquiries	468
Total Number of Other Safeguarding Enquiries	4

Please note this table collects counts of cases not counts of individuals

Demographic Information

Tables 2, 3 and 4 show the demographic breakdown of the Concerns raised with City of York Council – focussing on concerns raised, and enquiries undertaken, according to age, gender and ethnicity.

The figures in Table 2 initially indicate a higher proportion of Concerns raised and enquiries undertaken for individuals within the working age bracket (18-64yrs- 39% of all Enquiries undertaken). However, given that this spans a duration of 46yrs, if the remaining age brackets are combined to create a 65yrs+ category for parity, then in fact this would account for 61% of the concerns raised.

Table 2

Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+	Not Known
Individuals Involved In Safeguarding Concerns	334	99	195	207	23	5
Individuals Involved In Section 42 Safeguarding Enquiries	170	53	101	94	9	4
Individuals Involved In Other Safeguarding Enquiries	2	0	0	1	1	0

The figures in Table 3 show a higher proportion of Concerns being raised around the possible abuse or neglect of women with care and support needs (60% of total concerns raised), which is reflective of the national picture within the Safeguarding Adults Return in 2014-15 (source: http://www.hscic.gov.uk/catalogue/PUB18869/sar-1415-rep.pdf). The progression from Concern to Enquiry does not appear to be affected by gender.

Table 3

Counts of Individuals by Gender	Male	Female	Not Known
Individuals Involved In Safeguarding Concerns	340	523	0
Individuals Involved In Section 42 Safeguarding Enquiries	172	259	0
Individuals Involved In Other Safeguarding Enquiries	1	3	0

The figures in Table 4 show that 96% of the Safeguarding Concerns raised with City of York Council related to people of White ethnic origin. This is reflective of the City's overall demographic - the main ethnicities recorded in the 2011 Census were White British (90.2%) and Chinese (1.2%).

Table 4

Counts of Individuals by Ethnicity	White	Mixed/Multiple	Asian/Asian British	Black/African/Caribbean/Black British	Other Ethnic Group	Refused	Undeclared/Not Known
Individuals Involved In Safeguarding Concerns	829	3	7	5	2	2	15
Individuals Involved In Section 42 Safeguarding Enquiries	414	0	3	4	2	1	7
Individuals Involved In Other Safeguarding Enquiries	2	0	1	0	0	0	1

Section 42 and 'Other' Enquiries completed during 2015-16

There were 391 S42 enquiries completed during 2015-16.

Type, Source and Location of Risk

Table 5 shows the type of risk cross tabulated with the Source, and Table 6 the Location where the potential harm has taken, or is taking place (again cross tabulated with the Source of risk).
NB. Because some people are at risk from multiple types of abuse in multiple locations, the figures in these tables total more than the 391 completed enquiries, as all types and location of risk are recorded.

Table 5

Counts of Enquiries by Type and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries		
	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical Abuse	35	66	2	1	0	0
Sexual Abuse	5	9	2	0	1	0
Psychological Abuse	39	79	6	0	0	0
Financial or Material Abuse	18	68	8	0	0	0
Discriminatory Abuse	2	1	2	0	0	0
Organisational Abuse	23	4	1	0	0	0
Neglect and Acts of Omission	135	27	11	2	0	0
Domestic Abuse	0	4	0	0	0	0
Sexual Exploitation	0	0	0	0	0	0
Modern Slavery	0	0	0	0	0	0
Self-Neglect		4			0	

Type of Risk

Table 5 shows that neglect accounted for 31% of the concerns raised (78% of which was allegedly carried out by 'social care support'), followed by psychological abuse (23%) and physical abuse (19%). Financial or material abuse accounted for 17% of the concerns raised. This trend has been consistent in all quarterly reports to the Safeguarding Adults Board, and is reflective of the national picture outlined in the 2014-15 SAR.

Source and Location of Risk

The data in tables 6 and 7 indicates that the source of risk, has most frequently been people known to the adult with care and support needs (as per last year) and this has most frequently been located within their own home.

The number of concerns raised within residential and nursing care homes has increased from previous years by 46% (133 this year compared with 91 in 2014-15), but again the trends locally do appear to reflect national figures (i.e., location of own home accounts for 41% of total local concerns and 43% nationally in the 2014-15 SAR; location of care home accounts for 33% locally and 36% nationally in the 2014-15 SAR).

Notably, concerns located within hospital settings has increased locally by 50% compared to last year (41 concerns in the 2014-15 SAR , 66 concerns this year), where concerns located within community settings has decreased by 46% this year (13 in 2015-16 compared with 24 in 2014-15).

Table 6

Counts of Enquiries by Location and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries		
	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Own Home	45	112	11	0	0	0
Community Service	5	5	3	0	0	0
Care Home	102	28	2	1	0	0
Hospital	37	15	11	2	1	0
Other	2	21	4	0	0	0

Actions and Results from Enquiries

Table 7 show the outcomes reached for safeguarding enquiries concluded within 2015-2016. The total numbers in these tables include Enquiries that were completed by 31st March 2016.

Action was taken to reduce or remove the risk in the majority of cases (in 8% no action was deemed to have been taken). In 59% of all completed enquiries, the risk was noted to have reduced, and in 29% to have been removed. In only 4% of cases did the risk remain.

This looks to be an improvement in the outcomes for adults with care and support needs on previous years, as in 2014-15 22% of cases resulted in no action being taken and in 67% of cases the risk remained. The number of cases where risk reduced and where risk was removed looks comparable across the collections – at 42% and 29% respectively.

Table 7

Counts of Enquiries by Action, Result and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries		
	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	7	22	4	0	0	0
Action taken and risk remains	3	12	1	0	0	0
Action taken and risk reduced	118	98	17	0	0	0
Action taken and risk removed	61	43	5	3	1	0

Training

Introduction

The Workforce Development Unit (WDU) is responsible for ensuring that Safeguarding and Mental Capacity Act training is available at all levels for the workforce.

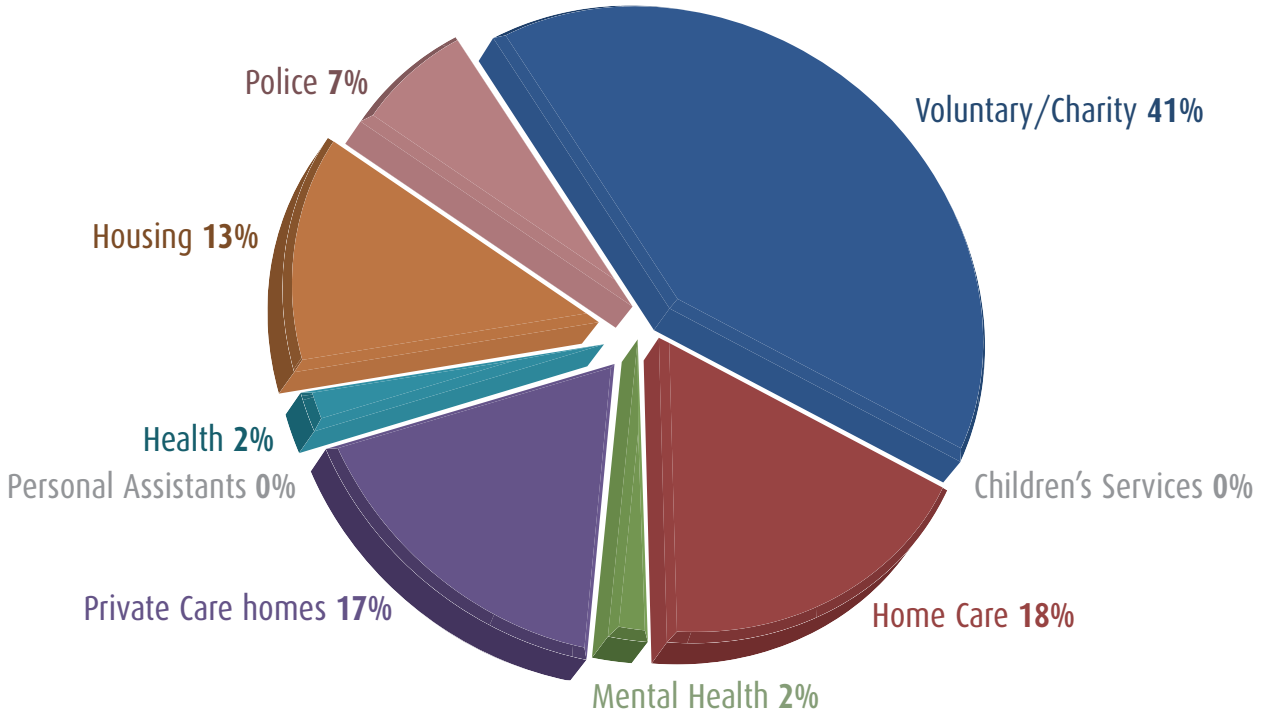
The Training Offer 2015/16

During 2015/16 our Safeguarding and Mental Capacity Act training was provided by Community Links.

Below shows a breakdown of courses that took place over 2015/16

Course	Number of Sessions	Total Cost	Total attendees	CYC attendees	PVI attendees	No Shows	% of internal CYC delegates	% of external PVI delegates
Safeguarding L1	14	£4,200	155	34	121	34	22%	78%
Safeguarding Level 2	6	£3,420	63	14	49	19	22%	78%
Safeguarding Level 3	2	£1,140	18	12	7	3	67%	33%
Safeguarding Level 4	1	£570	3	1	2	0	33%	67%
Safeguarding Train the Trainer	3	£1,950	22	2	20	1	9%	91%
MCA L1	8	£2,400	100	59	41	10	59%	41%
MCA L2	3	£1,710	20	16	4	1	80%	20%
MCA L3	2	£1,140	16	4	12	6	25%	75%
MCA L4	1	£570	7	6	1	0	86%	14%
MCA Train the Trainer	1	£650	13	1	12	0	8%	92%
Total	41	£17,750	417	149	269	74	35%	65%

Breakdown of external delegates by area:



Charging Policy

In April 2015 the pricing structure below was implemented, with the exception of Safeguarding Level 1 and Mental Capacity Act Level 1 which remain free of charge.

Full Day **£40.00**

Half Day **£20.00**

A non-attendance charge of £50.00 remained in place for all courses.

Developments

- The WDU continue to receive positive feedback from our course evaluation forms for all courses. This is monitored on a regular basis to highlight any areas for concern.
- An Impact Assessment tool for use by managers with staff attending training has been developed by WDU. This has been designed to support managers in checking on the transfer of learning from the classroom to their day to day roles. This is due to piloted on a small number of courses during May/ June 2016. If successful, we hope to roll out to all safeguarding courses during 2016/17 and would ask for the Board's support in ensuring its implementation within their own organisations.
- Following discussions with the commissioning team and feedback from providers, WDU have revised their charging policy for 2016/17. A range of courses including safeguarding and mental capacity act will be offered at no charge from April 2016 to March 2017. A non-attendance charge remains in place for all courses.
- A skills analysis of Board members was conducted in summer 2015. The responses to the needs analysis were varied and demonstrated the breadth of experience of members on the Board. In response two development sessions were held.
- The safeguarding training offer is currently being reviewed for 2016/17. The current levels 1-4 will no longer form part of the offer and a new range of courses is being developed based on making safeguarding personal principles, in conjunction with feedback from providers.

Strategic Plans

The Board agreed a Draft Strategic Plan for 2014-17 at the December 2013 meeting. Meeting of the SAB. This was completed ready for agreement at the March meeting in 2014, and placed on the Safeguarding website. The themes for action were agreed as:

A. Make sure safeguarding is embedded in corporate and service strategies across all partners
B. Ensure good partnership working
C. Focus on prevention of abuse
D. Respond to people based on the Personalisation approach, and with a clear focus on outcomes

Annex 4 shows the progress which has been made against each of the themes up to March 2016

Under the Care Act 2014 it is a legal requirement for the SAB to have a Strategic Plan and to produce an annual summary of its progress. A new Strategic Plan for 2016/19 in a very accessible format has been agreed by the SAB and is already on the website under "Board". It follows the six guiding principles of the Care Act:

1. EMPOWERMENT
2. PREVENTION
3. PROPORTIONALITY
4. PROTECTION
5. PARTNERSHIP
6. ACCOUNTABILITY

The new Strategic Plan for 2016/19 has an Action Plan for 2016/17 which will be reported on in the next Annual Report.

Safeguarding Adults Reviews/ Lessons Learned

There were no Safeguarding Adults Reviews needing to be conducted during 2015/16.

However, during 2014/15 the Board received two Lessons Learned briefing papers concerning the deaths by suicide of two individuals in York who had been in receipt of services from statutory bodies and other organisations. As Chair of the Board I had decided, as I am required to do, that the facts of neither case warranted the establishment of extended Serious Case Reviews (or Safeguarding Adults Reviews as they are known under the Care Act 2014). However, both contained issues which needed to be clarified so that the Board gained assurance both about what had been done to support the individuals concerned and also that the likelihood of any repetition had been minimised. As a result, the Lessons Learned procedure was activated in each case. Because of the timing of the two briefing papers the enquiries and actions they generated were reported to the Board during 2015/16 and so are featured in this Annual Report.

Aileen (previously 'Tracy', renamed)

The Learning Lessons review into the death of Aileen was signed off by partners at the City of York Safeguarding Adults Board meeting in December 2015. The death of Aileen and proposed review of the care she received in York services were described in the 2014/15 Annual Report. The following is a summary of the completed review and subsequent learning from it:

Aileen was born in 1978 and had a long history of mental health issues and substance misuse. She was suspected as being a victim of domestic abuse and sexual exploitation. Aileen repeatedly reported to services feeling hopeless and trapped in a cycle of relationship difficulties. She was noted as using self-harm from an early age to control her feelings and emotions. Aileen appeared to engage with services when in crisis but then disengage when the immediate crisis passed. During the time preceding the incident Aileen was not under the care of mental health services in York. She had moved repeatedly between York and London in the months before her death.

In December 2013 Aileen was taken to the Emergency Department at York hospital by ambulance following a self-harm incident. She had injuries to her arms, legs and neck. Aileen was under the influence of alcohol and possibly other substances. Following clinical review Aileen received care overnight on the High Dependency Unit and then was transferred the following day to a short stay acute ward. Approximately two hours following transfer Aileen was found unresponsive following a further significant episode of self-harm in an area away from the view of staff. Attempts made to resuscitate Aileen were unsuccessful and her death was confirmed a short time later.

The review highlights where the partners of the Safeguarding Adults Board could have worked better together to safeguard Aileen, with a focus on three main areas:

- The patient pathway between the Emergency Department; the Acute Ward Services and Mental Health Services
- The broader health context
- The window of opportunity and potential missed opportunities between Aileen's admission and subsequent death

The findings relate to systems failures rather than the actions of any individuals. Key Learning and Actions taken following the findings of the review were:

1) Focused work on the development of a multi-agency Mental Health Crisis Concordat in York, involving mental health services, acute hospital services, ambulance services, police services and the local authority.
2) Opening of a Section 136 'place of safety' suite where individuals in mental health crisis can be safely assessed and cared for.
3) Development of a 24 hour Mental Health Intervention Team based in the acute hospital so individuals attending the Emergency Department with mental health issues receive assessment, support and appropriate referral in a timely way.
4) Mental Health first aid training for key identified hospital staff to support them in managing people with mental health problems in acute medical settings.
5) Commitment to a Multi-Agency Safeguarding Adults Information Sharing Agreement to facilitate appropriate sharing of information to protect individuals at risk who are unable to protect themselves.

The City of York Safeguarding Adults Board wishes to extend their sincere condolences to Aileen's family and friends.

Daniel

The Learning Lessons review into the death of Daniel was signed off by partners at the City of York Safeguarding Adults Board meeting in June 2015. The death of Daniel and proposed review of the care he received in York services was described in the 2014/15 Annual Report. The following is a summary of the completed review and subsequent learning from it:

In November 2014 Daniel was seen walking unsteadily along an elevated platform in the centre of York. He was seen to climb over railings and fall approximately 40 feet to the ground. Daniel was taken to York District Hospital but his injuries were such that he could not be resuscitated and his death was confirmed a short time later. A note expressing his intention to take his own life was found in his pocket.

Daniel had been referred to Adult Safeguarding in the months prior to his death by a Housing Support Worker with a concern related to possible financial abuse. Daniel had been interviewed under caution and released on police bail following the death of a male at his address from a suspected drug overdose. Daniel was known to mental health services and mostly he engaged well with support services. He had a job at a local college and was receiving counselling support there. Daniel was frequently open about suicidal thoughts and plans. In the period leading up to his death Daniel had made several suicide attempts where he was found to be carrying a suicide note and he had received a number of welfare checks.

The review sought to ascertain if services could have worked better together to safeguard Daniel.

Key findings from the review:

- In general all involved services engaged well with Daniel, they shared their level of concern equally and exchanged information appropriately.
- The management and human resources team at the college deserve particular mention for going the extra mile in trying to keep Daniel safe and well.
- Daniel's suicidal ideas were regularly addressed by his Community Psychiatric Nurse (CPN) and these concerns fed into the safeguarding process.
- It was less clear to identify a proportionate response to the potential escalation of risk as a result of the death at his accommodation and the subsequent police investigation.
- There were however found to be no obvious omissions in Daniel's care: it appears that mental health services and the police worked effectively together to do what was reasonably possible to try to keep Daniel safe.

In order for North Yorkshire and York services to gain a better understanding of suicide and responses to it, a senior suicide prevention co-ordinator has been recruited to undertake a review of all deaths from suicide during the past five years. The York Safeguarding Adult Board will receive the report for York when it is completed and will continue to work with partners to address any themes or issues arising from it, in particular in relation to adults with care and support needs.

The City of York Safeguarding Adults Board wishes to extend their sincere condolences to Daniel's family and friends.

New Strategic Plan for 2016 onwards

Under the Care Act 2014 it is a legal requirement for the SAB to have a Strategic Plan and to produce an annual summary of its progress. The SAB was clear during 2015/16 that a new method needs to be employed to ensure that its new Plan was based on the views of local residents and staff. As a result the SAB commissioned York Healthwatch to develop an engagement strategy with the local community in York, which fed directly into the new Strategic Plan to be in place by April 2016.

The Strategic Plan for 2016/19 in a very accessible format has now been agreed by the SAB and is already on the website under "Board". It follows the six guiding principles of the Care Act:

Empowerment
People being supported and encouraged to make their own decisions and informed consent.

Prevention
It is better to take action before harm occurs.

Proportionality
The least intrusive response appropriate to the risk presented.

Protection
Support and representation for those in greatest need.

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability
Accountability and transparency in delivering safeguarding

The new Strategic Plan for 2016/19 has an Action Plan for 2016/17 which will be reported on in the next Annual Report.

Annex 1:
Contributions from individual member organisations:

Garrow House Yearly Safeguarding Report (2015/2016)

Training:
All staff employed at Garrow House, clinical or otherwise, undertake e-learning on safeguarding upon induction, which is provided from head office via the Turning Point e-learning resources, which is then refreshed each year. This training is focused upon recognizing the signs of abuse, the law, human rights issues, and similar 'awareness' issues. At the time of writing all staff at Garrow House have undertaken this training within the last year.

Further to the e-learning, all staff at Garrow House, clinical or otherwise, undertake face-to-face internal training using materials provided from head office that is facilitated either by the unit's safeguarding lead, or by members of Turning Point's 'risk and assurance' team. This training builds upon the e-learning training, re-capping the 'awareness' issues already touched upon, and adding a focus on the mechanics of the safeguarding policy, namely alerts and referrals. This training takes place as part of the induction process, and is then refreshed yearly. At the time of writing all but two (27 out of 29) staff have completed this training within the last year.

Regarding the external training on safeguarding provided by City of York council's Workforce Development Unit: Garrow House's operations manager and safeguarding lead do up to level 4, and the senior nurses doing on call duties up to level 2.

Safeguarding Concerns and Completed Enquiries:
the unit raised internally seven concerns in total in the year April 2015 – April 28th 2016.

Five of these pertained to allegations/concerns of sexual assault by third parties unknown to the service while patients were on leave, AWOL, or historical allegations.

Garrow House continues to experience a relatively low number of concerns this year. Generally we have about eight or nine a year, and most of these often pertain to historical claims of abuse from long before their stay at Garrow. This continues to broadly be the case.

Achievements/developments relating to safeguarding:

Regarding making safeguarding personal, patients are always asked their views before referrals are made. These are respected unless issues around capacity, coercion or overriding public interest are present. Training and policy has been adapted to reflect this.

The safeguarding lead produced a safeguarding file in the staff office for staff when they are on nights or weekend and no management are physically around (we have on call managers at all times however!). It contains flow charts regarding the need for putting in a concern; how to put in concerns; what to do in an emergency; how to document concerns etc. This was in response to staff saying that they wanted some more guidance re the process to enhance their confidence in safeguarding situations, in addition to the posters we have up and the policy document itself The flow charts were adapted and lifted from the local multi-agency policy to ensure quality and compliance.

Independent Care Group

Independent Care Group (ICG)

ICG is the representative body for independent care providers (care homes, homecare and supported living services) in York and North Yorkshire.

ICG keeps its members informed on all matters connected to Safeguarding including Safeguarding training and Mental Capacity Act which is offered at no charge from CYC. This includes that changes to Safeguarding Adults brought in by the Care Act. ICG keeps members informed of DBS news.

ICG gives information on Safeguarding training and how to access it on its website.

Leeds and York Partnership NHS
NHS Foundation Trust

Leeds and York Partnerships NHS Foundation Trust

The LYPFT have a high compliance rate for mandatory safeguarding training, the LYPFT provides mandatory training in three levels with the first being online, the second 2 hour face to face and a full day level three for senior clinicians. A number of senior clinicians from York forensic services have now completed this training. The York Forensic service have on site level two training which is aimed at where possible full team training to support the development of whole team approach to safeguarding.

The Safeguarding team attend all Health Action Group development sessions and have individual training priorities such as PREVENT health wrap training, Modern Slavery, DV and FGM.

A training plan has been developed and will be implemented for 2015/16, this builds on a rate of 80% uptake of safeguarding training with an aim of attempting to raise this compliance to 85-90% where possible.

We have safer recruitment in our 2015 audit plan to give more insight into staff awareness and compliance with safer recruitment.

The Safeguarding team contribute to all HR disciplinary enquiries and have provided a number of safeguarding reports for panel.

Training Evaluation

Questions are rated on a scale of 1 to 5. York Training – Nov 14 to March 15

Overall rating are as follows:
5 = 79.5%
4 = 17.7%
3 = 2.8%
2 = 0%
1 = 0%

The evaluation was based on a number of measures from suitability of venue to content The evaluation process was begun in November 2014.

The LYPFT strategy for 2015-16 has been to embed Safeguarding within practice across the Trust. The actions listed have gone some way to continue to raise the profile of Safeguarding across all LYPFT sites and empower staff to recognize and respond to risk where it occurs.

The LYPFT have successfully worked through a transition to transfer care provision in the York region to TEWV. This was complete on the 01/09/15.The aim was to transfer all care whist ensuring no patient care was affected or any patients harmed. A LYPFT Safeguarding advisor was allocated for this period to ensure all cases remaining open were handed over on completion to ASC safeguarding.

As part of this process the remaining LYPFT services within York have been offered an enhanced safeguarding package. To avoid any issues that may arise from providing services some distance from the mainstream, and to acknowledge the complexities that can arise within inpatient forensic services (provided in York); a package of safeguarding support has been offered to the unit in York. This includes attending MDT meetings, offering individual and team supervision and providing Safeguarding training on site at agreed regular intervals.

An external audit of Care Act 2014 compliance was completed in early 2016. This was carried out by the West Yorkshire Audit Consortium.

The audit found that the LYPFT Safeguarding team provided ‘Significant’ evidence that it was compliant with the Care Act and had successfully put in place changes to policy and practice to meet the demands of the new legislations.

An audit of PREVENT referrals has been completed and is awaiting a draft report.

Work was carried out to introduce a number of new work streams into the Safeguarding training packs. The team has had training in modern slavery, FGM and Think Family.

The Domestic Violence agenda is now well embedded within the Safeguarding team; the LYPFT clinical recording system has been updated to include the DASH DV risk assessment form. This now enables LYPFT staff to make risk assessments and direct referrals within the clinical record with the aim of embedding good practice around DV and mental health.

The LYPFT team are in the process of developing a Domestic Violence training pack to be offered across the Trust.

In 2015 the Safeguarding team was allocated a designated section in the electronic recording system (PARIS), this is a step forward in embedding safeguarding advice within the patient record. It is hoped this will develop and enable a strong auditing trail for safeguarding advice and risk. The aims to support staff with accessing safeguarding advice out of hours where advice and plans are in place.

The LYPFT Safeguarding Adult training plan has been updated and amended. Safeguarding Adult training was defined into three levels with a level 3 being introduced. This is aimed at senior clinical staff who have responsibility for supervising and leading staff. The long term aim is to have all clinical staff at NHS band 7 to be level three compliant, in the short term to have one or two senior clinicians to take on the role of safeguarding Adult link for their clinical area.

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital

Safeguarding Training undertaken

Training is fully embedded in Trust induction sessions and in the Trust statutory and mandatory training programmes at Level 1 and 2. This is a bespoke complete Safeguarding Adults, Mental Capacity Act and Deprivations of Liberty Safeguards package. Key individuals in high risk areas receive Level 2 training (how to respond to a safeguarding concern) and the Trust has a training plan for the delivery of Level 1 and further Level 2 training on a 3 year rolling programme.

The Safeguarding Adults Team are all trained to Level 3 (conducting multi agency investigations), and Level 4 (chairing multi agency case conferences) having accessed external training to achieve the necessary competencies.

As there were concerns regarding Level 1 & 2 uptake figures in 2014-15, significant changes have been made to delivery in 2015:

- To ensure increased accessibility the Level 2 training, previous a full day, was transferred to an e-learning package to good effect from April 2015.

- A bespoke Prevent e-learning training package was also developed and became part of the Statutory Mandatory Programme from October 2015.

The introduction of the Trust Learning Hub has also increased compliance of Statutory and Mandatory training uptake.

To further support staff, the staff intranet site now includes Safeguarding Adults resource pages which includes the Trust policy, guidance and paperwork necessary to safeguard a patient whether that is related to general Safeguarding, Mental Capacity or Deprivation of Liberty concerns.

Safeguarding Adults Training Figures 2015/2016

Level 1: 78%

Level 2: 81%

Prevent: 60%

Accessed externally

Level 3: 0

Level 4: 0

See above – all Safeguarding Adults Team staff are currently up-to-date with this level of training, thus there was no requirement to attend such training in 2015-16

Safeguarding Adult Referral/alerts analysis

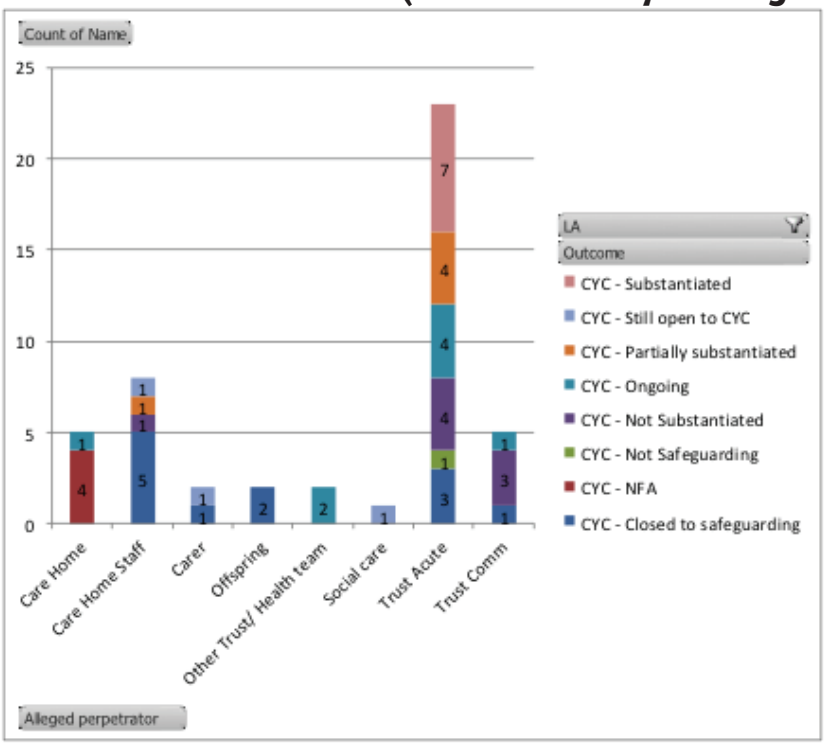
There were 87 Safeguarding Adults alerts received through the Trust Safeguarding Adults Team in 2015/16. This figure relates to all alerts referred through the Safeguarding Adults Team raised either against or by the Trust.

These alerts are either investigated by the Local Authority, or in cases where the concern regard care delivered by the Trust these alerts are investigated by the Trust Safeguarding Adults Team.

Of the 87, 48 were where City of York Council (CYC) was the lead Local Authority.

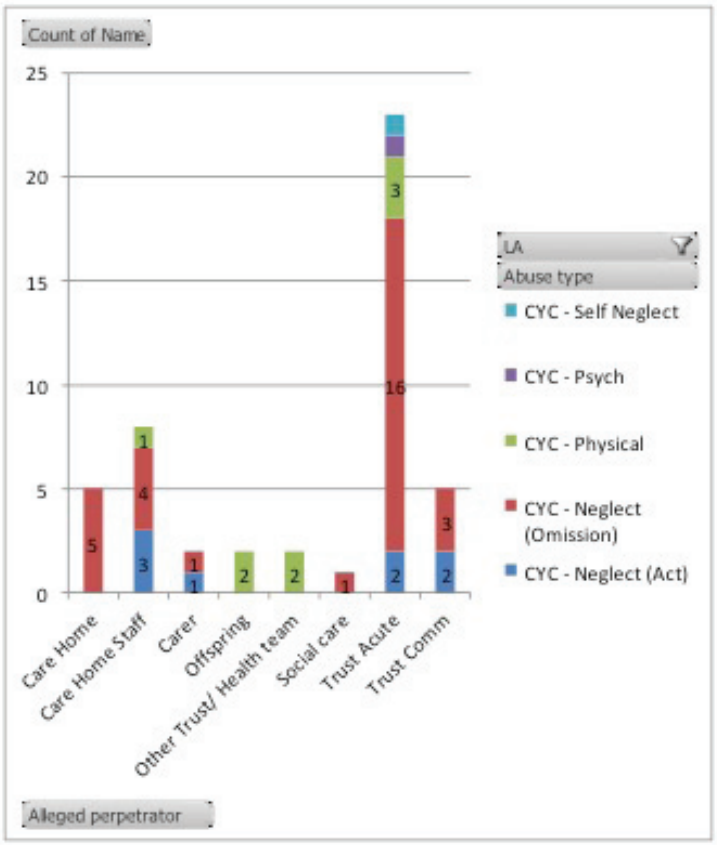
The following data relates only to alerts involving CYC Safeguarding Adults Team. Data is available for other local authorities the Trust serves.

Outcomes for all alerts (both raised by and against the Trust)

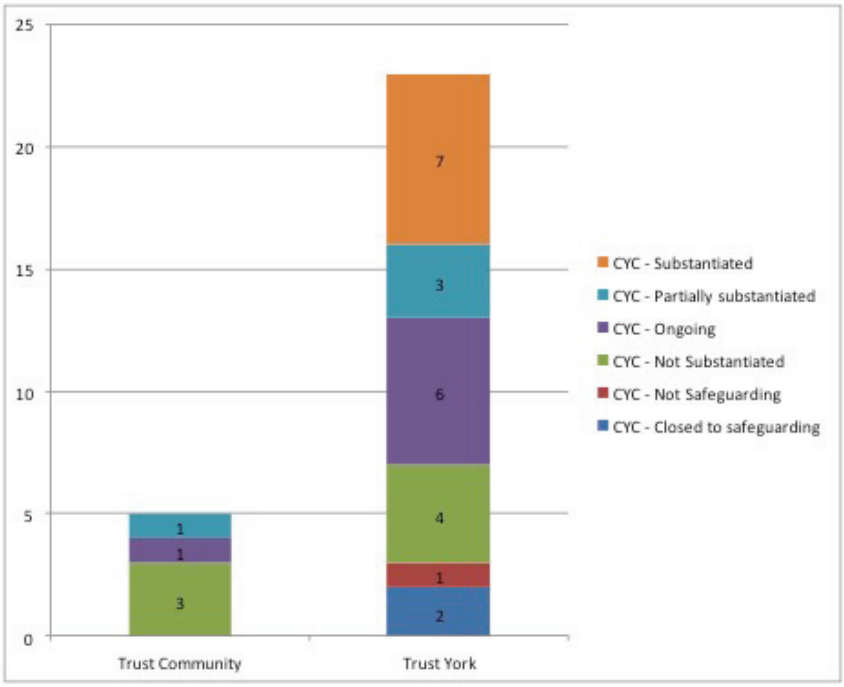


Where the outcome is shown as not known, this is as a result of the Trust raising an alert against another source and there has been no update received from the LA. The Trust Safeguarding Adults team are liaising with CYC for updates.

Type of abuse (all concerns raised against or by the Trust)



Outcome for Alerts raised against the Trust analysis (for CYC only)



Any achievements/developments relating to Safeguarding during the year

Activity within the Safeguarding Adults team continues to be at a high level of demand & complexity.

Under the Care Act (2015) there is a specified approach for the contribution the Trust is required to make in safeguarding adult concerns.

The work of the team has intensified due to fulfilling the scope of enquiries directed by the local authority. There is much more involvement with the patient and/or their representative to focus on their desired outcomes of any investigation and their views. All enquiries begin and end with consultation with the patient and/or their representative. There are also strict time scales enforced to the process which increases pressure on the Team.

The Safeguarding Adults Agenda profile has greatly risen and as a result, so has assurance expectations required from health providers.

Cheshire West ruling continues to dominate, with an ever-changing landscape to enable providers to manage the legislation. The Safeguarding Adults Team represents the Trust at relevant local forums to be in a position to provide regular up-dates of progression/developments.

The implementation of Prevent has been a large project and not without its challenges. However with training and guidance in place, the risk of non-compliance has been reduced to such an extent that it has been removed from the Trust Risk Register.

Trust policies and procedures include the following:

- Safeguarding Adults Policy and Procedures (based on Multi- Agency Policy and Procedures). This has been amended in light of the Care Act 2015.
- Therapeutic Restrictions Guidance
- Mental Capacity Act (NEEDS DATE) Guidance
- Deprivation of Liberty Safeguards (DoLS) Guidance
- Learning Disability Liaison Service Specification
- Prevent Policy

Learning from Safeguarding Adults Investigations

Learning from Safeguarding Adults Investigations have led to the following Trust initiatives:

- Task and Finish group to develop policies, training and risk management tools to support staff care for patients with Mental ill-health.
- Close liaison, training and policy development with the Head of Security in respect of vulnerable adults requiring the support of security
- Matron involvement in delivering actions arising from Safeguarding Adults Investigations.
- Review of Exclusion Policy
- Discharge Improvement Working Group
- Improved pre-operative body marking systems

Training

Significantly improved Safeguarding Adults mandatory Training uptake and compliance has been a major achievement in 2015. Concerning statistics in 2-014-15 meant that a fresh approach to delivery was required. As a result, previous face-to-face training was substituted by e-learning, and compliance was also increased by the introduction of the Trust Learning Hub, which facilitates all Trust staff, in a user friendly intranet site, to ascertain what training is available to them & whether they are currently compliant with their mandatory training requirements.

NHS England have recently published "Safeguarding Adults: Roles and Competences For Health Care Staff, Intercollegiate document" (2016) and as a result the current Trust training delivery is being reviewed to ensure all aspects of the competences are addressed at appropriate levels.

Nicola Cowley - Lead Nurse for Safeguarding Adults
April 2016

NHS England Yorkshire & the Humber

Contribution to Local Safeguarding Adult and Children Boards Annual Report 2014-15

The overall responsibilities of NHS England in relation to safeguarding

NHS England was established on 1 April 2013 and has an assurance role for local health systems and directly commissions some services. NHS England has worked with Clinical Commissioning Groups to ensure their commissioned providers take all reasonable steps to reduce serious incidents. NHS England provides assurance that the local health system, including Clinical Commissioning Groups (CCGs) and designated professionals, are working effectively to safeguard and promote the welfare of children and adults at risk (Safeguarding Vulnerable People Accountability and Assurance Framework, NHS England 2013). This role includes ensuring that CCGs are working with their directly commissioned providers to improve services as a result of learning from safeguarding incidents. These services include acute, community, mental health and ambulance care.

NHS England responsibilities in relation to direct commissioned services

NHS England is responsible for driving up the quality of safeguarding in its directly commissioned services and for holding these providers to account for their responses to serious safeguarding incidents, ensuring that safeguarding practice and processes are optimal within these services. In Yorkshire and Humber, this includes all GP practices, dental practices, pharmacies, optometrists, health and justice services and the following public health services:-

- National immunisation programmes
- National screening programmes
- Public health services for offenders in custody
- Sexual assault referral centres
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme)
- Child health information systems

From April 2015 onwards, NHS England will commence a programme of transferring responsibility for GP practices (and eventually all other primary care providers) to CCG's with delegated powers of co-commissioning.

NHS England has worked in partnership with local Safeguarding Boards to ensure that the NHS contribution is fit for purpose and that there is no un-necessary duplication of requests for safeguarding reviews to be undertaken. NHS England also has its own assurance processes in place concerning NHS safeguarding reviews, learning and improvements.

Sharing learning from safeguarding reports

In order to continuously improve local health services, NHS England has responsibility for sharing learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, making sure that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England North Yorkshire and Humber Safeguarding Forum has met on a quarterly basis throughout 2014-15 to facilitate this along with sharing learning.

Training programme for general practice

Designated safeguarding professionals are jointly accountable to Clinical Commissioning Groups and NHS England. They have overseen the provision of level 3 training for primary care medical services. Training sessions have been provided on a locality basis rather than to individual practices. The main source of training for other primary care independent contractors has been via e-learning training packages.

Assurance of safeguarding practice

NHS England North Yorkshire and the Humber have provided templates for CCGs to feedback on the assurance of safeguarding practice as well as developing safeguarding standards and aspirations for GP practices to benchmark themselves against. These standards will be reviewed and updated annually and incorporate learning from recent serious case reviews within Yorkshire and the Humber.

Standard Operating Procedure: Safeguarding Incidents

In order to establish a strong governance framework surrounding safeguarding incidents NHS England Yorkshire and the Humber have developed a Standard Operating Procedure: Safeguarding Incidents. This describes communication processes regarding these incidents and sets out NHS England's role and responsibilities in quality assuring review reports, signing off reports and ensuring improvement actions are implemented. It clarifies the interface between NHS England Yorkshire and the Humber and the North Yorkshire and Humber designated safeguarding professionals who are hosted by CCGs yet have a dotted line of accountability to us and work closely with us to enable us to deliver our statutory duties in relation to safeguarding incidents.

North Yorkshire Police

North Yorkshire Police is committed to protecting vulnerable people and taking positive action against those who commit crimes against them. This is achieved by:

- Investigating possible crimes, either as a single agency but more importantly by conducting joint investigations with our partners
- Gathering the best possible evidence to maximize the prospects for prosecuting offenders
- Achieving, with partners, the best protection and support for the person suffering abuse or neglect
- Enhanced access to counselling, where appropriate, for any victim

North Yorkshire Police have enhanced the MASH Unit – which is now called the Vulnerable Assessment Team. This enhancement has seen the setting up of meetings where those at risk of CSE are discussed in a multi-agency forum to ensure that all information is known by all agencies and a plan put into place, This is not only to protect the victim but also to gather evidence to identify offenders. This ensures that all those who are vulnerable and at serious risk of crime being committed against them, or already victims receive the best possible service and that all areas of Safeguarding are addressed.

This enhancement also ensures that there is a close working liaison with City of York Adult Safeguarding Team.

Staff within the Force Control Room has received enhanced training and awareness. They work to the THRIVE principle, which is - threat, harm, risk, investigation, vulnerability and engagement. This approach ensures that those with vulnerabilities re identified at the earliest opportunity and that the right response is given at the right time according to need, vulnerability and risk.

Training in relation to Safeguarding Adults is built into all of NYP's initial training programs in a variety of ways. All Police constables and all new PCSO and SC complete a Vulnerability Training Package. The aim of this training is for staff to understand their responsibilities and duty of care to vulnerable people and the actions that must be taken to reduce any identified risk.

Vulnerable Risk Assessments Training focuses on identifying t hose individuals that are at most risk in local communities, how to complete a VRA and what referrals need to be made to whom and when.

WRAP – Workshop to Raise Awareness of Prevent has also been rolled out to staff, assisting officers to identify those that maybe at risk of radicalisation because of vulnerability.

Training will be delivered this year to staff to include areas such as EDHR, Modern Slavery and Hate Crime.

It is estimated that incidents involving people with a mental vulnerability account for around 40% of policing time. For example, research suggests that:

- around 80% of people going missing from home are experiencing a mental health crisis
- people with a mental vulnerability are ten times more likely to be a victim of crime than the general population
- 69% of women and 49% of men with severe mental illness reported adulthood domestic violence
- 40% of women with severe mental illness had been the victims of rape or attempted rape
- Suicide is the leading cause of male mortality for those under 50yrs of age

NYP and University of York were successful in a £1.1M bid to the Police Knowledge Fund to undertake research into policing and mental health. The project also includes the development of a training package for frontline staff to improve our effectiveness in identifying, recording, responding to, referring and reviewing incidents involving a mental health component. To enhance capability in this area, NYP and OPCC have contracted with the NHS to employ Registered Mental Nurses (RMNs) to work alongside police in Mental Health Triage schemes in:

- Force Control Room
- Scarborough, Whitby and Ryedale
- Vale of York

NYP has also revisited the domestic abuse problem profile and written a Human Trafficking and Modern Slavery Problem Profile.

A draft Problem Profile on those who are 70+ in years has recently been completed with observations and recommendations. Further analysis is required before being presented to NYP's internal Operational Delivery board for governance and acceptance for action.

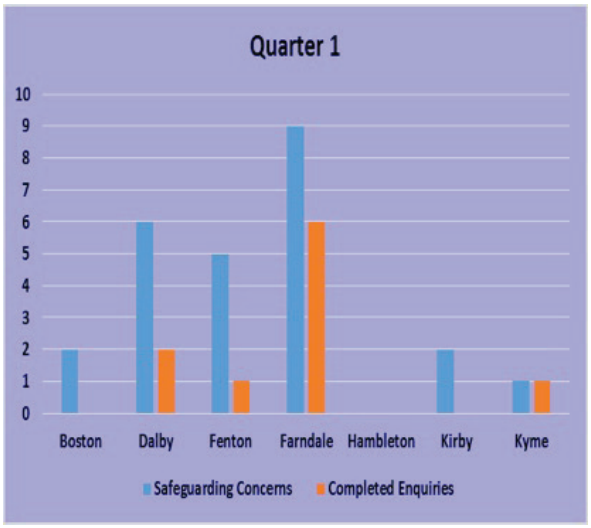
Partnerships in care

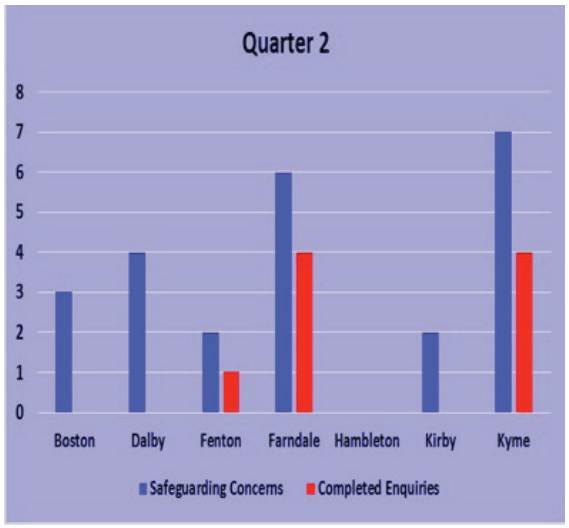
Stockton Hall Hospital, Partnerships in Care

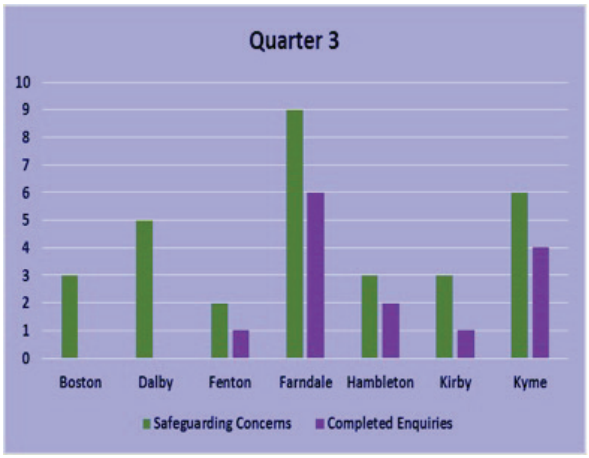
Information about safeguarding training undertaken internally and externally during the year by relevant staff plus any evidence of impact.

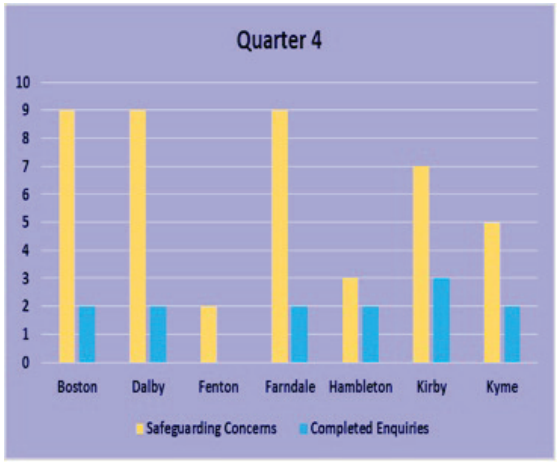
Newly recruited members of staff continue to receive level 1 safeguarding adults' awareness training during the induction course, 100% compliance. There is also a requirement for clinical and non-clinical staff to attend annual statutory/mandatory safeguarding training, 85% compliance. Additionally, Level 3 Safeguarding Investigator training has been provided to senior managers and clinicians by Community Links on behalf of City of York Council.

Workshop to Raise the Awareness of Prevent (WRAP) sessions, under the auspices of the Government's Counter Terrorism Strategy, have been provided to qualified clinical staff in accordance with NHS contractual requirements. During the year 95 members of staff have attended, 93% compliance. Members of staff employed to work in PIC regional units have also attended WRAP training whilst on induction at Stockton Hall Hospital. Feedback has been for the most part positive. The Safeguarding and Security Leads have completed the WRAP Train the Trainer session. WRAP sessions are being integrated into statutory/mandatory training for all members of staff who have contact with adults and children from April 2016.







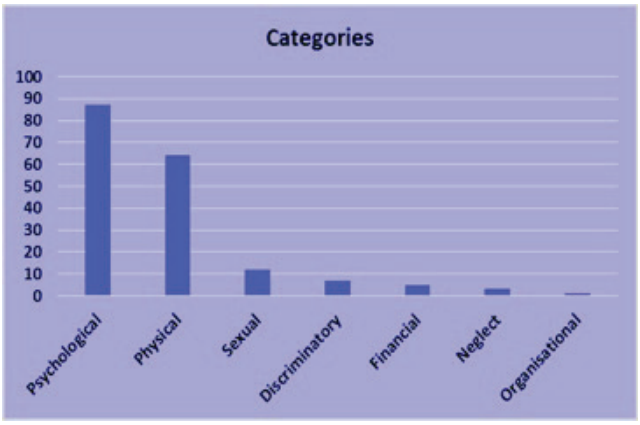


There were 124 safeguarding concerns during the year, of which there were 50 investigations/ enquiries (40%) following being reported to the CoY Safeguarding. This data demonstrated small increases compared with the previous year. Farndale, a 16 bed female ward had the largest number of safeguarding concerns (33) and investigations/enquiries (18), equating to 54.5% of concerns. Kyme, a 16 bed male learning disability ward had 19 safeguarding concerns and 11 Section 42 investigations/ enquiries (58%). It is noted that of the 17 safeguarding concerns on Dalby, a 16 bed male personality disorder ward, 2 (12%) resulted in investigations/enquiries and of the 17 safeguarding concerns on Boston, a 24 bed male mental illness ward, 4 (24%) resulted in investigations/enquiries. There were 10 outstanding investigations/enquires at the end of the year.

Patient Safety Meetings and safeguarding investigations/enquiries have become increasingly service user focused, thereby applying the principles of Making Safeguarding Personal. Of the 40 completed investigations/enquires 28 (70%) concluded that the safeguarding plan had led the adult at risk to feel significantly safer or there was no evidence that they had experienced harm or potential harm. Adults at risk now regularly attend patient safety meetings and documentation, including clinical notes and minutes from meetings, include direct quotes about the nature of the alleged neglect or abuse and the feelings of the individuals involved. However, it is acknowledged that further information is required to accurately reflect the longer term views of adults at risk regarding their involvement in the safeguarding process.

Twelve of the safeguarding concerns regarding members of staff, including a historical allegation from a previous care setting and inappropriate comments by four ex-members of staff on social media involving the disclosure of abusive and confidential information about a current service user and an ex-service user. Of the remaining nine safeguarding investigations/enquiries into alleged staff misconduct two resulted in investigations upholding the complaints and subsequent disciplinary action being undertaken.

An ethnicity audit was completed following the Safeguarding Adults Self-Assessment. Distribution of the patient population by ethnicity in the year 2015/16 indicates that just over 80% reported their ethnicity as British (White) this was followed by Pakistani (Asian or Asian British) at just over 5%, next was the African (African or Black British) at just above 3%. All other ethnic groups were at less than 2% each. Attention was given towards safeguarding concerns for all the ethnic groups. The most significant finding was that the Irish (White) ethnic group had a higher occurrence of safeguarding concerns proportionately in relation to population size. However, it is noted that this data was influenced by 7 safeguarding concerns being reported by one Irish (White) adult at risk.



The most significant change from the previous year has been the relative increase in safeguarding concerns under the category of psychological abuse, which is often a duel category with other forms of abuse. There was also a proportionate reduction in reported physical abuse allegations. It is noted that there have been no safeguarding concerns under the additional categories introduced by the Care Act 2014 which is being addressed through training.

Any achievements/developments relating to Safeguarding during the year.

A Safeguarding Practice Group has been established. The group meets monthly and includes the charge nurses as the ward based safeguarding leads and senior managers. The purpose of the group is to discuss practice issues arising from the safeguarding process, including lessons learnt and to discuss information from the SAB. It is an expectation that charge nurses will submit written reports in preparation for the meetings, including a review of actions taken to prevent concerns from arising, methods of addressing safeguarding concerns, reporting arrangements and a summary of open/closed safeguarding investigations/enquiries. It is planned for representatives of the PIC regional units to be invited to attend future meetings.

Liaison between the NHS England Specialist Commissioning Team and the Clinical Commissioning Group was facilitated following the request from the SAB regarding learning disability service users placed at the hospital from other regions of the country in order to be compliant with the Winterbourne Concordat.

A meeting, attended by the senior managers of the hospital, North Yorkshire Police and the City of York Safeguarding Adults Team took place to discuss reporting arrangements. The meeting reviewed the draft amendments to hospital policy to clarify lines of responsibility for the reporting of alleged crimes, ongoing liaison with North Yorkshire Police, communication between the hospital and the police including the establishment of a single point of contact and the coordination of criminal investigations and safeguarding investigations/enquiries. A revised protocol is being developed which the SAB will be requested to authorise.

There has been liaison with Rethink about ensuring that the Independent Mental Health Act Advocates (IMHAs) receive relevant training about the Care Act 2014 in order to represent the needs of adults at risk who lack capacity following safeguarding concerns being raised.

Partnership Commissioning Unit
Hambleton, Richmondshire and Whitby CCG
Harrogate and Rural District CCG
Scarborough and Ryedale CCG
Vale of York CCG

The Partnership Commissioning Unit (PCU)

The Partnership Commissioning Unit (PCU) is contracted to host the role of Designated Lead Professional for Safeguarding Adults on behalf of the NHS Vale of York Clinical Commissioning Group (CCG) and as such works closely with City of York Council, North Yorkshire Police and other health and independent sector partners to safeguard adults in York. The role and function of the Designated Professional covers the whole health economy across the City. In addition to the Designated Professional within the PCU there is a team of four safeguarding officers. The safeguarding officer function undertakes delegated enquiry work on behalf of the City of York Council where health concerns feature as a predominant factor.

The team of safeguarding officers have had a busy and challenging year. Their role has included attendance at enquiry planning meetings, undertaking investigations and writing reports for outcomes meetings. The safeguarding officers have also responded to requests from health and social care professionals for health and safeguarding advice and provided scrutiny and overview of safeguarding cases. The bulk of the enquiry work completed by the safeguarding officers has been in relation to care homes and as such they have worked closely with the Care Quality Commission and the Local Authority contracting team to undertake assurance visits to independent providers of care. They have maintained ongoing support to providers across the City where standards of care have required improvement, continuing that contact and overview until care standards have returned to an acceptable level.

The majority of safeguarding cases which the PCU safeguarding team have been involved in during 2015/16 have been in the categories of physical abuse and neglect or omission of care. The current database system for recording the work of the team has not easily supported providing data on the numbers of cases that the team has been involved in within York. This is an area that we would like to make improvements to in 2016/17. Also for 2016/17 the team will be further developing and embedding 'making safeguarding personal'. Whilst the principles are already in place – the practice requires further work and alongside our partners this will be an exciting challenge for 2016/17.

In addition to fulfilling their statutory and mandatory safeguarding training requirement in 2015/16 the safeguarding officers have attended specialist training in Safeguarding Concerns & Alerts (1 day); Root Cause Analysis (2 days); Mental Capacity Act and Advanced Decisions (1 day), Prevent WRAP (Workshop Raising Awareness of Prevent) and Fundamental Standards of Care (1/2 day).

The PCU has provided an additional role seconding the Deputy Designated Nurse Safeguarding Adults for NHS Vale of York CCG to undertake work related to the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS). This work has comprised developing assurance and embedding of MCA/DoLS in health care practice through: engagement, support, supervision, training and resource development.

The training below has been completed for GPs and primary care staff – jointly facilitated as part of Safeguarding Adults and Children 'Hot Topic' events with the Safeguarding Nurse Lead for primary care and for the Continuing Healthcare Team (CHC) – jointly facilitated with City of York Council DoLS team staff.

Date	Venue	Number attended
For CHC nurses & team leaders		
22.09.15	Sovereign House	15
20.10.15	Sovereign House	12

For GPs & Primary Care		
07.10.15	New Earswick Folkhall, York	21
10.11.15	Galtres Centre Easingwold	10
02.12.15	Maple Court York (Out of Hours GPs)	10

The PCU MCA/DoLS lead and the City of York DoLS Lead jointly facilitated a public engagement event 'No decision about me without me' on National Mental Capacity Act Day 15th March 2016 providing information and advice to members of the public around the principles of the Mental Capacity Act 2005 with particular focus on making advanced decision and Lasting Powers of Attorney.

The Senior Suicide Prevention Officer successfully recruited in 2015 and hosted by the PCU has been part of a team with Public Health and North Yorkshire Police working to complete an audit of all suicide deaths in York covering a five year period. The report will be completed later in 2016 and will add a valuable source of knowledge to inform the prevention and protection work of the York Safeguarding Adults Board.

The Designated Professional, in addition to undertaking the function of assurance work for the CCG and NHS England, has worked with partners in North Yorkshire Police, City of York Council and North Yorkshire County Council to develop and launch the joint protocol for 'Adults at Risk - missing and absent from home or care' which incorporates the Herbert protocol. Use of the protocol enables family members, carers and providers in care settings to share vital information when adults with significant vulnerabilities go missing from either their own home or a care setting so that they may be found, protected and hopefully returned safely within the quickest possible timeframe.

The Designated Professional has been an active member of the City of York Safeguarding Adults Board and has completed the two Learning Lesson Reviews on behalf of the Board.

(Christine Pearson, Acting Designated Professional for Safeguarding Adults)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Esk and Wear Valleys NHS Foundation Trust

Training

Level 1 training – raising a concern – is aimed at all staff within the Trust. This training is available to staff to access via e-learning. Face to face sessions will be organised within the York area in due course.

Level 2 training – responding to concerns – is aimed at all clinical staff, Band 5 and above within the Trust. This training is delivered face to face and sessions are arranged to commence April 2016 in the York area. However, staff can also access other venues across the Trust and bespoke sessions. To date there have been 12 staff trained in this time period.

Safeguarding Concerns

During Q3 & Q4, there were 58 concerns raised with the Safeguarding Adults team (see Fig 1). 29 of these concerns were referred on to the City of York Council. From these 58 concerns, 29 of them were regarding inpatients.

Fig 2. shows a breakdown of the concerns raised by speciality with the majority of concerns being raised within adult mental health and Mental Health for Older People services.

Fig 3. Highlights the categories of abuse that have been raised during Q3 & Q4. The predominant category of abuse raised is physical abuse (25) with 20 of these concerns related to inpatients (which are predominantly patient on patient assaults).

Figure 1

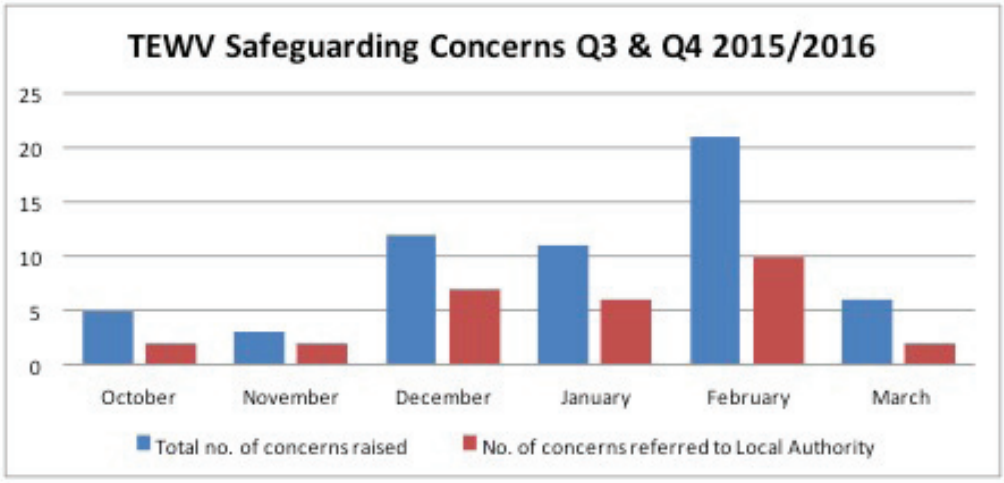


Figure 2

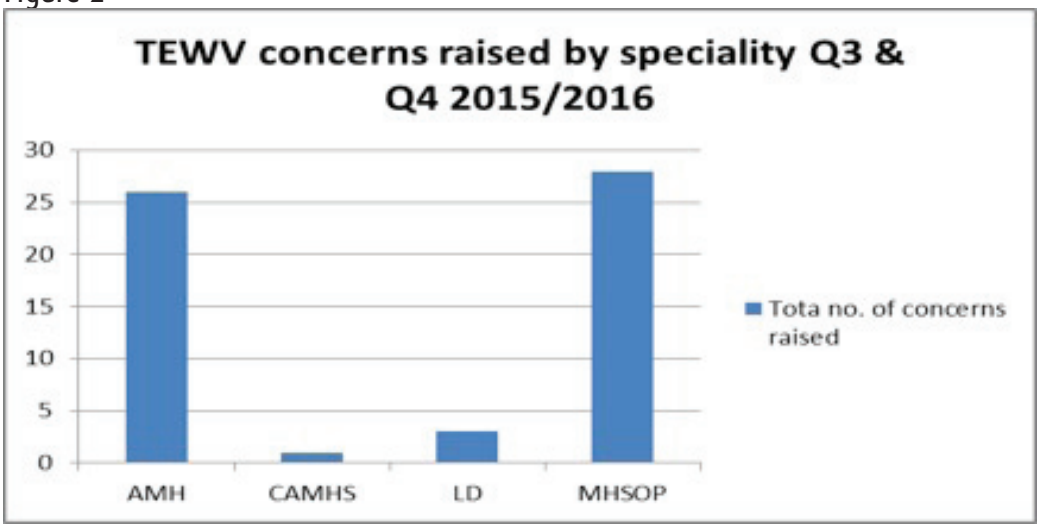
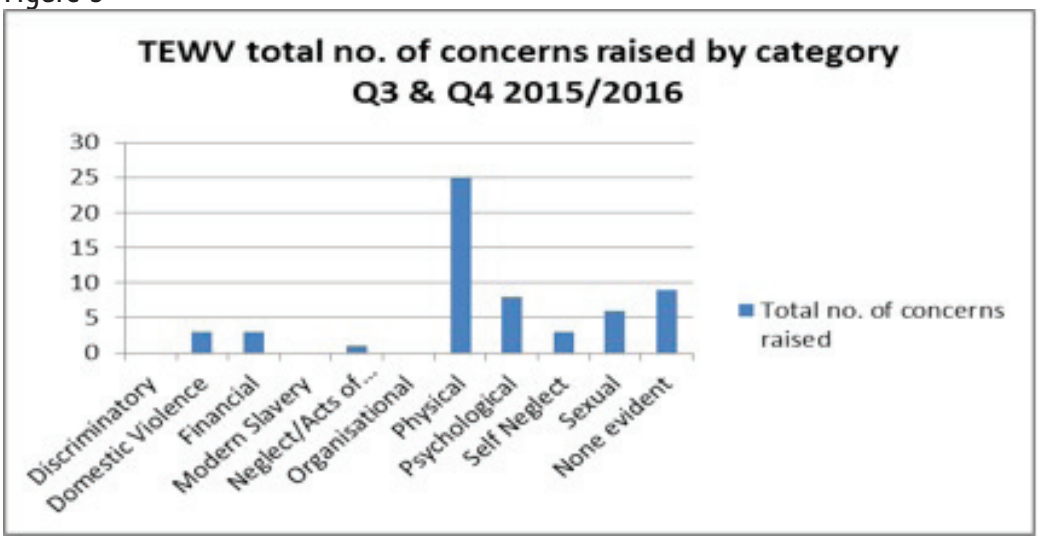


Figure 3



Any achievements/developments relating to Safeguarding during the year

Development of a York based TEWV Safeguarding resource including safeguarding adults, safeguarding children and MARAC, to provide advice and support to York staff, facilitate multi agency collaboration and provide staff training.

York staff are now aware how to access TEWV Safeguarding Adults team for advice and support in relation to any safeguarding concerns raised. Verbal feedback from staff is they feel this assists them to feel more confident around raising a safeguarding concern.

Bespoke Level 2 training sessions have been offered to York staff during Q3 & Q4. Training in York, for both Level 1 and Level 2, is planned for 2016/2017.

Safe transfer of patients from Bootham Park in December 2015 following CQC closure notice.

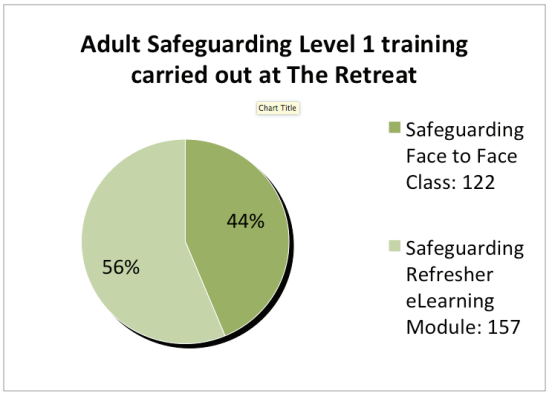
Attendance at York MARACs to facilitate information sharing and risk assessment and management.

The Retreat Yearly Safeguarding Report (2015/2016)

Safeguarding training

Adult Safeguarding Level 1 (Alerter) Training compliance for the hospital was 94% (279 people out of 296 required to complete). The safeguarding training level 1 is delivered face to face to all new starters (122) and as an eLearning refresher module (157).

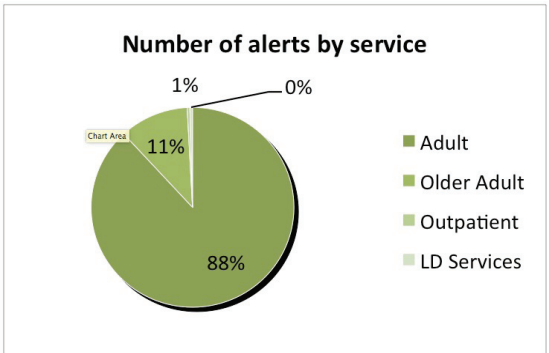
Compliance for external training: Adult Safeguarding Level 2 (Responder) was 85%, Level 3 (Investigator) was 100% and Level 4 (Chair) was 50%. Training compliance for hospital varied due to problems with accessing the training at WDU.



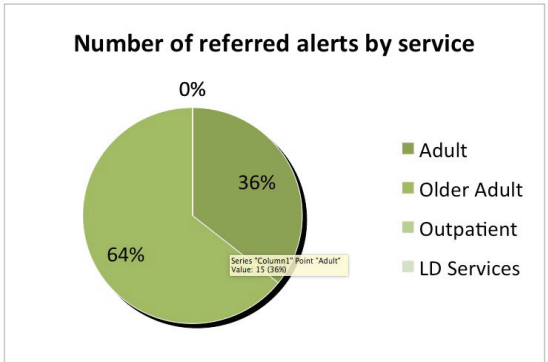
The impact of the new safeguarding training (revised at the beginning of 2014 and again in 2015 following the changes brought by the Care Act 2014) has been positive. The rate of reporting low level incidents has improved; also the levels of understanding and confidence have increased among the frontline staff.

Safeguarding alerts and responses

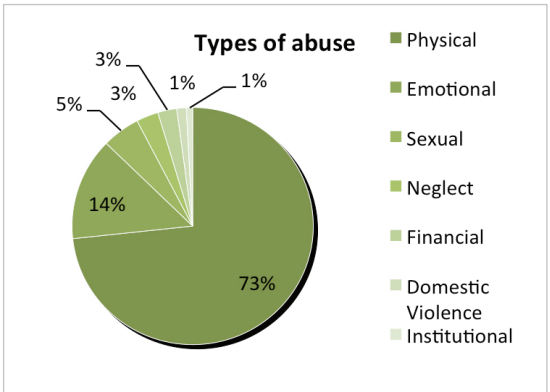
The number of reported safeguarding alerts has been on the rise over the last 4 years: 62 in 2012, 85 in 2013, 159 in 2014 and 236 in 2015. The number of alerts received is much higher than the previous year (increase of 48%) and as mentioned before this can be associated with an improvement in reporting.
The number of alerts which were later referred to the City of York Council Safeguarding Team and Care Quality Commission did not change much over the last few years: 39 in 2012, 39 in 2013, 32 in 2014 and 42 in 2015. The number of the referred alerts did not go up with the increase of the alerts.



The new average for the quarter is 59 alerts, in comparison with 55 in the previous year (increase of 7%). The average number of referred alerts per quarter was 10 (8 in previous year), which has been a fairly stable number for the last three years.



The significant majority of alerts: 208 (88%) were submitted within older adult services in comparison to 26 (11%) reported on adult units and 1 each reported in Outpatient and Learning Disability (LD) services (0.5% each). However when it comes to the referred alerts the figures present a different picture: 64% of cases were from older adult, 36% were from adult services (none from Outpatient and LD services). Further analysis shows that only 12% of all alerts submitted within older adults are referred, while in adult services this figure is significantly higher (58%).



The cases of physical abuse account for the majority of all of the alerts: 173; emotional abuse was reported in 33 cases, sexual in 12, neglect in 7, financial in 6, domestic violence in 3 and institutional in 2 cases.

The cases of 3 major types of abuse recorded an increase: physical abuse have increased by 50%, emotional abuse by over 80% and sexual abuse by 30% in comparison to the previous year. The neglect cases have fallen by 20%.

Person alleged to cause harm (PATCH) was in 185 cases a current patient of The Retreat, in 28 cases allegations were made against staff, and in 23 cases the PATCH was identified as external which includes family members, friends, ex-patients, agency staff and other agencies.

In 158 cases the allegations were proved, in 67 cases they were disproved and in 11 cases the social workers were not able to determine the outcome.

Achievements in relation to safeguarding

The Retreat have made significant improvements both in 'Making Safeguarding Personal' and the overall involvement of people who use our services, or where they lack capacity to involve their families. Each time a safeguarding concern is raised the view / outcome a person wants from the safeguarding process is sought by the safeguarding link worker. The Retreat now monitors if the outcome identified has been met.

The Retreat has reviewed its safeguarding enquiry process to good effect and now ensures that people who use our service are involved throughout; also by involving different clinical disciplines safeguarding is now everybody's business and as such safeguarding enquiries are now carried out by members across a multi-disciplinary team.

The Retreat has allocated a full time post to manage the safeguarding process; this has ensured consistency for the people who use our service and the development of multi-agency process and policy. The Retreat's social work department has further improved its own system of monitoring data, which has helped to analyse the safeguarding within the organisation and determine current trends.

The Retreat continues to hold a strong relationship with the local authority safeguarding team and is working currently to complement our reviewed processes in line with the Care Act 2014.The Retreat continues to co-chair the safeguarding implementation group to share and develop good practice.

NHS Vale of York Clinical Commissioning Group

The best health and wellbeing for everyone.

NHS Vale of York Clinical Commissioning Group (CCG)

NHS Vale of York Clinical Commissioning Group (CCG) is responsible for commissioning hospital and community healthcare services for the Vale of York which includes the City of York population and has a range of statutory duties which includes Safeguarding Adults. The Chief Nurse is the Executive Lead for Safeguarding in the CCG and as such works closely with the Partnership Commissioning Unit (PCU) Safeguarding team, NHS England, the City of York Council, North Yorkshire Police and other partners on the City of York Safeguarding Adults Board.

To strengthen the commitment to safeguarding the CCG also employs a Deputy Designated Nurse for Safeguarding Adults with a particular focus on supporting quality in the independent care home sector. As part of this commitment the CCG has continued to develop a care home meeting forum 'Partners in Care' where care home managers can connect with CCG staff and get involved in training events and project work with a focus on innovation and improvement of patient care.

During 2015/16 the deputy designated nurse has worked together with the PCU on a number of safeguarding enquires and investigations, in addition to spending time with the City of York Council contracts team shadowing assurance visits to care home providers. As part of a secondment role the deputy designated nurse has worked with the Partnership Commissioning Unit as Lead for Mental Capacity Act and Deprivation of Liberty Safeguards – more about this role is in the Partnership Commissioning Unit section of the report.

The CCG has developed a soft intelligence tool to capture information from General Practitioners, Primary Care staff and Care Home Managers in relation to concerns that they have with the care and treatment of vulnerable people. The CCG meets with colleagues in City of York Safeguarding team and the Care Quality Commission to share 'early warning' signs which may indicate that services are struggling to maintain safe services. This has been developing work in 2015/16 and the challenge for 2016/17 along with partners will be to structure the support that is offered to struggling services at a point before it impacts on the care of those most vulnerable.

In 2015/16 the CCG secured the roles of Nurse Consultant and Named Doctor for Safeguarding in Primary Care Services. Each GP practice in York also identified a lead for safeguarding in their primary care team. This structure has enabled a clear pathway for information sharing, specialist advice and support and improved visibility of the primary care commitment to safeguarding. A number of safeguarding 'hot topics' training events have been completed in venues across York to support GPs and primary care staff in their safeguarding roles. The training events have been successful and following feedback gathered from attendees the programme of training for 2016/17 has been developed. The Nurse Consultant has also standardised the safeguarding adults' policy and procedure for primary care – with the completion of a generic policy which practice managers can adapt for their particular surgeries.

NHS Vale of York Clinical Commissioning Group (CCG) announced Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) as the provider of mental health and learning disability services in the Vale of York for the next five years, commencing on 1 October 2015. The contract was developed with partners after a series of in-depth discussions with local service users, members of the community and clinicians through DISCOVER. This was an extensive engagement programme to listen to and collate the views of people from across the Vale of York to help develop high quality mental health and learning disability services. The CQC did not re-register Bootham Park Hospital as it did not meet the standards and this occurred at very short notice. This was an unforeseen consequence which had the potential to compromise the care of people with a high level of vulnerabilities. The CCG worked jointly with NHS England and other key partners to learn lessons from the closure and is continuing to work closely with partners in TEWV to provide in-patient acute services back in York by summer 2016 and a new permanent base for mental health services in York with facilities that are fit for the 21st century.

The financial picture for 2016/17 is a challenging one across the health economy in York and the CCG is working in conjunction with its partners to transform services and create sustainability of safe services for the population. The CCG will continue to uphold the six principles of safeguarding adults in all its work and will continue to meet its statutory obligations as a partner of the City of York Safeguarding Adults Board.

yorkcvs

York CVS

The ILS (Independent Living Service) team have undertaken safeguarding training in relation to the adults they support. We have begun to review our safeguarding policy so we can use this to provide staff training in 2016/17.

We continued to provide forums (8 in total) across the year so organisations who support older adults, and adults with learning disabilities, can come together and share concerns and good practice. Safeguarding was a standing item on the agenda for these forums.

Information (ie graphs, numbers) about any Safeguarding Concerns and Completed Enquiries during the year including analysis by location and type

We logged two safeguarding incidents with City of York Council during the year.
Any achievements/developments relating to Safeguarding during the year

We have attended the Safeguarding Adults and Children's Board Development Days and attended both the Safeguarding Adults and Children's Boards.

YORK HOUSE
A neurobehavioural service for acquired brain injury

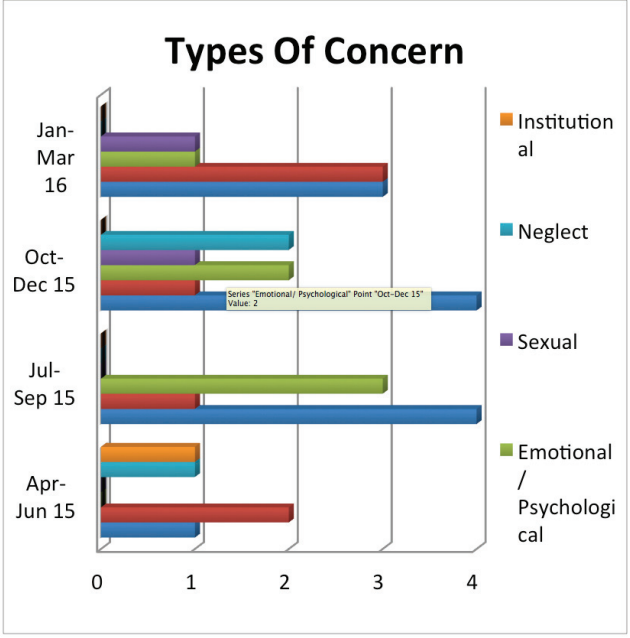
York House

Training

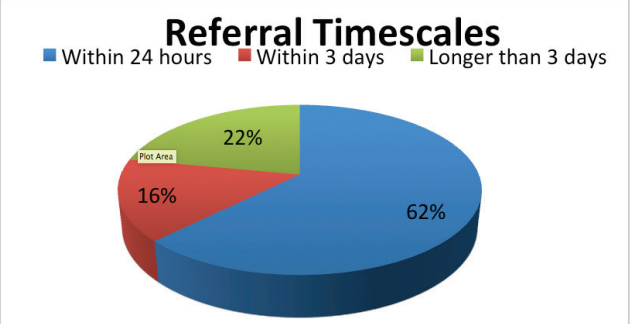
All new staff must complete the in-house Safeguarding training within their initial induction week before they start working with Service Users and they complete two shadow sessions. After this induction period the aim is for all staff to attend training yearly to ensure they are kept up to date with any changes and refresh their knowledge. The table below shows the percentage of staff who have completed Safeguarding training between 31st March 2015 and 1st April 1016:

	Contract	Bank	Total
% Completed Training	72	68	71

York House aims to realistically have 95-100% of staff completing yearly training in safeguarding. The current low percentage is down to down to a higher staff turnover this year and staffing numbers falling below our ideal staffing establishment levels and so facilitating training has been more difficult. All staff have completed the initial training, however the numbers reflect the completion of the yearly mandatory refresher. We have reintroduced e-learning safeguarding training, however the preference will always be for staff to complete face-to-face training delivered by our Legislation and Safeguarding Manager.
100% of the safeguarding sub-committee have completed level 2 external training and we are in the process of sourcing levels 3 and 4 from Work Development Unit.



The training package has been updated to incorporate the new legislation brought in by the Care Act in April 2015.



Types of Abuse

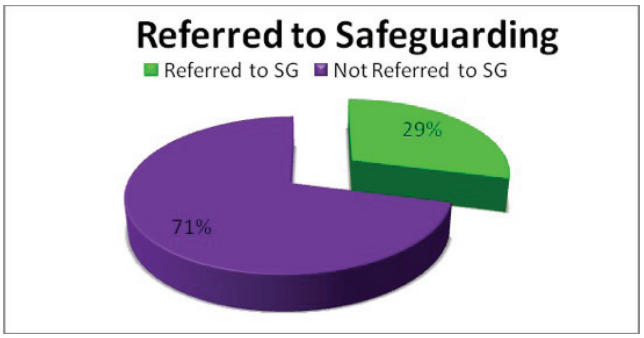
There were 31 concerns raised in total between April 2015 and April 2016. The graph shows the types of concerns raised in each quarter. The majority of the cases were physical abuse accounting for 12 incidents all of which were service user on service user incidents. Financial abuse accounted for 7 of the cases, emotional/psychological in 6 of the cases and sexual, neglect and institutional jointly making up the other 6.

Timescales

62% of concerns raised in the last 12 months have been referred to the safeguarding subcommittee within York House and then to City of York Council id necessary within 24 hours of the concern being raised.

Referrals

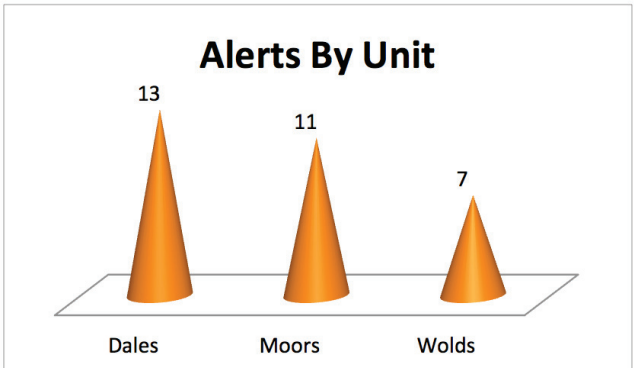
71% of all concerns were not formally referred on to the City of York Council Safeguarding and were managed in-house following discussion with the safeguarding subcommittee and/or members of the MDT were it is assessed that the risk and management is sufficiently in place. Those that were dealt with in-house were all closed based on the effective management of risks and protection plans and/or support measures being implemented.



Some of those handled in-house were discussed with City of York Council but it was agreed with them that it was more appropriate that they were dealt with in-house. 29% of concerns were referred to CYC Safeguarding; there are still two that remain open (both from December 2015 and in relation to York District Hospital). These have been regularly followed up in the aim to bring them to a close, however due to the investigating hospital not completing the investigation we are unable to.

Alerts by Unit

As you can see from the graph shown the majority of alerts are from the Dales unit followed by the Moors. The Dales is the main assessment unit (males only), however any females whether or not under assessment reside on the Moors as the only mixed gender ward. Due to the Dales being the main assessment unit the behaviours are often more challenging and unpredictable with care plans and management of challenging behaviors still being formulated. This can lead to difficult dynamics between service users. The Moors is a slightly slower stream assessment unit where as expected behaviours are often more stable, however there has been an increase in the number of female admissions to the Moors and so there may be an increase in the number of incidents due to the challenging behaviours displayed, however we do not believe there to be a safeguarding concern at this time. The Wolds unit is focused on long term care needs with a focus on quality of life as opposed to rehabilitation. However the mix of Service Users are complex, variable and long standing challenging behaviours can still contribute to safeguarding issues raised.



Summary

Due to various staff members leaving York House, the safeguarding sub-committee has been re-established in the past 6 months. It now includes a cross section of clinicians, led by the legislation and safeguarding lead. Training plans are in place to increase education and awareness of new staff nurses to York House, in addition to the induction training. One of the main challenges faced in "making safeguarding personal" continues to be in relation to communication, memory and cognitive processing difficulties experienced by those service users with Acquired Brain Injuries. However the involvement of speech and language therapist to aid communication and advocacy and family where capacity is lacking is heavily incorporated into the safeguarding process when establishing outcomes. Links with a new police liaison officer have aided communication and working with North Yorkshire Police as concerted efforts have been made to understand the challenges faced in the environment of York House, but more importantly for those living with Acquired Brain Injuries.

As a hospital we continue to struggle without an integrated computer system to log, maintain and monitor safeguarding risks and outcomes, rather relying on manual interpretation and collation of data.

York House continues to attend the Safeguarding Implementation Group to share and develop good practice with other independent Hospitals in the local area and receives feedback from the Safeguarding Adults Board both via email and through this group.

CITY OF YORK COUNCIL

City of York Council Housing department

Training

Housing staff are expected to complete online safeguarding training for adults and children's services. The department has also purchased online training from the Housing Quality Network (HQN) and this includes safeguarding training. Safeguarding is included in new starters induction training.

Any achievements/developments relating to Safeguarding during the year

Employing mental health workers at hostels, Annual severe weather and NSNO, Provision of shower facilities at Peasholme for rough sleeper drop in, the older persons housing options worker and the research that we have done into housing hazards and the opportunity to target interventions to reduce falls and excess cold, Creation of respite beds in sheltered schemes, the housing first scheme for difficult to place adults.

Annex 2

Members of City of York Safeguarding Adults Board, March 2016

	Name	Title	Organisation	Address
1	Karen Agar	Associate Director of Nursing (Safeguarding)	Tees, Esk & Wear Valley (TEWV) NHS Foundation Trust	Flatts Lane Centre, Flatts Lane, Normanby, Middlesbrough, TS6 0SZ
2	Sarah Armstrong	Chief Executive	York CVS	Priory Street Centre, 15, Priory Street, York YO1 6ET
3	Sian Balsom	Healthwatch Manager	Healthwatch York	Priory Street Centre, 15, Priory Street, York YO1 6ET
4	Tom Brittain	Head of Housing	CYC	West Offices, Station Rise, YO1 6GA
5	Michelle Carrington	Chief Nurse	NHS Vale of York CCG	West Offices, Station Rise, York YO1 6GA
6	Martin Farran	Director Adult Social Care	CYC	West Offices, Station Rise, York YO1 6GA
7	Beverley Geary	Chief Nurse	York Teaching Hospital NHS Foundation Trust	Wigginton Road, York YO31 8HE
8	David Heywood	Safeguarding Lead	Stockton Hall	The Village, Stockton-on-the-Forest, York YO32 9UN
9	Caroline Johnson	Director of Operations	The Retreat	Heslington Road, York, YO10 5BN
10	Tim Madgwick	Deputy Chief Constable	North Yorkshire Police	Newby Wiske Hall, Newby Wiske, Northallerton DL7 9HA
11	Kevin McAleese CBE	Independent Chair,	York Safeguarding Adults Board	c/o West Offices, Station Rise, York YO1 6GA
12	Michael Melvin	Assistant Director	CYC	West Offices, Station Rise, York YO1 6GA
13	Christine Pearson	Deputy Designated Nurse, Safeguarding Adults	NHS Vale of York CCG	West Offices, Station Rise, York YO1 6GA
14	Victoria Pilkington	Head of Partnership Commissioning	Partnership Commissioning Unit (PCU)	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
15	Cllr Carol Runciman	Cabinet Lead	City of York Council (CYC)	West Offices, Station Rise, York YO1 6GA
16	Amanda Robson	Senior Nurse	NHS England, NY and Humber Area Team	Unit 3, Alpha Court, Monks Cross, York, YO32 9WN
17	Steve Wilcox	Designated Professional for Adult Safeguarding	Partnership Commissioning Unit (PCU)	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
18	Keren Wilson	Chief Executive	Independent Care Group	10 North Park Road, Harrogate, HG1 5PG

Annex 3

City of York Safeguarding Adults Board Membership & Attendance 2015/16

(Key: Y = present or substituted; A = Apologies sent; NA = Not yet a member/replaced as a member)

Organisation	Designation	June 2015	Sep 2015	Dec 2015	March 2016	Nominated representative or substitute
	Independent Chair	Y	Y	Y	Y	100%
City of York Council	Director of Adult Social Care	Y	N	Y	Y	75%
	Assistant Director, Adult Assessment and Safeguarding	Y	Y	Y	Y	100%
	Safeguarding Service Manager	NA	NA	Y	Y	100%
	Cabinet Member for Health, Housing and Adult Social Services	Y	Y	N	Y	75%
	Head of Housing	NA	NA	NA	Y	100%
Healthwatch York	Manager	Y	Y	Y	Y	100%
Independent Care Group	Chief Executive	Y	N	Y	Y	75%
1.4.15-30.9.15, Leeds & York Partnerships NHS FT	Head of Safeguarding	Y	N	NA	NA	50%
NHS England,	Assistant Director	Y	N	Y	Y	75%
North Yorkshire Police	Deputy Chief Constable	Y	Y	Y	Y	100%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	Y	Y	Y	100%
	Designated Professional for Adult Safeguarding	Y	Y	Y	N	75%
The Retreat	Director of Operations	Y	Y	Y	Y	100%
Stockton Hall	Social Work Manager	Y	Y	Y	Y	100%
1.10.15-30.3.16, Tees, Esk & Wear Valley NHS FT	Associate Director of Nursing (Safeguarding)	NA	NA	Y	Y	100%
Vale of York CCG	Chief Nurse	Y	Y	Y	Y	100%
	Designated Nurse, Safeguarding	Y	N	Y	Y	75%
York CVS	Representative	Y	N	N	Y	50%
York Teaching Hospital NHS Foundation Trust	Chief Nurse	Y	Y	Y	N	75%
Overall Board attendance		**100%**	**65%**	**88%**	**90%**	

Independent Chair's comments on Board attendance:

We have worked hard once again to ensure that all partner organisations on the Safeguarding Adults Board are represented by a post holder of sufficient seniority and expertise and that ideally the same person should attend each meeting.

However, there are inevitably operational pressures on individuals as well as annual leaves to be allowed for, given that the SAB only meets four times a year. There are also personal crises in the best managed of diaries, and even unexpected weather problems as in March 2016. In the ideal world the thirteen partners would each have achieved 100% attendance records. During 2015/16 a total of eight of them did just that, an increase of one from 2014/15.

Each SAB meeting ends with a meeting review, which is then published in the SAB minutes which are available on the SAB website. Those reviews confirm a broadly consistent picture that SAB members find meeting together four times a year to be appropriately challenging and rewarding. I am very grateful to the senior representatives of each organisation listed in Annex 1 who have given so much time, interest and commitment to the work of the Board during 2015/16.

Annex 4

2014/2017 Strategic Plan and Action Plan Outcomes for 2015/16

	Objective	Action	Timescale for completion	Lead	March 2016 update
A	**Make sure safeguarding is embedded in corporate and service strategies across all partners.**				
A1	Ensure key strategic plans evidence that adult safeguarding is a priority and is being addressed.	Partners to identify key strategies and include in annual reports to Boards	March 2015	All	Annual Reports Submitted
A2	Ensure a robust interface with Community Safety Plans	Engage with Domestic Violence strategy Board. Improve information sharing on Domestic Abuse. Engage with Community Safety Board regarding Hate Crime, safe Places etc	March 2015 March 2016	Chair and CYC safeguarding Lead	Both are now members of the Board. May 2015 saw work coordinated by North Yorkshire Police together the information held by all agencies about domestic violence to improve our strategic response. North Yorkshire and York SAB and partners held Joint Domestic Abuse Working Conference Oct 2015 Safeguarding Systems Leadership Group in place February 2016
A3	Influence Joint Strategic Needs Analysis and Health and Well Being strategy	Feed messages from this strategy to JSNA refresh. Annual review of performance indicators for key strategic messages on need.	March 2015 March 2016	CYC safeguarding Lead	Refreshed JSNA contains information on referral rates of vulnerable population groups.
A4	Ensure a robust interface with the Health and Wellbeing Board.	Standing item on Safeguarding Board agenda – items from and to HWB	From March 14	Chair	See Chair's reports

	Objective	Action	Timescale for completion	Lead	March 2016 update
A5	Ensure that Adult Safeguarding Board members, and non – Executives, Board Members and Councillors of partner organisations understand their role in safeguarding and have attended basic awareness training.	Members of Partner Boards to monitor through annual assurance reports to Board Each partner agency to consider in their competency framework Introduce Adult Safeguarding Board Development Days – minimum 1 per year Training needs review for Board members Induction training for new Board members .	March 2015 March 2015 March 2015	All All Chair	Partners to confirm Safeguarding Training Needs survey developed and put to Board members by CYC WDU Needs Survey sent out to board members and proposal for development submitted to Dec 15 SAB Safeguarding Board Development Day completed, January 2016 (second day on 4 April 2016)
A6	Assurance that all partners present an Annual Safeguarding Report to their relevant governing body.	Partners to advise Board when Annual report received by their Board. Summary of reports in Annual Adult Safeguarding Board report.	Annual Annual	All Chair	Completed Completed

	Objective	Action	Timescale for completion	Lead	March 2016 update
B	**Ensure good partnership working**				
B1	Ensure that all partners are signed up to, and working in line with Multi agency procedures and practice. Procedures' to be reviewed for Care Act readiness.	Annual check for changes and updates. Full review every 3 years. Seminar/event for voluntary sector groups.	December 14, 15 16 March 15 March 15	CYC CYC and Voluntary sector	CYC Safeguarding Adults Audit including Care Act Readiness shows substantial assurance. Regional and local policy and procedure for discussion at June 2015 Board. Development day held Nov 2014. Care Act stock take reports good progress on safeguarding adults. Care Act subgroup work completed and stepped down Sept 2015. West Yorkshire, North Yorkshire and York Multi-Agency Procedures adopted. Work ongoing to develop local operational guidance consistently across the North Yorkshire Locality. Dec 2015. Local Guidance drafted and circulated February 2016.
B2	Share learning from practice, Lessons Learned and Serious Case Reviews.	Review of serious case review protocol. Develop a lessons learned protocol. Continue with regular agenda item on each Safeguarding Adult Board meeting to share case studies.	March 15 March 15 ongoing	Board sub Group Board sub Group Chair	Protocols at December 2014 Board agreed. In place. Subgroup in place and to be formalised through proposal to the board Sept 2015 Sub group Structure in place Dec 2015.
B3	Senior level, regular, attendance at Board from all partners.	Attendance reported in Annual Safeguarding Board report.	Annual	All/CYC	In place.

	Objective	Action	Timescale for completion	Lead	March 2016 update
B4	Ensure a shared approach to understanding and managing risk of abuse in safeguarding.	MCA/DoIS training – monitor uptake and feedback.	Quarterly reports to Board	CYC	Reports to SAB on impact of training.
B5	ure best use of resources to meet growing demand and shared priorities.	Development of the multi agency safeguarding hub with police and children's safeguarding Develop virtual network for safeguarding advisors in partner agencies Review of thresholds for referrals	Sept 14 March 15	CYC Police All	Agency DASMs in place, network to be developed. DASM meeting established August 2015, role then abolished nationally.

	Objective	Action	Timescale for completion	Lead	March 2016 update
C	**Focus on prevention of abuse**				
C1	Raise awareness and empower community to keep people safe.	Review of Adult Safeguarding Adults website. Annual radio or Press interview/article on Adult Safeguarding. Develop information for the community. Ensure housing and support providers, drug and alcohol service, A&E can access alerter training.	March 15 Annual March 15 Annual review of training attend-ance.	CYC Chair CYC CYC	CYC Website with updated Safeguarding Adults taken from current website to be launched end May 2015. SAB website launch set for Jan 2016. Alerter training advertised to all providers through WDU Dec 2015 SAB Website structure and content developed on track for Jan 2016 launch.
C2	Reduce risk of harm through effective and intelligent commissioning.	Winterbourne concordat assurance. Sponsor work between health and social care commissioners and contract managers on sharing intelligence on quality of providers, Ensure that Contract monitoring has a focus on safeguarding and dignity and any shortfalls in standards are addressed Commissioning and contracting with regulated providers includes Care Quality Commission (CQC) registration guidance in relation to safeguarding. Ensure commissioners review their training needs regarding safeguarding and quality assurance. Ensure arrangements for commissioning of advocacy services.	6 Monthly updates June 15 March 15 Annual assurance Annual assurance June	Partnership Commis-sioning Unit (PCU) and CYC CYC/PCU/ CCG CYC/PCU/ CCG/NHS England CYC/PCU/ CCG/NHS England CYC/PCU/ CCG/NHS England	Regular Soft intelligence meetings are now established. Advocacy service commissioned by CYC April 2015 includes advocacy for people with safeguarding needs.

	Objective	Action	Timescale for completion	Lead	March 2016 update
C3	Workforce development plans to develop quality provision.	Work with city wide Workforce Strategy Group to ensure training delivered on: Managing challenging behaviour and reducing incidents between residents. Medication management. Reduce risks of pressure sores. Dignity agenda. Review themes and areas of risk emerging from performance data to continue to inform training plans.	June 2015	CYC	CYC have developed and delivered training in Administration of medication in domiciliary and residential care settings Managing Challenging behaviour. Pressure Sore Training and Dignity agenda require further work. Commitment in WDU report to develop MSP approach April 2016-Dec 2016, Updated training planned underpinned by new operational guidance.

	Objective	Action	Timescale for completion	Lead	March 2016 update
D	**Respond to people based on the Personalisation approach, and with a clear focus on outcomes**				
D1	Commit to an outcome focus for safeguarding activity.	Engagement in Making Safeguarding Personal Programme.	March 15	CYC	MSP report at March 2015 Board.
D2	Enhance and improve user 'voice' in all the Board does.	Improve links with Healthwatch York and Safeguarding Board. Develop proposals for greater user involvement.	March 15 March 15	Chair and Health-watch York Health-watch York	Healthwatch agreement to public involvement in strategic plan refresh to be compete April 2016.
D3	Ensure people with personal budgets in health and social care are supported to manage safety and risk at the same time as preserving the right to choice and control.	Consider evidence from the Research underway with York University on Safeguarding and personalisation.	March 15	CYC	Research complete and circulated to care managers Feb 2015.
D4	Empower people to be able to make good choices about quality care and support.	Continue to develop information for public on care and support choices.	March 15	CYC	Connect to Support information and advice major refresh completed April 2015.

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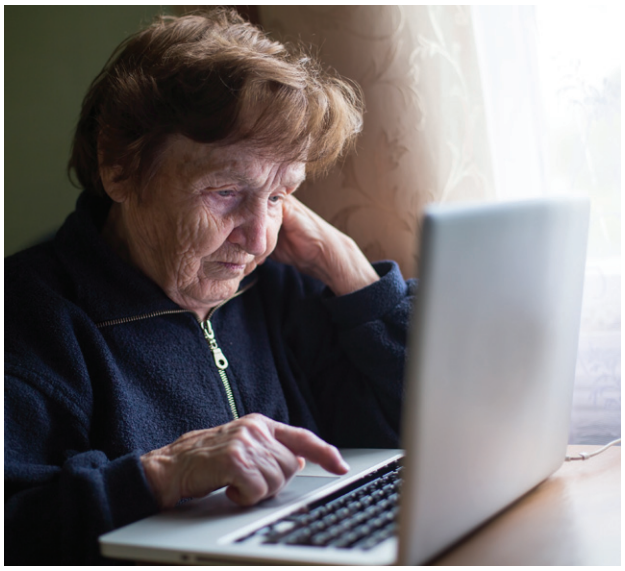

City of York Safeguarding Adults

CITY OF YORK COUNCIL

City of York Safeguarding Adults Board Annual Report 2015/16

Kevin McAleese CBE, Chairman

City of York Safeguarding Adults

CITY OF YORK COUNCIL

www.safeguardingadultsyork.org.uk

Route: Home/Safeguarding Board/Annual Report 2015/16

1. Introduction
2. Board's work and vision
3. Work undertaken in 2015/16
4. Care Act implementation
5. Performance and activity information
6. Training
7. Strategic Plans
8. Serious Case Reviews and Lessons Learned
9. New Strategic Plan from April 2016 onwards
10. Contributions from individual member organisations

City of York Safeguarding Adults

SAB Board members

- City of York Council
- Healthwatch York
- Independent Care Group
- NHS England
- North Yorkshire Police
- Partnership Commissioning Unit
- Stockton Hall
- Tees, Esk & Wear Valley NHS Foundation Trust
- The Retreat
- Vale of York Clinical Commissioning Group (CCG)
- York Teaching Hospitals NHS Foundation Trust
- York CVS

City of York Safeguarding Adults

Work undertaken

Making Safeguarding Personal (MSP)

Annie has a number of physical health conditions and historically declined to engage with services including declining medical treatment. She came to the attention of the Safeguarding Adults Team as she was being financially exploited by people she knew. Through an MSP approach, Annie was spoken with about this concern and asked how services could support her

Annie said that she would like to move to another property so that the people could no longer target her, with steady support from the team, she identified that moving closer to family may be of benefit to her wider welfare, as family members could support her to attend medical appointments.

Annie agreed to accepting support from an agency who supported her with applying for a housing transfer; she has now moved home, which has removed the risk of financial exploitation, and she continues to attend medical appointments, which has improved both her physical and mental wellbeing.

City of York Safeguarding Adults

Activity I

In line with the national picture, over 60% of both Concerns and Referrals involved female adults

Year 2015/16	Alerts/Concerns	Referrals to Enquiries
2012	690	200 (29%)
2013	912	213 (23%)
2014/15	1,058	294 (28%)
2015/16	1,108	468 (42%)

2015/16

- People over 65 and above were significantly over-represented in referrals, with 85s and over being the most over-represented
- 75% of adults reported to be at risk were already known to Social Services

City of York Safeguarding Adults

Activity II

These patterns of abuse have been consistent in quarterly reports to the Safeguarding Adults Board, and reflect the national picture.

2015/16: Type of abuse referred	%
Neglect	31%
Psychological/Emotional	23%
Physical	19%
Financial	17%
Organisational	4%
Sexual	2%

2015/16

Neglect and Organisational abuse are the only categories of abuse where “social care support” is the main source of risk

Activity III

As last year, the source of risk has most frequently been **people known to the adult with care and support needs** and this has most frequently been located **within their own home**.

2015/16: Location of risk referred	%
Own home	36%
Care home	28%
Hospital	14%
Community Services	3%
Other	6%

2015/16

Care homes up by 46%, Hospitals up by 50%, Community down by 46%, compared to 2014/15 and in line with national figures

City of York Safeguarding Adults

Activity VI
Outcomes of Enquiries for 2015/16

- Action was taken to reduce or remove the risk in the majority of cases. In 8% no action was deemed to have been taken.

- In 59% of all completed enquiries, the risk was noted to have reduced, and in 29% to have been removed. In only 4% of cases did the risk remain.

- This was an improvement in the outcomes for adults with care and support needs on previous years, as in 2014-15 22% of cases resulted in no action being taken.

City of York Safeguarding Adults

Not a Safeguarding Adults Review, but Lessons Learned Case II

In November 2014 Daniel was seen walking unsteadily along a wall in the centre of York he climbed over railings and fell approximately 40 feet to the ground. His death was confirmed a short time later and a note expressing his intention to take his own life was found in his pocket.

Daniel had been referred to Adult Safeguarding in the months prior to his death with a concern related to possible financial abuse. He was known to mental health services and mostly he engaged well. He had a job at a local College and was receiving counselling support there. Daniel had made several suicide attempts previously where he was found to be carrying a suicide note and had received a number of welfare checks.

City of York Safeguarding Adults

Lessons Learned findings

- In general all involved services engaged well with Daniel, they shared their level of concern equally and exchanged information appropriately.
- The management and human resources team at the College deserve particular mention for going the extra mile in trying to keep Daniel safe and well.
- Daniel's suicidal ideas were regularly addressed by his Community Psychiatric Nurse (CPN) and these concerns fed into the safeguarding process.
- There were no obvious omissions in Daniel's care: it appears that mental health services and the police worked effectively together. *In order for North Yorkshire and York services to gain a better understanding of suicide and responses to it, a senior suicide prevention co-ordinator has been recruited to undertake a review of all deaths from suicide during the past five years.*

City of York Safeguarding Adults

2016/17 Planned developments include

- ✓ Adding more publicly accessible information on the website about abuse and neglect
- ✓ Developing a prevention strategy
- ✓ Using public feedback on the website to review and update safeguarding arrangements
- ✓ Monitoring and reporting on the use of advocates for people who lack mental capacity
- ✓ Developing local operational guidance on safeguarding for all SAB partners, underpinned by new training arrangements
- ✓ Planning and hosting an annual Safeguarding week, in conjunction with West and North Yorkshire Councils
- ✓ Publicising and presenting the SAB Annual Report to any community group requesting it

City of York Safeguarding Adults

Questions and comments?

Kevin McAleese CBE, Chairman

City of York Safeguarding Adults

CITY OF YORK COUNCIL

Health and Wellbeing Board 20 July 2106

Report of the Director of Adult Social Care, City of York Council

Monitoring and Managing Performance

Summary

1. The Health and Wellbeing Board at its meeting on 9th March 2016 expressed an intention to strengthen the way it exercises its oversight and performance monitoring responsibilities.

2. This report sets out some thoughts in relation to strengthening performance management to improve outcomes and the effectiveness of the health and social care system.

Background

3. The Health and Wellbeing Board is currently reviewing its role, purpose and effectiveness and is being supported by the LGA who are facilitating a number of development sessions to reflect on the achievements and impact of the Board to date. This work includes a review of our 2020 vision for York and considering how the Board will drive service transformation to meet the aspirations of local people.

4. The Health and Wellbeing Board currently receives quarterly reports on the performance of a suite of 22 performance measures, which are matched against the high level priorities of the board. These priorities were drawn from pre-existing performance measures, so as not to increase the burden upon partners, at a time of diminishing resources. The Board will need to review these 22 measures when it has concluded its review of the outcomes it wants to achieve.

5. In the meantime, the Board may wish to consider agreeing a set of principles that will drive the development of our performance management framework.

6. Similarly, the Board could consider what information it wishes to receive, to form a more comprehensive view of the impact of strategies to improve public health and health inequalities, using more than data alone.

7. Formal mechanisms are also needed to monitor performance of the most immediate and urgent strategic challenges facing our local health and care system, such as the progress of the Better Care Fund.

Key Considerations

8. Any performance management framework must first of all demonstrate how effective the Health and Wellbeing Board are in fulfilling their principle statutory duties:

   - To assess the needs of the local population through a JSNA
   - To set out how the needs are being addressed through the Joint Health and Wellbeing Strategy
   - To promote greater integration and partnership working, including joint commissioning, integrated provision and pooled budgets

9. An effective performance management framework will help ensure that the principle work of the board stays relevant and reflects emerging concerns of local people, communities of interest and partner agencies.

10. It should demonstrate how the Health and Wellbeing Board is actually making things happen, not just through traditional interventions but also through changing thinking, expectations and behaviours.

11. The Health and Wellbeing Board needs a holistic view of performance so that it can see not just what has been achieved but also what the experience felt like for local people and communities.

Principles

12. Performance management information presented to the Health and Wellbeing Board should**:**

   - Demonstrate ambition and build confidence in the system

- Be strategic, concentrating on major goals and initiatives
- Inform and engage people in addressing the challenges facing health and social care
- Highlight major risks and enable remedial action to be taken during the planning timeframe
- Display openness and transparency
- Keep it simple and minimise the burden on partner organisations

A more comprehensive view of the impact of strategies and plans

13. We cannot provide a 'rich picture' of performance using data alone.

a) SMART performance measures are needed – hard performance indicators and benchmarking information – to report on direction of travel against the Joint Health and Wellbeing Strategy.

These should be a mix of locally determined measures and national measures selected from national outcome frameworks relating to public health, NHS and social care. These measures should be chosen to reflect and provide evidence of improved outcomes of each of the key strategic priorities of the Board.

It is important that the Health and Well Being Board does not duplicate the work of any sub-board or other partnership body and that it maintains a strategic focus. A simple hierarchy of measures is required to support the partnership network. This can only be finalised when the development of the Health and Wellbeing Board and the review of the Joint Health and Wellbeing Strategy are complete. Discussion can begin immediately however on the measures that provide an insight on direction of travel based on current and demerging priorities.

If pre-existing measures are chosen, to avoid increasing the data collection burden, then the board need to be clear whether the indicators are simply 'can openers' highlighting a need for the Health and Wellbeing Board (or one of its sub-boards) to drill down further to look for other signs that may indicate that we are not on track to achieve the strategic outcomes.

b) Soft intelligence, perception measures and customer surveys are also needed to measure how far we are meeting citizen's expectations and confidence levels. People stories/customer journeys can be a very powerful way of enabling the board to understand the customer experience and practical effect of policies, strategies and practices of the partners.

c) The Health and Wellbeing Board should receive an annual update, reporting population and demographic changes affecting the Joint Strategic Needs Assessment (JSNA), including a gap analysis. The JSNA should indicate whether significant issues are emerging that need addressing or a change in commissioning priorities.

d) A Joint Commissioning Strategy guiding the priorities of all partners to the board should be presented to the Health and Wellbeing Board, progress reported in year and reviewed annually along with a single Integration and Transformation Plan.

e) A suite of other documents should routinely be reported to the HWBB so that system leaders can align activity and raise awareness of issues. These include:

- Annual reports of the sub-boards to Health and Wellbeing Board
- Annual safeguarding reports for adults and children
- Annual report of other partnership boards, such as the Community Safety Partnership.

f) The Health and Wellbeing Board may want to receive exception reports from sub-boards and operational groups rather than receive a large suite of performance information on a regular or *ad hoc* basis.

The Most Immediate and Urgent Strategic Challenges

14. An Integration and Transformation Board has recently been formed and has been established as a sub-board to the Health and Wellbeing Board. It is a delivery group, made up of local system leaders, which will act as a catalyst for whole system, integrated, person centred care.

15. The Integration and Transformation Board is focusing on the most difficult issues facing the system and is identifying projects that will

'breakthrough' the professional, organisational and cultural issues that act as barriers to change. This sub-board is accountable and can provide regular reports to the Health and Wellbeing Board.

16. The Health and Wellbeing Board has to agree and sign off plans for national programmes, such as the Better Care Fund. Negotiations to agree the 2016/17 BCF Plan have been hampered by under-performance in previous years and the Board should receive regular reports on progress, results and financial performance in future.

17. Exception reports also need to be made in relation to programme and project management information relating to programmes for which Health and Wellbeing Board has an oversight responsibility.

18. Minutes from sub-boards can be used to identify emerging issues that require escalation to the Health and Wellbeing Board.

Consultation

19. This report marks the beginning of a discussion around a new performance monitoring regime for the Health and Wellbeing Board.

Options

20. The Health and Wellbeing Board are asked to consider suggestions for monitoring progress against the Joint Health and Wellbeing Strategy and for fundamental transformation of the health and social care system in York.

Analysis

21. Options are not presented in the report.

Strategic/Operational Plans

22. Any changes to the performance management framework will have implications for the arrangements in place in each of the partner organisations. Detailed proposals will only be possible after the review of the Health and Wellbeing Board and the Health and Wellbeing Strategy are concluded.

Implications

- This report is intended to stimulate thinking in relation to performance monitoring and there are no direct implications at the present time.
- **Financial**
- **Human Resources (HR)**
- **Equalities**
- **Legal**
- **Crime and Disorder**
- **Information Technology (IT)**
- **Property**

Risk Management

23. The strengthening of the performance management framework for the Health and Wellbeing Board will assist in identifying and managing risks across the whole health and social care system.

Recommendations

24. The Health and Wellbeing Board are asked to:

i. Comment on the principles put forward to assist in strengthening the performance management framework for the Health and Wellbeing Board

ii. Consider what type of information the Board would like to receive to provide a more comprehensive view of performance

iii. Consider what formal mechanisms are needed to monitor performance of the most immediate and urgent strategic challenges facing our local health and care system

Reason: To start the conversation about strengthening the performance management framework for the Health and Wellbeing Board.

Contact Details

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01904 554070

Chief Officer Responsible for the report:
Martin Farran
Director of Adult Social Care
City of York Council
01904 554045

Report Approved ✓ **Date** 11.07.2016

Specialist Implications Officer(s) None

All X

Wards Affected: All wards will be affected

For further information please contact the author of the report

Background Papers:
None

Annexes
None

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Glossary

BCF – Better Care Fund

HWBB – Health and Wellbeing Board

JSNA – Joint Strategic Needs Assessment

LGA – Local Government Association

NHS – National Health Service

SMART – Specific, Measurable, Attainable, Realistic, Timely

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Health and Wellbeing Board 20 July 2016

Report of the Chief Operating Officer, NHS Vale of York Clinical Commissioning Group

Sustainability and Transformation Plans

Summary

1. This report is to update the Board on the latest arrangements for the development of Sustainability and Transformation Plans in the NHS for the Vale of York area.

Background

2. The NHS planning guidance sets out the requirement for a five-year place based Sustainability and Transformation Plan (STP), supported by an annual operating plan for each CCG.

3. The Humber, Coast and Vale (HCV) Sustainability and Transformation Plan (STP) covers a diverse rural, coastal and urban community with a population of 1.4m. As depicted in the map below, the Humber, Coast and Vale footprint covers six CCG boundaries, six local authority boundaries as well as services provided by a number of health and social care organisations:

NHS commissioning organisations

- NHS East Riding of Yorkshire Clinical Commissioning Group
- NHS Hull Clinical Commissioning Group
- NHS North Lincolnshire Clinical Commissioning Group
- NHS North East Lincolnshire Clinical Commissioning Group
- NHS Scarborough and Ryedale Clinical Commissioning Group
- NHS Vale of York Clinical Commissioning Group

Healthcare provider organisations

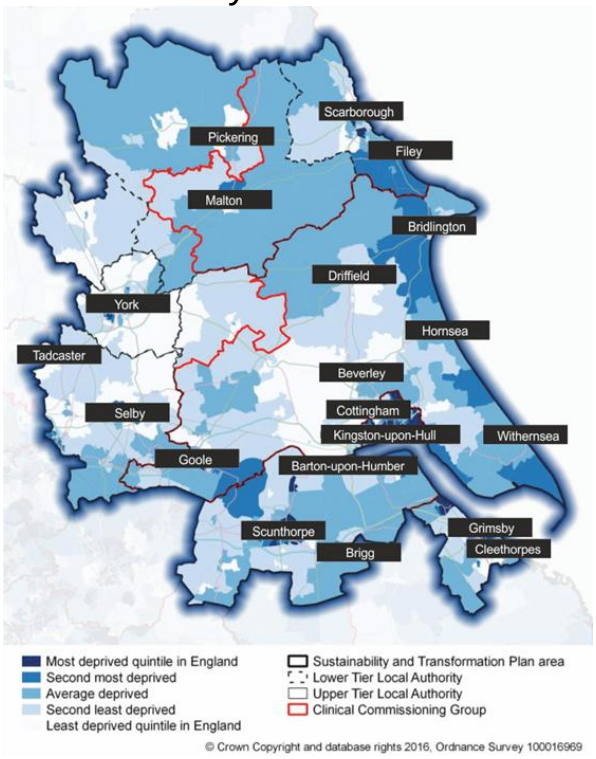
- Humber NHS Foundation Trust
- North Lincolnshire and Goole NHS Foundation Trust

- Tees, Esk and Wear Valleys NHS Foundation Trust
- City Health Care Partnerships CIC
- Hull and East Yorkshire NHS Foundation Trust
- Navigo
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- York Teaching Hospital NHS Foundation Trust
- Yorkshire Ambulance Service
- East Midlands Ambulance Service

Local Authorities

- City of York Council
- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- North Yorkshire County Council

Fig 1. Sustainability and Transformation Plan footprint



4. The STP is required to set the direction for the local area to achieve the ambitions of the Five Year Forward View, which are to close the health and wellbeing gap, the care and quality gap and the funding and efficiency gap. It is expected to provide a clear and powerful shared vision across the local NHS system, local government and

local communities, underpinned by an open, engaging and iterative process of development and consultation.

5. The STP is an overarching plan, supported by a number of more detailed plans on primary care sustainability, prevention, self-care and patient empowerment and a joint plan for the delivery of the Better Care Fund requirements. A summary of the initial draft is provided for the Board at Annex A.

6. The STP has been developed across the footprint, coordinated by the Humber Coast and Vale Strategic Partnership Board, supported by a dedicated STP programme team across the footprint. NHS Vale of York CCG has representation on the Strategic Partnership Board, and has coordinated the submission of local data and priorities across local providers.

7. Within the local area, the System Leadership Board, comprising Chief Officers and Directors from the City of York Council, North Yorkshire Council County, York Teaching Hospital Foundation Trust, Tees, Esk and Wear Valley NHS Foundation Trust, NHS Vale of York CCG and NHS Scarborough and Ryedale CCG, has developed and reviewed the draft submissions.

Consultation

8. The STP programme team are developing the consultation and engagement plan to support the Humber, Coast and Vale STP.

Options

9. Not applicable.

Analysis

10. The development of the STP has been informed by a range of analysis, including public health needs assessments, financial analysis across the health care sector and operational performance and delivery.

Strategic/Operational Plans

11. The STP in an umbrella plan, which will align to and support local delivery of the new Health and Well-Being Strategy and local operational plans for healthcare commissioners and providers.

Implications

12. The implications are:

- **Financial** – Implications cannot yet be quantified, but the strength of the plan will influence the area's eligibility for future funding pots.
- **Human Resources (HR) -** No implications have yet been identified
- **Equalities** - No implications have yet been identified
- **Legal -** No implications have yet been identified**.**
- **Crime and Disorder –** No implications have yet been identified**.**
- **Information Technology (IT) –** The local 'Digital Roadmap' is aligned to the development of the STP
- **Property -** No implications have yet been identified**.**
- **Other -** No implications have yet been identified**.**

Risk Management

13. There are no known risks associated with the noting of the contents of this report.

Recommendations

14. The Health and Wellbeing Board are asked to note the contents of this report.

Reason: To keep Health and Wellbeing Board apprised of progress against the development of STPs.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Lynette Smith Head of Corporate Assurance and Strategy NHS Vale of York Clinical Commissioning Group	Rachel Potts Chief Operating Officer NHS Vale of York Clinical Commissioning Group
01904 555780	Tel No 01904 555780

Report Approved √ **Date** 6 July 2016

Wards Affected: **All** √

For further information please contact the authors of the report

Annexes

Annex A – Coast Vale and Humber STP Summary June 2016

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ANNEX A

East Riding of Yorkshire Clinical Commissioning Group
Hull Clinical Commissioning Group
North Lincolnshire Clinical Commissioning Group
North East Lincolnshire Clinical Commissioning Group
Scarborough and Ryedale Clinical Commissioning Group
Vale of York Clinical Commissioning Group

STP: Latest position

Developing and delivering the Humber, Coast and Vale Sustainability and Transformation Plan

July 2016

East Riding of Yorkshire Clinical Commissioning Group
Hull Clinical Commissioning Group
North Lincolnshire Clinical Commissioning Group
North East Lincolnshire Clinical Commissioning Group
Scarborough and Ryedale Clinical Commissioning Group
Vale of York Clinical Commissioning Group

Who's involved?

NHS Commissioners
East Riding of Yorkshire CCG
Hull CCG
North Lincolnshire CCG
North East Lincolnshire CCG
Scarborough and Ryedale CCG
Vale of York CCG

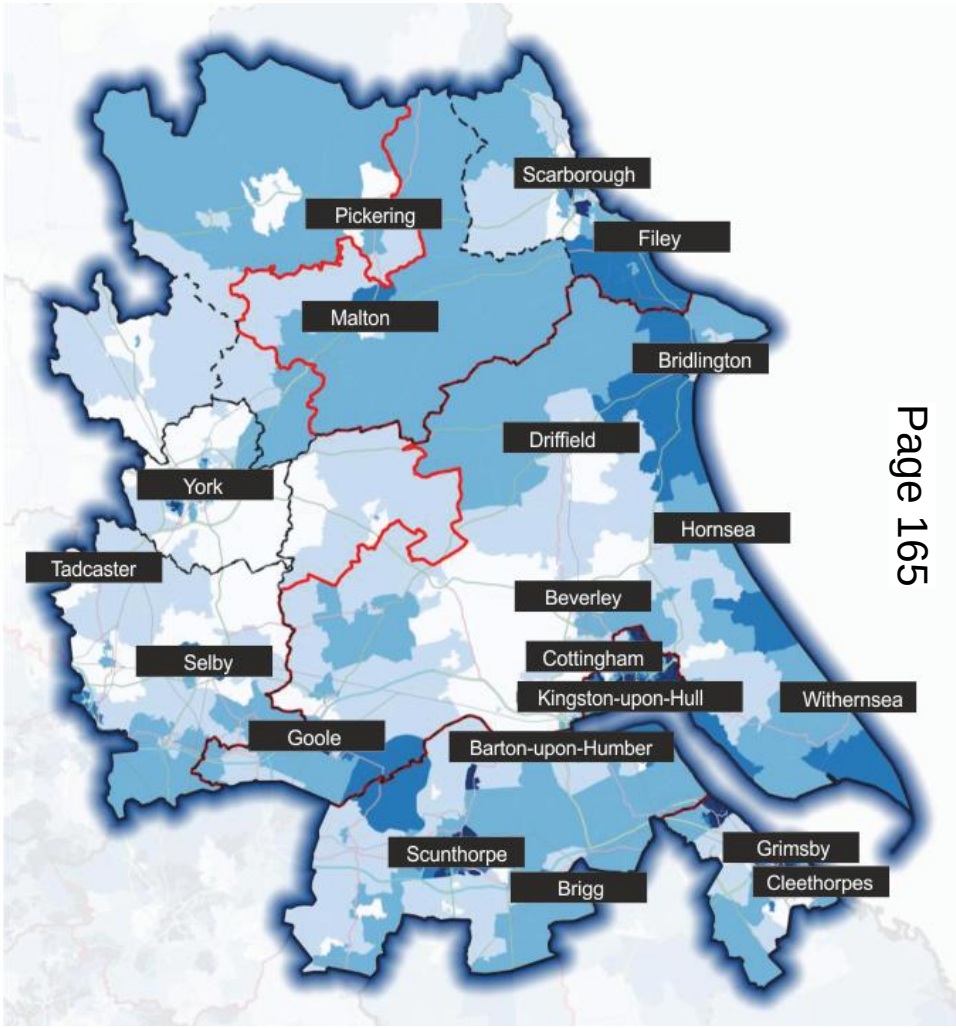
Providers
Humber NHS Foundation Trust
North Lincolnshire and Goole NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
City Health Care Partnerships CIC
Hull and East Yorkshire Hospitals NHS Trust
Navigo
Rotherham, Doncaster and South Humber NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

Local Authorities
City of York Council
East Riding of Yorkshire Council
Hull City Council
North Lincolnshire Council
North East Lincolnshire Council
North Yorkshire County Council

Our footprint

Population characteristics
1.4 million population
23% live in the most deprived areas of England
Diverse rural, urban and coastal communities
Huge variation in health outcomes

Three main acute providers
Hull and East Yorkshire Hospitals NHS Trust
North Lincolnshire and Goole NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust



Drivers for change

- **Financial pressures across the system –** significant and growing financial deficit across the system, doing nothing is not an option
- **Average life expectancies** across the footprint range widely
- **Smoking, child and adult obesity rates and excessive alcohol consumption** are above (some significantly) national averages
- **Stroke** – our premature mortality rates from stroke are higher than average across the footprint
- **Diabetes** – average for prevalence has risen year on year for those aged 17+ diagnosed with Type 1 and Type 2 diabetes

Drivers for change (cont'd)

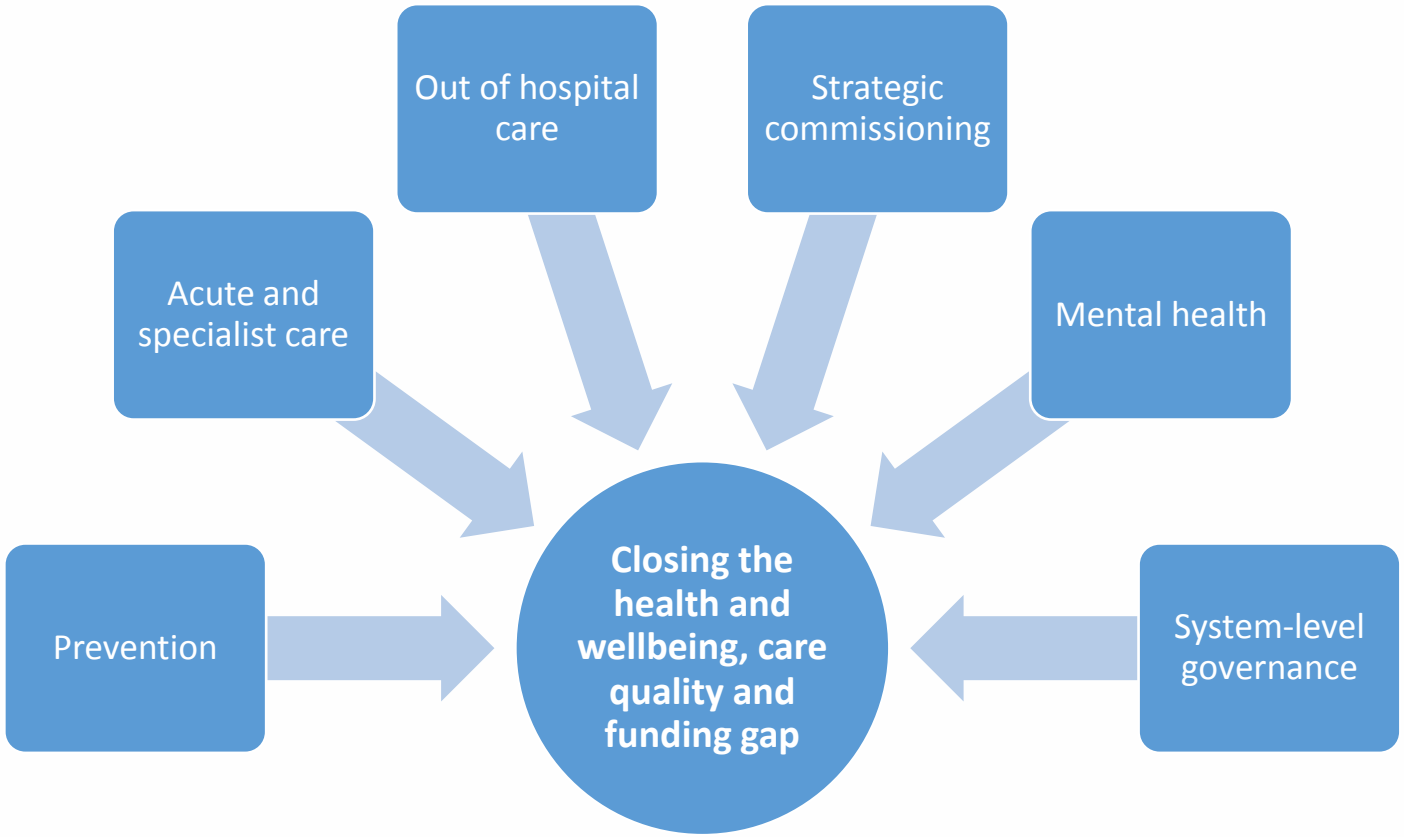
- **Hypertension** – many people with undiagnosed hypertension which could be prevented if diagnosed and managed
- **Cancer** - mortality levels are generally worse than England average
- **Mental health** - 14% of people aged 16-74 are estimated to have a common mental health disorder
- **System collaboration** – some historic examples of collaboration but with little meaningful impact on the system
- High levels of **failure to meet national targets** for urgent care, cancer and mental health with significant pressures on most providers

Drivers for change (cont'd)

- **Primary care** - variations in quality and performance leading to high referral rates and significant prescribing spend
- **GP appointments** - around half of patients can't get a GP appointment on the day they want
- **Workforce challenges** - especially in General Practice and for Registered Nurses
- **Mental health outcomes** - overall the standard admission ratio for hospital stays for self-harm is significantly higher than England
- **Technology** – we have not kept pace with technology to improve access and user experience

East Riding of Yorkshire Clinical Commissioning Group
Hull Clinical Commissioning Group
North Lincolnshire Clinical Commissioning Group
North East Lincolnshire Clinical Commissioning Group
Scarborough and Ryedale Clinical Commissioning Group
Vale of York Clinical Commissioning Group

Six key priorities of our STP



Our commitments

- **Working together** to develop our detailed STP
- Defining the interventions that will help us to close our **financial gap** and **improve outcomes** for our local population
- Ensuring **co-production and engagement** with our communities

Progress to date

- ✓ **First version of our STP submitted** to NHS England on 30 June – only high level at this stage
- ✓ Established a **vision and six priorities**
- ✓ Established our system governance and **Partnership Board**
- ✓ Mobilised a **Technical Finance Group** who have sized our financial challenge
- ✓ Defined a programme of work for getting to a detailed plan and financials completed by **September 2016**

Next steps

- The STP is **still a draft document** and therefore still subject to change
- We are **receiving feedback** from NHS England during July, after which time further refinements will be made and more detail developed
- **Establish working groups** for each priority to develop robust plans - identifying actions and clear timescales
- We are **committed to engaging** with stakeholders and the public as the plan develops and aim to start this process **ahead of the next submission in September**

Keeping you updated

- A **communications network** has been established across all health and care partners involved in the STP
- Information and updates about the STP can be found on **partner websites, newsletters** etc
- If you have any questions, please email: **HULLCCG.contactus@nhs.net**

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Health and Wellbeing Board 20 July 2016

Report of the Health and Wellbeing Board Healthwatch York Representative

Healthwatch York Report – Access to GP Services

Summary

1. This report asks Health and Wellbeing Board (HWBB) members to receive a new report from Healthwatch York entitled 'Access to GP Services' (Annex A refers).

Background

2. Healthwatch York produce several reports a year arising from work undertaken as part of their annual work programme. These reports are presented to the Health and Wellbeing Board for consideration.

3. The agreed procedure adopted for Health and Wellbeing Board is to receive these reports initially and then delegate these to the JSNA/JHWBS Steering Group who will consider the most appropriate way of implementing the recommendations. This may include incorporating them into ongoing JSNA work; asking other sub-boards of the HWBB to add them to their action plans or considering them for inclusion within the Joint Health and Wellbeing Strategy.

Main/Key Issues to be Considered

4. There are a number of recommendations arising from Healthwatch York's most recently produced report and these are set out in the table below:

Recommendation	Recommended to
Support GP practices to improve their systems for making appointments, particularly by phone.	NHS England Vale of York Clinical Commissioning Group

Recommendation	Recommended to
Explore the practicalities of opening up e-booking systems to under 18s in those practices where this is not currently possible.	
Support GP practices to increase their use of technology (phones and computers) to improve access to services for patients. • Text reminders • Online booking systems for appointments and repeat prescriptions • Use of telephone consultations • Wi-Fi for patient areas	Vale of York Clinical Commissioning Group / Virtual Clinical Network
Support GP practices to increase awareness of Patient Participation Groups (PPGs) to ensure they are representative of the patient population including young people, disabled people, and people from the BME community. Consider how Healthwatch York might be involved in this work.	Local Medical Committee (LMC) Vale of York Clinical Commissioning Group
When planning mergers, consider all the practicalities which will affect patients' experience of accessing their GP and consult with patients prior to the merger.	Any GP practices in York considering a merger
Consider the role of GP practices in providing information to enable people to take more responsibility for their own health. Explore ways of involving patients of all ages and backgrounds to make sure the information is useful and useable.	Virtual Clinical Network All GP practices in York

Recommendation	Recommended to
Consider using Patient Participation Groups to find out patients views on whether there is a need for additional early morning, evening or Saturday morning appointments.	All GP practices in York Vale of York Clinical Commissioning Group NHS England
Consider how to enable all GP surgeries to be fully accessible for all members of the community.	Property Physical Access Committee

Consultation

5. There has been no consultation needed to produce this accompanying report for the Board. Healthwatch York has consulted extensively to produce the report and details of this are at Annex A.

Options

6. This report is for information only and as such there are no specific options for members of the Board to consider.

Analysis

7. Not applicable.

Strategic/Operational Plans

8. The work from Healthwatch contributes towards a number of the themes, priorities and actions contained within the current Joint Health and Wellbeing Strategy.

Implications

9. There are no implications associated with the recommendations set out within this report. However there may be implications for partners in relation to the recommendations within the Healthwatch York report.

Risk Management

10. There are no known risks associated with the recommendations in this report.

Recommendations

11. Health and Wellbeing Board are asked to:

- Receive and comment on the report from Healthwatch York at Annex A
- Refer the report to the JSNA/JHWBS Steering Group for further consideration

Reason: To keep members of the Board up to date regarding the work of Healthwatch York.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator Tel: 01904 551714	Sharon Stoltz Director of Public Health

Report Approved ✓ **Date** 06.07.2016

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report
Background Papers:
None

Annexes
Annex A – Access to GP Services

Glossary

A & E – Accident & Emergency

ADHD – Attention Deficit Hyperactivity Disorder

BMA – British Medical Association

BME – Black and Minority Ethnic

BSL – British Sign Language

CCG – Clinical Commissioning Group

CQC – Care Quality Commission

CVS – Centre for Voluntary Services

DNA/DNS – Did not Attend/Did not Show

DWP – Department of Work & Pensions

ESA – Employment Support Allowance

GP – General Practitioner

HWBB – Health and Wellbeing Board

JSNA – Joint Strategic Needs Assessment

JHWBS – Joint Health and Wellbeing Strategy

LGBTI – Lesbian, Gay, Bisexual, Trans, Intersex

LMC – Local Medical Committee

NHS – National Health Service

OCAY – Older Citizens Advocacy York

PIP – Personal Independence Payment

PPG – Patient Participation Groups

YACRO – York Association for the Care and Resettlement of Offenders

YOPA – York Older People's Assembly

YREN – York Racial Equality Network

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Access to GP Services

June 2016

Annex A

healthwatch York

Contents

Access to GP Services

Background

The role of GPs has undergone significant change in recent years. As the first point of access for the general public when they need help and advice with a medical issue, primary care services (services from GPs, dental practices, community pharmacies and high street optometrists) play a pivotal role in the provision of care within the NHS. However, GPs today face many challenges which directly affect the way in which they serve the needs of their patients. In 2014, it was reported that GP consultations have increased by 24% since 1998. Over 90% of NHS patient contact happens through GP practices.[i] Despite this, funding levels have fallen as a percentage of total NHS spend, representing 7.2% of NHS funding from April 2016.[ii] This has had a significant impact on levels of patient involvement and satisfaction in certain areas of access and the ability of services to meet the increasing needs and demands of the local community.

Following the implementation of Clinical Commissioning Groups in 2013, GPs have assumed responsibility for “buying” services for the local population as well as continuing to provide them directly to their patients within their surgeries. The idea behind this decision was that GPs were in a better position to use their local knowledge of the population and what they needed and could therefore have a direct influence on which services were commissioned at a local level.

However, this dual role for GPs has led to a greatly increased responsibility and the suggestion that they do not have as much time to spend in their surgeries with patients. As a result, morale amongst GPs has declined[iii] because they are now dealing with an increasing amount of paperwork and bureaucracy[iv]. In a BMA survey of 2015 more than nine in ten GPs (93%) said that their heavy workload has negatively impacted on the quality of patient services.[v] Many older GPs are taking early retirement as they have become increasingly disillusioned with the system which has led to a national shortage of GPs in many surgeries. It is also more difficult to attract new recruits to general practice in England, with one in 10 training places not being taken up[vi], as the

concept of the “family” doctor who knows their patients seems to be a thing of the past. Around one in five (19%) GP trainees - the youngest cohort in the profession - are considering working abroad before 2020.[vii] The resulting workload pressures have led to talk of a “GP crisis.”[viii]

In order to meet the demands of this new way of working, many general practices have merged with at least one, sometimes more, to become so called “super practices”. They have a large number of doctors and often work across several sites in a local area in order to provide a wide range of care services with other health professionals such as practice nurses. This has led to some concerns that these practices are more like businesses, are more impersonal, and that it will be harder to see the doctor of your choice[ix].

In some ways the NHS has been a victim of its own success. As a result of advances in medical treatments, people are living longer but an ageing population brings its own pressures and challenges. Many older people experience long term health conditions (for example respiratory problems and diabetes) which GPs are being encouraged to manage in the community to try and reduce admissions to hospital and keep them in their familiar home environment. These patients should have a named GP to provide continuity of care. However, whilst this is recommended for continuity of care, it is not always possible to achieve. As a result, patients may feel uncomfortable discussing their care with a GP who does not know about their condition and be more reluctant to share concerns. Although electronic records are readily available to view by any GP in the practice, this does not replace the comfort of having a "family doctor" who is familiar with the social as well as medical aspects of the patient's condition.

The general public has become much more informed of advances in medicine and are keen to exercise their right to access the latest treatments regardless of availability and cost. This means that sometimes they may have unrealistic expectations of the services that their GP can provide and this leads to frustration and resentment. However, despite recent changes and budget restrictions, patient satisfaction at a national level with GPs has remained relatively high. Patients want to go to a surgery that is relatively close to home where it

is easy to make an appointment and has opening hours that fit in with their lifestyle and commitments. It is therefore not surprising that it is in these areas that most dissatisfaction is expressed. This tallies with local trends based on survey results.[x] Many surgeries operate a system where patients call at 8am to make an appointment but are unable to get through to a receptionist. When they do so, it is not uncommon to be told that there is a 3 week wait. This has led to extra pressure on Accident and Emergency Departments as patients will go there to seek advice if they cannot get an appointment with their GP quickly.

Some surgeries operate a triage system. When a patient rings the surgery an ‘on call’ GP rings them back to discuss their problem and give appropriate advice. This allows the GP to clarify the urgency of the problem, decide whether an early appointment is necessary or signpost the patient to other services such as the local pharmacy for appropriate advice and treatment. Patients feel more reassured following a discussion about their problem and are encouraged to take responsibility for their own health when alternative options are suggested. The disadvantage is that it is not always convenient for patients to wait for the GP to ring them back.

Patients do seem to appreciate the fact that overworked staff are doing their best to provide a good service in a climate of exceptional demand and reduced budgets. Their frustration is directed at the system rather than the staff. The increased use of technology such as the internet and Skype is transforming access to GP services for patients with busy lifestyles and hopefully surgeries will be able to share ideas about what works well in order to improve patient experience in the future.

Why is Healthwatch York looking at access to GP services?

60% of the respondents to Healthwatch York's work plan survey 2015-16 told us that access to GPs should be part of our work plan. Their comments included:

> "Getting an appointment at the GP is getting increasingly difficult."
>
> "Make it easier to make appointments at doctors – not getting up at 8 am to make an appointment for that day"
>
> "There are severe difficulties obtaining GP appointments. Appointments are only booked two weeks in advance. I am repeatedly advised to ring back in two weeks' time."

In addition to the feedback from the work plan survey, we received comments and concerns from members of the public about access to GP services. This feedback was provided via the online feedback centre on the Healthwatch York website, by email, letter, phone or in person. The main areas people gave us feedback about were:

- Problems making appointments
- The impact of mergers and federations
- Physical access at GP services
- The named GP scheme
- Practice Participation Groups (PPGs)

Healthwatch England's report "Primary Care – a review of local Healthwatch reports"[xi] was published in March 2015. The report reviewed the findings of over 550 visits to GP surgeries by local Healthwatch and the experiences shared by 11,000 patients across England.

The Healthwatch England report identified five key concerns:

1. Access: People are concerned about accessing appointments due to a lack of wheelchair access, poor translation services for people who are Deaf and difficulty booking appointments

2. Choice: People said they were ‘rarely’ or ‘never’ able to see a doctor of their choice or given the opportunity to elect to see a GP of a particular gender
3. Information and education: People said they do not always have enough clear information to make informed choices about their care
4. Being listened to: People said they often felt rushed through appointments and that the system for complaining about primary care is difficult to navigate
5. A safe, dignified and quality service: Some people were unhappy with the attitude of some care staff, particularly GP receptionists

A number of local Healthwatch submitted evidence to the House of Commons Health Select Committee for their review of Primary Care in September 2015. We were able to submit some of our initial findings from workshops, our issues log and our online feedback centre to the committee. The full report was published in April 2016.[xii]

The Simplyhealth / YouGov Everyday Health Tracker measures consumer attitudes and behaviours towards their everyday health. 2,000 people are surveyed every quarter. In September 2015 24% of the people surveyed indicated that they were willing to pay 'some of the cost' or 'all of the cost' of visits to their GP[xiii]. This may indicate that nationally attitudes are changing towards charging for missed appointments for example. Healthwatch York wanted to explore whether this was the case locally.

Not every patient seen by a GP needs the expertise of a doctor. The report “Making Time in General Practice” was commissioned by NHS England in October 2015[xiv]. GPs used an audit tool to identify consultations which were potentially avoidable. From a study of almost 5,000 consultations 73% were identified as unavoidable contacts and 27% were identified as potentially avoidable contacts. The main areas for potentially avoidable appointments were:

- Patients who could have been seen by others in the practice such as a practice nurse

- Patients who could have been seen by other services, particularly pharmacies
- Patients who could, given the right support, have been in a position to self-care
- Requests from other clinicians, such as opticians and secondary care clinicians that could have been avoided
- Requests for documentation such as fit notes for employers, gyms, benefit appeals etc.

Healthwatch York wanted to explore which other services local people had used instead of their GP.

What we did to find out more

1) We held group discussions at the Healthwatch York Assembly in April 2015, focussing on what Healthwatch York should do to find out about local peoples' experiences of accessing GP services and how organisations would be able to help. The Assembly was attended by 20 people representing key stakeholders (Vale of York Clinical Commissioning Group (CCG)); York Hospital; York CVS; City of York Council, Healthwatch York partners (Age UK, York Older Peoples' Assembly (YOPA), St Nicks and Older Citizens Advocacy York (OCAY)) and Healthwatch York volunteers.

2) Throughout 2015 we continued to gather feedback and issues via the online feedback centre on the Healthwatch York website, by email, letter, phone or in person.

3) We held workshops at the Healthwatch York Annual meeting in July 2015, asking questions about the key issues people had raised:

(i) Making appointments and opening hours

- Does your surgery offer appointment times to suit you, for example, early mornings, evenings, weekends?
- Do you want your surgery to offer extended hours?
- How easy is it to make appointments?
- How far in advance can you book?
- Can you book and cancel appointments online?
- Does your surgery offer text/email reminders for appointments?
- What are your thoughts on charging for missed appointments/ cancellation policies?

(ii) Impact of practice mergers and federations

- Have you been affected by a practice merger?
  For example, is there now a central booking number rather than speaking to your own surgery? Have the opening hours changed?

Are some services, e.g. blood taking, only offered at certain surgeries? Are there different policies on repeat prescriptions?

- Is there a Patient Participation Group for the individual practice or the group? If it is for a group practice is it at a location you can get to?
- Were you fully informed about the merger? Was there any consultation about changes/ impact

(iii) Examples of good practice

- Support for people with long term conditions
- Communication
- Keeping in touch, such as practice newsletters
- Approachable and helpful staff
- Facilities, e.g. toilets
- A visible and proactive Patient Participation Group
- Detailed practice information enabling patients to make best use of services, for example, details of doctors' specialisms, range of services offered by the Practice nurse
- Easy access to repeat prescriptions and medicine use reviews
- Confidentiality (especially around reception desks)
- Named GP for over 75s
- Clear information about chargeable services – e.g. letters for insurance, travel, some vaccinations

(iv) Barriers

- Are there barriers to you getting the service you need, e.g. receptionist will not give you an appointment, have to book online, appointments for certain services only on certain days of the week which you cannot make?
- How physically accessible is your surgery, for example, automatic doors, ramp access?
- Will they provide an interpreter if you need one?
- Is there a car park at the surgery? Are there disabled spaces? Is it on a bus route?
- What if I cannot get into the surgery? Can I have a home visit?
- Does your practice provide/help with e.g. further information about your condition, information and support for carers, travel costs for medical appointments?

- Any experiences of 28 day prescribing (where you can now only have 28 days' worth of medication for a single prescription)?

4) We carried out a survey asking people about their experiences of accessing GP services in York. The survey was available online and in paper form from October to December 2015. It was emailed to 838 individuals, groups and organisations. 1300 paper copies were distributed by post and via community venues, pharmacies and libraries. Working with Healthwatch York partner York People First, an independent self-advocacy group run by people with learning disabilities for people with learning disabilities, we produced and distributed an easy read version of the survey with additional questions about annual health checks and accessibility.

There were 260 responses to the survey in total, 36 of these were easy read.

5) We asked York's Young Inspectors to help us by giving us feedback on their own GP practice from a young person's point of view. The York Young Inspectors' programme recruits and trains a group of excluded young people (13 to 18 years, or up to 24 years with a disability) to inspect services in York and give feedback from a young person's perspective on how they could be improved.

Eight young people aged 12-17 reported back to Healthwatch York about their experiences during January 2016. Three of the young people were males aged 12, 14, 15. Five were females aged 13, 14, 15, 16, 17.

The following is a summary of their activity:

Activity	Number of young people
Visited surgery	2
Attended an appointment with GP	3
Made an appointment with GP	1
Attempted to make an appointment	2
Carried out website research	5

6. We attended a York Racial Equality Network (YREN) Open Forum – Health for All in April 2016. The aims of the Forum were to:

    - Improve understanding of how health services in York are organised and planned
    - Improve understanding of how individuals and organisations can influence decisions about the provision of health services
    - Provide feedback on work YREN has been undertaking relating to health inequalities
    - Provide a consultation opportunity to identify specific changes that YREN would like to see, that would make health services more appropriate and accessible to Black and Minority Ethnic (BME) residents
    - Recruit volunteers to become more involved with the YREN Empowered Voice project

In addition to the feedback gathered from the five YREN members at the April 2016 Open Forum meeting, we were also able to record details of the health inequalities issues raised by YREN members at their health inequalities Open Forum meeting in June 2015.

7) We had conversations with other local agencies including York Association for the Care and Resettlement of Offenders (YACRO) and Citizens Advice York.

What we found out

1 At Healthwatch York's Assembly in April 2015 concerns were raised about difficulties making GP appointments, particularly in getting through on the phone. There was also concern about surgery staff lacking awareness of the needs of patients with autism, visual impairments, hearing impairments and other conditions. People at the Assembly felt that more information about GP services and other services should be more widely available. In particular it was felt there is a lack of information about the GP Out-Of-Hours service, how it works and its role at York Hospital.

Notes from the discussions held at Healthwatch York's Assembly in April 2015 are included as Appendix A.

2 A summary of the comments and concerns from the Healthwatch York Feedback Centre and issues log is included as Appendix B.

The main themes from the Feedback Centre and issues log were:

- Problems making appointments. People reported delays in getting appointments - typically 2-3 weeks. Problems getting through on the phone, particularly at 8 am. Problems with booking systems, including patients being told by their GP that they need to make another appointment in 3 or 4 weeks' time but the booking system only allowing booking for 2 weeks in advance. Long waits for students to get appointments and a lack of consistency as to whether they can get appointments at other practices within the group they are registered with.
- The impact of mergers and federations. People reported confusion over which surgery their appointment was at, difficulty getting appointments with the GP of their choice, reception staff not being as helpful as they could be.
- Access to GP surgeries. People reported problems accessing buildings – such as front doors which cannot be opened if patients use a wheelchair or mobility scooter, problems for Deaf patients accessing British Sign Language (BSL) interpreters, problems with parking, queries about the named GP scheme, problems accessing Patient Participation Groups (PPGs).

- Other feedback included the issue of privacy at the reception desk, complaints about the volume of music played over the phone and in the waiting room, the inconvenience caused when patients are unable to get repeat prescriptions over the phone.
- A number of examples of good practice were reported. A number of GPs were praised for being friendly, good at listening, trans-friendly and good with people with learning difficulties.

3 The notes from the workshops held at Healthwatch York's Annual Meeting in July 2015 are included at Appendix C.

Feedback on making appointments and opening hours included:

- People would like appointments at times to suit them – early mornings, evenings and Saturday mornings.
- Making appointments by phone can be very hard.
- People felt that booking systems should allow appointments to be made for more than 2 weeks in advance.
- Booking online presents a barrier for some people – patients have mixed experiences but generally have a favourable opinion once they have been able to get it set up.
- People felt that text and/or email reminders for appointments are very useful.
- People had mixed views about charging for missed appointments – concerns were expressed about the cost and difficulty of administering charges, and that there are potentially many reasons people don't attend.

Feedback on the impact of practice mergers and federations included:

- Concern that travelling to different surgeries would be an inconvenience for frail and elderly patients to have to go to an unfamiliar surgery.
- One patient who experienced a practice merger said that it was 'messy' at first but has now settled down – there are now more

options for appointments but less chance of seeing a doctor that you know.

- Some people raised concerns about what larger practices would mean for them; such as ‘Can you still see your own GP?’
- It was reported that one practice used to have a prescription line which was stopped after a merger – patients can now request prescriptions online, however using the internet is a barrier for some people.

Experiences of Patient Participation Groups (PPGs) were mixed:

- One person commented that the PPG appears to be for the group rather than for each surgery
- Many people were not aware if their practice or group has a PPG.
- Not everyone whose practices had been involved in a practice merger were aware if there had been opportunities to consult on the merger.

Feedback about barriers to accessing GPs included:

- The lack of car parking spaces at some surgeries is an issue, and the need for accessible spaces for disabled people.
- A surgery on a convenient bus route is an important factor for some patients.
- There are issues for Deaf people who need a BSL interpreter.

Workshop attendees made a number of suggestions for improvements including:

- Making sure that if someone is a carer, this is on their medical record and on the record of the person they care for.
- Offering support for former carers. “It would be good to have access to information such as leaflets without having to ask – it can be embarrassing to ask for some subjects.”
- “Some practices have a ‘health hub’ to provide information about medical conditions and information such as support for carers – this should be promoted better.”
- “Provide more information for patients so they can do more to help themselves.”

4 Survey results

All the quantitative results of our general access to GPs survey and our easy read access to GPs survey are included at Appendix D. We received responses from patients at ten local GP practices, both large group practices and single practices. Respondents had attended 29 different GP surgeries.

Making appointments

A number of questions asked respondents about their experiences of making appointments. In response to Question 5, 50% of respondents said they made their appointments by phone. Question 12 asked people to comment on the statement: “When I ring to make an appointment, it’s easy to get through” 45% disagreed or strongly disagreed, 42% agreed or strongly agreed, 13% neither agreed nor disagreed. A lot of comments were added in response to this question, mostly if people disagreed or strongly disagreed that it was easy to get through on the phone to make an appointment. The main themes were:

If it’s difficult to get through on the phone, people go to the surgery to book in person. Comments included:

> “I make my appointments in person because it’s so difficult to get through.”
> “It is a free for all at 8am and it's a hell of a job, redial, redial, redial. I now go to the surgery at 8am and enter as soon as the doors are open.”

It can take a long time to make an appointment by phone. Comments included:

> “It can take up to 30 minutes of constant attempts to get through.”
> “Sometimes it has taken 20 minutes, or 1 hour with multiple rings of 5 to 10 minutes.”
> “Frequently I cannot even get in the phone queue - the message says that there are too many callers. It can take 5 minutes of ringing back until I can be put on hold to wait for the next operator.

> It is then typically at least 10 mins (though is often at least 20 mins) on hold."
> "Rings for hours. Once spent 20 hours, in one week, on the phone, listening to stupid irrelevant messages, but due to my perseverance, I did get an appointment."

Making appointments by phone is not convenient for a number of people. Comments included:

> "It usually takes at least 15 minutes to get through which makes it particularly difficult for me as I have a 2 year old."
> "My phone bill is going up!"
> "Call at 8:30 when lines open and it's always a waiting game and no one answers phones during lunch. For people who work full time it's ridiculous."

Question 19 asked about the ways people can make urgent appointments at their practice. 75% make urgent appointments by phone – either early morning or at lunchtime.

Question 11 asked people to comment on the statement "I can get appointments with my GP whenever I want them." 40% agreed or strongly agreed, 45% disagreed or strongly disagreed, 15% neither agreed nor disagreed. A lot of comments were added in response to this question. The main themes were:

People said it was easy to get appointments for their babies and young children, but not so easy to get appointments for themselves.

Booking systems can make it hard for patients to get appointments when they want them. Comments included:

> "My husband needs an implant every 12 weeks for prostate cancer, the surgery will not let us book in advance."
> "I can only book appointments for that day (practice policy), and they have often all gone by the time I get through despite being on the phone as the line opens at 8am. This is really frustrating when I am looking for an appointment for my young children."

> "I can rarely see a GP when I want/need to unless I book an emergency appointment."

Question 13 asked people to comment on the statement "My surgery offers a good range of early morning, evening and weekend appointments." 54% agreed or strongly agreed, 22% disagreed or strongly disagreed, 24% neither agreed nor disagreed. Comments indicated that many people felt that evening and weekend appointments were not relevant to them. Some people said they didn't know if there were weekend or evening appointments.

Other comments were about the difficulties of working people getting appointments including:

> "Evening and weekend appointments are needed especially for those that work. Taking time off work can be expensive and may cost you your job. If no doctors are available do I go to A&E?"

> "There are no weekend appointments - if I didn't work part time I would find it difficult to be seen."

> "No weekends, evening only till 18.30 and nothing before 8.30 - not ideal for working people."

Reception staff and confidentiality at reception

Questions 14 and 15 asked about reception staff and confidentiality at reception. When asked to comment on the statement "Reception staff are friendly and helpful" 78% agreed or strongly agreed, 10% disagreed or strongly disagreed, 12% neither agreed nor disagreed.

Comments made by people who agreed with the statement included:

> "Very helpful and caring"

> "Most of the time my experiences have been excellent"

The main theme of the comments made by people who disagreed with the statement was that reception staff were perceived as 'gate keepers'. Comments included:

> “I feel that reception staff block you getting appointments, they say try next week because the computer won't book that far in advance, when you ring the following week you’re told the same again.”
>
> “Most of the reception staff are friendly but some are hard to get past.”

When asked to comment on the statement “I can speak confidentially at reception if I need to” 42% agreed or strongly agreed, 38% disagreed or strongly agreed, 20% neither agreed nor disagreed. The overwhelming theme of the comments people made in response to this question (19 comments) was that people felt they could not speak in confidence at reception because other people could overhear. Comments included:

> “You cannot speak in confidence with a queue of patients behind you in a small space.”
>
> “Anyone in reception can hear everything, including phone conversations.”
>
> “Receptionists generally don't allow for confidentiality at the counter.”
>
> “Everybody can hear what I am talking about.”

Question 16 asked respondents to comment on the statement: “I can choose which doctor I want to see.” 57% agreed or strongly agreed, 28% disagreed or strongly disagreed, 15% neither agreed nor disagreed. The main theme of the comments made was that people felt they had to wait longer if they wanted to see a particular doctor.

Responses to the Easy Read version of the survey (which did not have an option for ‘neither agree nor disagree’) revealed that 54% agreed with the statement, 46% disagreed.

Question 17 asked respondents to comment on the statement “My GP gives me time to talk through my health concerns.” Of respondents to the standard survey 79% agreed or strongly agreed, 9% disagreed or strongly disagreed, 12% neither agreed nor disagreed.

Of respondents to the Easy Read survey (which did not have an option for 'neither agree nor disagree') 89% agreed, 11% disagreed.

Question 18 asked respondents to rate their experience of their most recent GP appointment:

Excellent or good	76%
OK	18%
Poor or very poor	6%

Question 21 asked respondents which services they had used instead of their GP:

Pharmacist	27%
A & E	20%
GP Out of Hours	14%
Walk in centre	19%
Minor injuries unit	7%
Practice nurse	13%

The majority of the comments in response to this question were about the walk in centre which was located on Monkgate. There were also comments which indicated that some people are unsure whether there is a minor injuries unit in York. Comments included:

> "I miss the walk in centre on Monkgate when A&E isn't appropriate and pharmacists aren't sufficient."
>
> "The walk in centre seems to have disappeared"
>
> "I can't find the walk in centre."
>
> "What walk in centre?"
>
> "Minor injuries unit? – don't have one."

Questions 22- 26 were about GP practice mergers. Almost half (49%) of all respondents said their practice had merged with another practice.

When asked about whether consultation had taken place prior to the merger, and whether patients' views had been listened to, the majority of respondents felt they were not sure.

Question 25 asked whether there had been any impact, positive or negative, following the merger:

Yes – a positive impact	8%
Yes – a negative impact	36%
No impact	56%

The main themes of the comments about practice mergers were that people felt that it had become harder to book an appointment and the inconvenience of attending a surgery further away from home. Comments included:

> "Appointments offered at other surgery – I can't get there!"
>
> "The local surgery has closed and the joint surgery is the other side of town. If I need a taxi it costs £5 each way."
>
> "Not able to see preferred GP at nearest practice venue."
>
> "More doctors but worse phones."
>
> "Too big – too many patients so people have to wait for an appointment."

Questions 27-32 were about access and attitudes. Question 27 asked whether respondents considered themselves to be a disabled person:

Yes	24%
No	76%

Question 28 asked respondents who considered themselves to be a disabled person "How accessible is your GP practice?" A number of comments were about the lack of automatic doors and problems with heavy or narrow doors. There were a number of comments specifically about issues for people who use wheelchairs including:

"I have a daughter with a disability who is a wheelchair user. Our GP practice is in quite an old building and access isn't great. There isn't much space inside either and it always seems we're in someone's way."

"Difficult to gain access (heavy doors) but once inside there is a lift but space in the waiting room is limited."

"There is a ramp and automatic doors but getting the wheelchair down the corridor and into a treatment room is difficult as there isn't enough space to turn."

Question 29 asked respondents whether they considered themselves to have a mental health condition:

Yes	20%
No	80%

Question 30 asked respondents who considered that they had a mental health condition how supportive their GP practice is. The majority of people responded to this question with positive comments including:

"Incredible. My GP is absolutely amazing. She gives me so much time and goes above and beyond her job description."

"The doctors and receptionist have been incredibly understanding, supportive and helpful with me and genuinely do care"

"My GP practice have always been very supportive. On occasion when I could not get an appointment, I spoke to a GP on the phone. They discuss with me possible treatment options and have referred me to see the primary mental health worker at the practice for regular on-going support."

The main theme of the responses to this question was the importance placed on the continuity of seeing the same GP. Comments included:

"My GP is very supportive, it is the same GP I have seen since day 1, and she is excellent, having sent me emergency prescriptions when I have been unable to physically get to the practice."

> “Very poor. Not enough time in appointments to discuss mental health issues. Never the same doctor so unable to build trust and open up to them.”

Question 31 asked whether or not respondents were carers:

Yes	14%
No	80%
Former carer	6%

Question 32 asked respondents whether their GP had asked if they are a carer:

Yes	10%
No	90%

Comments included:

> “I am always asked how I am coping even if I'm escorting my husband to an appointment.”

> “There is a displayed notice to say that carers are supported but I don’t feel that happens at all.”

> “Always asks if I'm ok and how things are when I go alone and are very supportive.”

> “It's on the system clearly on both mine and my husbands who I care for.”

Respondents to the Easy Read survey were specifically asked two additional questions:

Does your doctors’ practice provide you with easy read information?

Yes	47%
No	53%

Do you get offered an annual health check?

Yes	82%
No	18%

Question 33 asked respondents to tell us about things they felt their practice does really well. The main themes were:

- Praising GPs – for listening to people, being friendly and supportive, treating patients as individuals, coming out to the waiting room to invite patients in.
- Praising reception and other staff –for being welcoming, helpful, greeting patients with a smile.
- Making appointments – providing same day appointments for urgent cases, sending text reminders, putting aside set appointments for urgent cases every day, online same day appointments, GPs calling patients when appointments are not appropriate.
- Other feedback – taking care that the waiting queue is kept at a suitable distance from the appointment counter with notices prominently displayed regarding confidentiality, an active PPG which is well supported by the medical staff, pop in Saturday flu clinics, a good diabetic clinic, excellent mental health care, minor skin surgery, good practice nurses in the community.

Questions 34-37 were about Patient Participation Groups (PPGs).

Question 34 asked whether respondents were members of their PPG:

Yes	8%
No	64%
Not sure what it is	28%

Question 35 asked respondents who were not members of their PPG why they were not. The majority of comments indicated that people had not heard of the PPG or did not know what it was. There were also a number of comments from people who felt they did not have enough time to join their PPG. Comments included:

> “I don’t think there is one in my practice.”
>
> “I don’t know how you become a member.”
>
> “I currently work full time so don’t have enough time”

A number of comments were from people who felt that their particular circumstances would prevent them from joining their PPG. Comments included:

> “I have dementia.”
>
> “It’s impossible for us to attend in the evening.”
>
> “I would be unable to access this group as not online.”
>
> “I am a carer 8 hours per day”
>
> “I use Makaton to communicate”
>
> “I did sign up, expecting meetings to be at my local surgery, my mobility is slightly impaired, and the other surgeries are not so conveniently located.”

Questions 36-38 were about how effective PPGs are, whether they are representative of the practice population and whether PPG meetings are online. The vast majority of responses to these questions was “Don’t know”.

Question 39 asked respondents if there was anything else they would like to tell us. The main themes were:

Appointments:

> ‘I’m always told to ring at 8.30am when they release more appointments. I can’t, as this is when I start work.’
> ‘They need to sort out their phone system.’
> ‘It takes over 2 weeks to get an appointment with any doctor.’
> ‘I think it has got slightly better since you can talk to a doctor over the phone as you sometimes don’t need an appointment just to talk through something.’
> ‘Sometimes we have just given up trying to get an appointment.’

Waiting times at the surgery:

> ‘Each time I’ve had an appointment I’ve had to wait almost an hour, without apology or being informed of the delay upon arrival. Quite annoying when taking time off work.’
> ‘Ensure staff explain to us when there is a delay and apologise for keeping us waiting. It is a simple matter of courtesy and respect to say sorry when you’ve been waiting 20 minutes and had arrived early in the first place.’

Other comments:

> ‘When I asked one of the practice nurses about seeking information and advice about the sexual health needs of older LGBTI (Lesbian, Gay, Bi-sexual, Trans, Intersex) people she asked me what I meant by the term.’
> ‘We’ve just registered but haven’t really heard anything from them. I wonder if it might be good to give people a welcome or information pack. Or even an induction.’
> ‘Zero understanding of cerebral palsy.’
>
> ‘Since the merger almost all of the GPs have left or retired. We now have a surgery where I feel little sense of belonging.’
> ‘Space is very limited – my practice now has its own pharmacy in the waiting room so there are queues of people at reception or pharmacy desk almost constantly. The limited space is tricky for me – using a mobility scooter and for wheelchair users and Mums with pushchairs.’
> ‘No visual signing for waiting patients, so the hard of hearing might miss appointments. Limited display of leaflets in surgery.’
> ‘Staff helpful and efficient but somehow the patient views are not fully exploited/understood/listened to/used to maximise GP patient communication.’

Positive comments received in response to this question included:

> ‘Generally very good when you need an urgent appointment.’
> ‘I am very satisfied with my GP’

> ‘The people on reception, and also at the pharmacy, which has relatively recently been added to the practice, are always helpful.’
> ‘I am very well received as soon as I walk through the door’
> ‘I can’t praise them enough and always recommend them.’

5) The young inspectors reported back to us about their experiences, a summary of their findings is included here:

All but one of the young inspectors has never made an appointment or attended their GP without a parent or carer. More often than not it is their mother who decides they need an appointment and makes the appointment for them.

> “I’m too scared to make my own appointment and to go alone.”

> “My parents always make an appointment and come with me.”

Two female young inspectors and one male young inspector said they would feel more comfortable making their own appointment if they were supported to do so.

Only one young inspector has made their own appointment in the past, sees the doctor alone and feels confident in doing so. She is 15 years old. The last time she visited her GP was over 3 months ago. She always goes into the surgery to make an appointment on the way to school because it is easier than trying to ring because it takes ages to get through, especially if she has no credit on her phone. She also stated that whilst she can go the doctors alone, she had been informed she was too young to pick up her prescription.

> “It’s easier to go in to make an appointment than use the phone. It takes ages to get through and I have no credit.”

At one surgery the Young Inspectors discovered that you must be 18 years of age or over to register for online booking.

All the young inspectors say their parent/carer accompanies them to see the doctor. Their doctor has never requested to see them alone or requested the parent/carer to leave. One young inspector said they had left the room whilst mum spoke to the doctor alone.

None of the young inspectors said they would request to see a specific doctor, they would see any.

Two male young inspectors expressed a level of embarrassment about seeing a doctor if it was a more personal issue. They would rather suffer than see a doctor.

Five surgery websites were looked at in varying detail. Four young inspectors looked at their GP surgery websites to see how they could get involved as a patient. They said they couldn't easily find information specifically about involving young people. They also reported that some of the general information about patient involvement groups, such as minutes of meetings, was out of date.

Petergate surgery has set up a virtual patient participation group which they hope will "attract members from a variety of different age groups and backgrounds so that the group is as representative of our patients as possible."

Heworth Green surgery, which is part of the Priory Medical Group, has a display board dedicated to young people. They have consulted with young people and offer teenage clinics. In the Priory Pulse Quarterly newsletter Autumn 2015, which is produced by the Patient Participation Group (PPG) they stated: "We've been thinking that a young people's PPG could be just what's needed".

Qualitative feedback from the Young Inspectors

Appropriate training needs to be provided to receptionists and doctors to deal with the following issues

- Anxiety
- ADHD
- Personality disorders
- Self harm
- Depression
- Other mental health issues

Important qualities from staff

- Friendly
- Non-judgemental
- Warm
- Sincere
- Make you feel safe

Things young people need to help them access/ feel comfortable

- Visual things to look at help you feel less nervous
- One-to-one spaces to talk/disclose
- To be able to access independently of parents
- To be put at ease as soon as they enter the building

Most disliked phrases heard from GPs

‘Its just a phase’
‘Its quite common’
Young people also fed back that laughing is a big no-no.

<u>What young people would like to see more of</u>

Improved access to services online

Opening hours outside school times

Confidential spaces

An understanding on what they can say confidentially

Being able to go to the Doctors without their parents, or having the option to take someone else.

<u>Quotes</u>

‘Surgeries need teenage stuff like magazines, gaming and WIFI so we can check our phones’

‘We found it really hard to make an appointment’

‘We found lots of out of date information on the websites we looked at’

‘We would like more self-help information online’

6) Notes from the YREN open forum are included as Appendix E. YREN members told us that there are issues for Muslim, African and Asian women particularly, but women generally, who want to see a female GP. Men who want to see a male GP face the same issues. They feel they face confrontation and challenge at reception. There are also issues for YREN members around interpreting:
    - Few people are aware of interpreting services
    - Close community members and children are used inappropriately as interpreters

7) From our conversations with York Association for the Care and Resettlement of Offenders (YACRO) we understand that there are a number of issues around ex-offenders accessing GP services, particularly for women. Unfortunately we were not able to explore these issues within the scope of this piece of work.

Citizens Advice York told us that a number of issues had been raised with them in 2015/16 about charging for medical evidence, particularly from clients on low or limited incomes. Most of the issues were from people who were charged for evidence for appeals against the Department of Work and Pensions (DWP) decisions not to award Employment Support Allowance (ESA). Citizens Advice York have written a report to the Health and Wellbeing Board which contains a number of qualitative examples. This report is included at Appendix F.

Conclusion

Problems making appointments were reported from the Healthwatch York Assembly, our feedback centre and issues log, workshops at our Annual Meeting and our Access to GPs survey. People reported difficulties getting through on the phone, particularly at 8am when the phones are very busy. The need to ring at 8am to get an appointment is stressful and causes problems for carers and people at work.

Booking online presents a barrier for some people. Patients have mixed experiences but are generally in favour once they have been able to get it set up.

Booking system restrictions are the cause of a lot of frustration and inconvenience for patients. Many people reported that 'the system' only allowed them to book appointments 2 weeks ahead. This restriction is particularly a problem when a GP has told the patient to book an appointment for 3 or 4 weeks time and they are not able to do this.

Not everyone can get an appointment at a time to suit them – early mornings, evenings and Saturday mornings. However many people do not feel they need appointments at these times.

Positive feedback was received about the use of phones and e mail. Many people welcome phone consultations with their GP where appropriate. Appointment reminders via text and e mail were appreciated by patients where GPs offered them.

Our survey showed a general lack of awareness of Patient Participation Groups (PPGs). Our conversations with members of the BME community and Deaf people indicated that there were particular issues in getting patients from these communities involved.

Getting to see the doctor of their choice was an issue for almost half of the respondents to our Easy Read survey. This may mean that patients with learning difficulties are not able to see a GP they are familiar with and feel comfortable with.

Our survey showed that most respondents don't have much understanding or awareness about practice mergers. From conversations with patients, feedback we received via our feedback

centre and issues log it would appear that patients' main concerns are about the practical aspects of mergers – the things that affect their experience such as changes to booking systems and phone numbers. Attending appointments at different sites can cause confusion and misunderstandings for some patients who have to go to an unfamiliar surgery.

Many of the comments we received show that there is confusion about some of the alternatives to going to see a GP. A number of people did not know whether we had a walk-in centre or minor injuries unit in York.

Physical accessibility issues were reported via our survey and our face to face meetings with people. In some cases it was difficult for patients using wheelchairs or mobility scooters to open the main door to their surgery. Issues about lack of space for wheelchairs in waiting rooms and corridors were also reported.

The work that the York Young Inspectors carried out revealed a lack of confidence among young people when accessing GP services.

Lack of awareness of options around interpretation was an issue for members of the Black and Minority Ethnic (BME) community and Deaf people. Inappropriate use of children, other family members or other community members as interpreters was reported.

Charges for medical evidence are having a significant impact on disabled people and people with health problems who have low or limited incomes. They are being charged more than they can afford in order to increase their income through work.

Good practice examples were reported:

- There was praise for GPs and other staff from patients with mental health issues
- Most of the respondents to the Easy Read survey agreed their GP gives them enough time to talk about their health concerns
- GPs were praised for being friendly, good at listening, trans friendly, good with people with learning difficulties, treating patients as individuals, coming out to the waiting room to invite patients in.

- Reception staff were praised for being welcoming, helpful, greeting patients with a smile.
- Parents of a child with autism praised staff at one practice who understood that the surgery waiting room was a challenging environment for their child. Staff suggested that the family went for a walk outside while they were waiting and texted the parents when the doctor was ready to see them.

Recommendations

Recommendation	Recommended to
Support GP practices to improve their systems for making appointments, particularly by phone. Explore the practicalities of opening up e-booking systems to under 18s in those practices where this is not currently possible.	NHS England Vale of York Clinical Commissioning Group
Support GP practices to increase their use of technology (phones and computers) to improve access to services for patients. • Text reminders • Online booking systems for appointments and repeat prescriptions • Use of telephone consultations • Wifi for patient areas	Vale of York Clinical Commissioning Group / Virtual Clinical Network
Support GP practices to increase awareness of Patient Participation Groups (PPGs) to ensure they are representative of the patient population including young people, disabled people, people from the BME community. Consider how Healthwatch York might be involved in this work.	Local Medical Committee (LMC) Vale of York Clinical Commissioning Group
When planning mergers, consider all the practicalities which will affect patients' experience of accessing their GP and consult with patients prior to the merger.	Any GP practices in York considering a merger
Consider the role of GP practices in providing information to enable people to take more responsibility for their own health. Explore ways of involving patients of all ages and backgrounds to make sure the information is useful and useable.	Virtual Clinical Network All GP practices in York
Consider using Patient Participation Groups to find out patients views on whether there is a need for additional early morning, evening or Saturday morning appointments.	All GP practices in York Vale of York Clinical Commissioning Group NHS England
Consider how to enable all GP surgeries to be fully accessible for all members of the community.	Property Physical Access Committee

Consider how best to meet the needs of all patients who need interpreters including Deaf people, and members of the BME community. Revisit the recommendations in Healthwatch York's report – Access to Services for Deaf People.	All GP practices in York Vale of York Clinical Commissioning Group NHS England
Consider what can be done to explore the issues around ex-offenders access to GPs, particularly women.	City of York Health and Wellbeing Board

Appendices

Appendix A: Notes from Healthwatch York Assembly April 2015

Appendix B: Comments and concerns from Healthwatch York feedback centre and issues log

Appendix C: Notes from Healthwatch York Annual Meeting workshops July 2015

Appendix D: Results of Access to GPs survey and Easy Read Access to GPs survey

Appendix E: Notes from YREN Open Forum meeting April 2016

Appendix F: Citizens Advice York report on charging for medical evidence

Appendix A - Notes of discussions from the Healthwatch York Assembly April 2015

Concerns raised:

- Phones not being answered
- The practice of asking patients to ring at 8am for urgent appointments
- Lunch breaks with no cover at Reception
- Lack of staff awareness of the needs of patients with autism, visual impairments, hearing impairments and other conditions
- Misinformation from Reception staff

Suggestions to reduce demand on GP services:

- Sending reminders such as text messages to reduce the number of 'Did Not Show' (DNS)
- Can people turn up without an appointment to use the DNS slots?
- Use of technology such as online booking systems for appointments and repeat prescriptions
- Use of telephone consultations

Demand for more information regarding GP services and other health services available:

- Clear messaging about what you should go to your GP for
- Information about the GP Out of Hours services
  How does it work?
  How to contact the service
  Barriers to using the service e,g, unknown GPs
- The role of the GP Out of Hours Service at York Hospital
- NHS 111 and Pharmacy services – are these alternatives to GPs advertised?

Specific issues regarding students:

- Many students don't register with GPs
- They are more likely to go to Accident and Emergency Departments
- Do students get the correct information?

Appendix B - Comments and concerns from the Healthwatch York Feedback centre and issues log

1. Problems making appointments
   (i) Problems with delays in getting an appointment:
   - Patient with shingles could not get an appointment for 3 weeks
   - Patient had an 8 day wait for an appointment for a sore throat. The throat was better by then so he cancelled the appointment. The patient said that there is no walk in centre so A&E was the only alternative.
   - Patient couldn't get an appointment within 10 days. They tried three times to get through by phone. The receptionist was 'off hand'.
   - Concern over a 4-5 week wait with blocked ears causing hearing difficulty.
   - Appointments take weeks to get and there is no parking
   - There is a problem with the appointments system. I usually wait 2 weeks.
   - It's difficult to get an appointment.
   - I used to get appointments in 2-3 days, now it is 2-3 weeks.
   - The appointment system (at Priory Medical Group) is a disgrace. Almost impossible to get an appointment at the time you are ill – usually 2 weeks later
   - Difficult to get an appointment with GP immediately. Always days to wait.
   - Since 30 April I have been trying to make an appointment to see a nurse. I have called at least 8 times only to be told there are no available appointments and I should call back tomorrow. Ridiculous and insulting waste of my time.
   - After having treatment for cancerous cells at just 25 years old I was horrified when I tried to make an appointment for my 6 month check-up. The only day I can make it to the doctors is a Friday, after 20 minutes on hold, I was told the practice do not offer cervical smears on a Friday and that was that. No help on where I could go for a check-up. After searching online I have since made an appointment at Monkgate who miraculously do take appointments on a

Friday! I think my next step will be to change doctors, you would think with 3 practices to choose from you could get an appointment with 2 weeks notice, but not here!

Jorvik Gillygate Practice replied: We are sorry you felt our staff to be unhelpful. We normally offer Friday nurse appointments but we recently had a brief spell when we had a shortage of nurses due to sickness leave and recruitment delays. We are now fully staffed again and have also trained another nurse to take smears to reduce likelihood of this happening in future.

(ii) Problems getting through on the phone:

- It is a problem for carers to ring at 8-9 am for a GP appointment. They may call the GP out for a visit instead.
- Problems with a recorded message when ringing at 8am and phone blocked or engaged all morning. (The patient thinks the phone system is linked to the hospital switchboard.)
- You can never get through on the phone and expect to wait for over 5 minutes (more like 10) for them to answer the phone. You can do repeat prescriptions online but you have to return again with a passport, driving licence or utility bill which defies the point really!
- Surgery closed for lunch from 12:00 until 1:30 with no phone or Reception service. Patients who phone are given an emergency number. (Patient thinks this is related to the closure of Gillygate Surgery.)
- Receptionists can be stroppy and unhelpful on the phone.
- In an emergency you can get a 'same day appointment' but only by joining the even longer phone queue first thing in the morning.

(iii) Problems for patients who work full-time:

- Patient tried to make an appointment for a health check he had been invited for (40-74 year olds). He couldn’t get an appointment outside working hours.
- A full-time worker had problems making an appointment by getting through on the phone.

(iv) Problems with the booking system:

- A patient was told they needed an appointment in 3 weeks but the system only lets them book 2 weeks in advance.
- Staff ignore the contact form on the website and are then stroppy and unhelpful on the phone.
- I've registered to use the online booking system, and was able to book an early morning appointment. I didn't realise initially that there are tabs across the top to change the dates looked at, so I thought there were no appointments available at Cherry Street at first. It didn't come up on the list of surgery options because there were no appointments for the shorter time period. But once I'd twigged that, it was very simple to get an appointment I wanted. It was great to be able to do that at my convenience!
- I regularly get asked by the doctor to "Come back in four weeks" only to be told by a receptionist that the booking system won't allow me to make an appointment more than three weeks in the future. This means that I have to phone a week later, and wait in a fifteen minute queue, to make my appointment.
- Jorvik Practice replied: We are reconsidering our management of review appointments. Pre-bookable appointments can be booked up to 3 weeks ahead. We previously extended this to 4 weeks but this resulted in a higher rate of patients failing to attend or notify us. Many more appointments were being lost, wasting NHS resources and denying other patients of an opportunity to see a doctor or nurse.

(v) Students

- There is a 3 week wait for students to get an appointment
- Some receptionists within Unity practices will let students go to other Unity practices if there is a long wait, but some won’t.

2. Impact of Mergers and Federations

From the Self Advocates Forum (for people with learning difficulties):

- Not enough information given about the merger though better range of services available after the merger happened

From the issues log:

- Invited for a routine check but not told it would not be at their usual surgery.
- Following mergers, reception staff should help patients and not assume they know their way around the building.
- The surgery was disorganised with uncaring, unpleasant staff. It was stressful and I was made to feel unwelcome like a nuisance and a burden. (Healthwatch York contacted the person who left this comment. It became clear that the merger had led to some miscommunication. We raised this direct with the practice manager. They were very responsive, and agreed to make changes to letters inviting patients to appointments, to make sure the location for these appointments was clear. They also discussed challenges arising from the merger with all reception staff to help make patient's first visits to new sites as easy as possible. We were impressed with their willingness to address the concerns raised and make changes to services.)
- My GP is great but the merging of the York Medical Group (4 practices?) is a BIG problem. One central telephone number has been introduced - on the switchboard at this central location (in the city?) they have all the details of your appointment and probably many other details! I'm a mobility scooter user and unfortunately there aren't automatic doors in the Acomb practice. This means I have to phone the central number to ask them to inform reception that I am outside and could the heavy door please be opened. They do this by sending a 'pop up note' to the Acomb reception. I only do this if it's raining, otherwise I'll wait outside until someone leaves or enters the practice. I have been assured that there will be a more direct telephone number in the future - I'll still need to telephone to get the door opened but it will be easier! This puts me off seeing my GP but it cannot be avoided at times.

Update on this issue: The practice now has its own 'personal' number again – back by popular demand! There are 2 members of staff in reception that are solely present to answer the phone as

well as the ‘greeting’ staff when you turn up for an appointment. No difficulties with my scooter now!

- I have been with the surgery for a while, Gillygate was great on its own. The merger happened and things got worse, really difficult to get appointments, staff I was comfortable with had left and the reception team did not want to help, this I think should be expected with such a big change really.... when I think about the surgery now it is so much better than it ever was, the doctors are fantastic really caring and down to earth, felt really comfortable with one of the doctors, it was easy to get an appointment and so fast. I feel like the change was necessary and needed now that it has in fact gotten better but I can also see why the surgery got such bad reviews during the transition period. I say keep it up Jorvik Gillygate you are now doing a smashing job!

  Jorvik Gillygate Practice replied: We are pleased that, now Gillygate branch surgery has closed and we all staff & clinicians have relocated to our Woolpack House site, we now feel able to offer a better service to our patients.

From NHS Choices:

I have been a patient at Southbank Jorvik Medical Practice for many years. They were an outstanding practice. But since the merger things seem to have gone quite wrong. I can never get an appointment with the doctor I want at Southbank - the receptionists seem to want everyone to be seen at Stonebow. I live less than 5 minutes walk from the Southbank surgery, but at least 30 mins walk to Stonebow so this is really inconvenient for me. They have also removed the function where you could book appointments online the night before. This was brilliant, and I cannot understand why this fantastic idea has been reversed. I can now never book online and always have to speak to a receptionist - surely this cannot be more efficient than patients booking their own appointments. The doctors are still great (when you are allowed to see them), but I have to say the administration side and ease of dealing with reception has gone badly wrong. Jorvik Practice replied: We have recently introduced our Urgent Care, same day, clinics at South Bank as well as at Woolpack House (Stonebow) in response to patient demand.

3. Access to GP Services

   Comments and concerns from the Healthwatch Feedback service and issues log:

   a. Access to the buildings:

- The front door is not automatic – difficult to open if using a stick or in a wheelchair.(Heworth Green Surgery)
- Patient has to ring reception desk for the door to be opened for her mobility scooter. Made worse when centralised telephone system installed as could not speak to receptionist at the surgery direct but this has now been addressed (York Medical Group, Acomb)

   b. Problems for Deaf patients:

- Problems with access to BSL interpreters for Deaf patients.
- A receptionist wouldn't book an appointment, with a BSL interpreter, for a Deaf patient.(various surgeries)

   c. Problems with parking:

- There is a problem with parking. Some people restrict access. More signs are needed.(Fulford Medical Group)
- Problems with parking. (Clifton Medical Practice)

4. The named GP scheme
   - Do all GPs have a Well Woman Clinic?
   - Patient received a letter giving the named doctor for older people. The patient went for a health check which was very good. "Really good service."

5. Practice Participation Groups
   - Patient tried to join a PPG online but got no response.
   - The practice have an online PPG. The patient thinks face to face would be better.

6. Other feedback
   - The only small issue is the privacy of your details from the reception staff. I have had comments directed at me about my medical records in front of other patients by one particular

receptionist and have left feeling embarrassed. I do not feel that they should be commenting on your medical issues when they ask you what the appointment is for when you are booking it.

- Please can you cancel this horrendous sound (music while waiting on the phone) which we are subjected when trying to make a medical appointment? The TV in the waiting room is also unnecessarily loud and obtrusive. Some of us wish to read. It is a medical practice not an entertainment lounge.

  Jorvik Gillygate Practice replied: We don't have any control over the music played over the phone but have requested from our support team that this be turned down, if possible.
  To improve confidentiality for patients at the Reception desk, we play a radio in the waiting room. The volume of this is checked daily. We are investigating other alternatives to improve confidentiality.

- Patients are inconvenienced because they cannot get repeat prescriptions over the phone. Jorvik Practice replied: Our Prescription Phone line was closed to improve:
  - Patient Safety – many people use mobile phones, messages are often unclear and drug names are often complicated, with many sounding similar.
  - Telephone Access - to increase capacity for patients booking appointments and ringing with clinical emergencies.
- I can usually be seen when I need to be (by calling on the morning), and most of the GPs are able to help me. The care when I was pregnant was good, and the office staff are always very helpful. The Antibac hand gel is often broken, which is a bit annoying.

7. Good practice examples from local GP surgeries
   - “Excellent GP. Can always see my preferred GP” (My Health, Huntington)
   - “Friendly staff. GPs spend time” (Heworth Green Surgery)
   - “Trans friendly doctor” (Jorvik Medical Practice)
   - “Receptionist is very good” (The Petergate Surgery)

- “GPs are excellent”
- Good treatment from receptionist and nurse following a dog bite.
- Praise for GPs from Self Advocates Forum for people with learning difficulties.
- “Evening appointment offered” (Clifton Medical Practice)
- “Home visit on same morning” (Old School Medical Practice)
- “Very good for same day urgent appointments” (Haxby Group, Huntington)
- Praise for surgery and GP – “Appointment next day and children are seen straightaway”
- A new doctor introduced himself to needy and vulnerable patients.
- Patient suffered recurrence of an eye problem. He rang his GP and got a GP appointment and an appointment at the eye clinic the same day.
- Patient received a letter giving the named doctor for older people. The patient went for a health check which was very good. (Haxby Group)
- Haxby Group Practice are very good for same day urgent appointments
- On two occasions I phoned Huntington Surgery at 8.30am and was able to make an appointment to see a doctor that morning
- All staff are friendly and the GPs are always willing to spend time to ensure you understand the medication
- I have been using this practice for over 25 years since I was a child and will never use another one as long as this practice stays open. Most of the doctors and Nurses are friendly, welcoming and easy to talk to without feeling fobbed off. 1 doctor in particular I find to be excellent at listening and dealing with your problems and even will call you at home to ensure you have all the information you need.
- Dr Barrett is very Trans friendly and understands. Also Dr Lockett referred my daughter to the Tavistock Clinic with no problem or questions.

- Very good service. Unable to stand up due to balance problems. Surgery called.GP visited me at home later that morning, diagnosed and wrote prescription.
- My GP always asks about my general life and work. (i.e. he remembers details about me although I don't see him that often, perhaps once or twice a year), he listens properly, explains things clearly and does not rush the appointment. I have always managed to see him and not been forced to see another GP.

Appendix C - Feedback from Annual Meeting Workshops 28th July 2015

1. Making appointments and opening hours

Does your surgery offer appointments at times to suit you eg early am, evenings, weekends?

- Monkgate surgery do Saturday mornings, had been offered 8.30am.
- Can get an appointment at any time but not to see a specific GP.
- Where there is a village surgery which is only open two days a week, there is no provision for patients who need urgent appointments on the other days. They have to make their own arrangements to get to the surgery in the main town.
- Aware of 8am calls for emergencies.
- Fulford is very good for making appointments - never had a problem. Sometimes had to see the nurse
- Making appointments is no issue - but no early, evenings or weekends though. Some only open from 8 on one day
- Extended hours - yes. Saturday morning and evenings would be helpful

How easy is it to make appointments?

- Making appointments by phone can be very hard but the service is usually great when you get there.
- Where there's a central reception for booking appointments, you may have to wait if a specific time is required eg at Lavender Grove there is a two week wait for an appointment with a specific GP. At Cornlands Road this is reduced to a 10-day wait.
- Triage system where you phone and the GP calls back. One example given of having to wait one week for the GP to phone back.
- Phoned in for an emergency appointment, nurse phones back to ask about the problem.
- Phoned to see a GP and ended up seeing a nurse practitioner instead with no warning.
- Had to wait a long time for the phones to be answered at all practices.
- Not able to get an appointment on the day to see a specific GP.
- Can phone as soon as they open and not get through until 10am.

- Telephone systems in York are getting old (Haxby surgery) – there are a restricted number of lines coming into the surgery therefore making it difficult for patients to get through. All GP practices in York, bar one, come under the hospital telephone system. This will change in the next 6 to 12 months and there will be a new telephone system and network. If there was more than one telephone line in, more staff would be needed to answer it.

How far in advance can you book?

- Patients are asked to return in three or six weeks, etc. but the booking system only allows an appointment two weeks in advance. The onus is on the patient to remember to make the appointment later. This means they may forget.
- How far in advance can you book? Only up to 2 weeks in advance; Fulford allows you to book further in advance; you may have to wait for quite a while to see a particular GP - had to wait 3 weeks to see a specific GP. Dentists allow you to book 6 to 12 months for the next appointment - should be able to do this with the GP.
- DNA appointments tend to be the pre-booked appointments, so a case could be made that this is why bookings are not allowed so far ahead.

Can you book and cancel appointments online?

- Booking online presents a barrier for some people. Patients have mixed experiences but generally have a favourable opinion once they have been able to get it set up.
- Can book appointments four weeks in advance online at some practices, others only two weeks.
- Monkgate surgery (York Medical GP) have difficulties with online service.
- Booking online is useful and you can also cancel online.

Does your surgery offer text/ email reminders for appointments?

- Text and/or email reminders for appointments are very useful.
- Email and text reminders are available at all three practices within the group
- Some practices use text messaging for designated appointments but the Government is removing funding for text messaging services. There is ongoing discussion about what this will mean.

What are your thoughts on charging for missed appointments/ cancellation policies?

- Concerns were expressed about the idea of charging for missed appointments. People felt this might give a negative view of the practice or cost too much to administer. Also some people have good reasons for not attending. Sending a text reminder was considered a better option.
- Charging would be hard to police and carry out. Perhaps if three appointments are missed in a row some form of penalty, but not financial, should be considered – possibly remove from the practice list.
- Not concerned about charging but it would be difficult to identify an appropriate amount.
- Always thought we should charge for people who habitually don't attend for appointments - some people can miss in the tens of appointments
- Some practices send a letter to DNA (after 3 times DNA) - check with GP first as there may be a reason they didn't attend. But may not be straightforward - dependent on the individual patient/may have dementia/maybe Englishis not their first language/frightened
- No power to charge - would need national authority to charge and then how would you administer it.

2. Impact of practice mergers and federations

Have you been affected by a practice merger? For example, is there now a central booking number rather than speaking to your own surgery? Have the opening hours changed? Are some services, eg blood taking, only offered at certain surgeries? Are there different policies on repeat prescriptions?

- Constant mergers since 1981! Now the practice is really large and not positive from a patient's point of view.
- One patient who experienced a practice merger said that it was 'messy' at first but has now settled down. There are now more options for appointments but less chance of seeing a doctor that you know and so forming a relationship.
- Another patient said that the appointment system had changed following a merger. Patients now have to phone at 8.00 and it

takes around 20 calls before they are even put in the queue to be put through.

- One practice used to have a prescription line which was very good. This was stopped after a merger. The patients can now request prescriptions online which is a good service. However, using the internet is a barrier for some people.
- Some people feel that smaller practices can offer more personalised services.
- Some people raised concerns about larger practices such as – "Can you still see your own GP?"
- A patient wondered if a merger meant more costs for the practice with the increased administration burden and number of doctors involved.
- A patient suggested that larger practices would be able to purchase more equipment and possibly offer more clinics and minor surgery.
- Some people wondered if larger practices would have a wider range of GP specialist areas. This thought related to the practice of York Hospital referring some patients with long term conditions back to the care of their GP. It was felt that a GP in the practice who took an interest in, for example, MS would be very helpful and reassuring for patients.
- Would a GP with a particular special interest be able to establish 'fast track' communication with the relevant consultant?
- Would other GPs be able to give patients the option of seeing a colleague with a special interest in their condition?
- GPs must find it stressful – no continuity with patients as they used to have. No idea which GP you are going to see and you have to give all the background over and over again each time you see a new GP.
- It is hard for GPs to keep up with new services available through the NHS.
- Important for patients with mental health problems as they need continuity of service and care with the same GP. This could make a massive difference to the patient.
- Non-holistic service now; families used to be treated as a whole, not now.
- Blood taking can be done at any surgery within the Group, wherever the nurse is available.

- Much travelling to different surgeries within a Group although this is not always a problem as some may be close to home. A number have very small car parks.
- Travelling to different surgeries would be an inconvenience for frail, elderly patients to have to go to an unfamiliar surgery.
- There are no positives in relation to mergers as they become impersonal. Small is beautiful.
- A 92-year old patient was booked a taxi journey to Haxby surgery for a B12 injection. A nurse visits the patient on a daily basis for insulin injections therefore no logic in the Haxby appointment.

Is there a Patient Participation Group for the individual practice or the group? If it is for a group practice is it at a location you can get to?

- The PPG appears to be for the group rather than for each surgery.
- Experiences were mixed. Of two patients from the same practice, one had heard of and was a member of the PPG and the other had never heard of it!
- The PPG member commented that the PPG was a little like Healthwatch, in that, knowing she was a member of the PPG, people would tell her things they would not raise directly with the surgery.

Were you fully informed about the merger? Was there any consultation about changes/ impact?

- Information on the mergers was in the surgeries, not sent out to patients. No awareness of the opportunity to consult on the merger.
- Not fully informed about merger but this doesn't seem to have made any difference. It would have been nice to receive letter. Asked about automated prescriptions and can be sent electronically to prescriptions - not all practices can do this. Some are enabled and some aren't - is in process in York. Pharmacists have to be set up for this as well.
- Most are not aware if the practice or group has a patient participation group - only one aware of it but not involved.
- Need younger people involved to find out what their wants and needs are - need a cross-age group to reflect all.
- Is there a two-way mechanism - sounding board for practice and feedback opportunities for patients as well.

- Mergers can give you more options for appointments - more chance to go to a different surgery if all the appointments are taken at your usual one.
- Must be compliant with CQC as well
- Was there any consultation - one says yes, some don't remember and some knew it was happening but can't remember how they knew or whether there was any formal consultation. Some were informed but were not sure if they had been consulted. Is there a formal process that surgeries have to go through to merge?

3. Examples of good practice

- Some practices keep in touch with patients by having a newsletter, for example, My Health and Haxby Group.
- Praise for staff – “Good customer service”
  “Receptionists are much better now. Some are excellent.”
  “My GP practice were excellent. I had a fast track appointment for cancer care”
  “Community practice is excellent.”
- Accessible premises at Priory Centre Acomb, My Health and Haxby Group (Haxby and New Earswick surgeries).
- Some people with long term conditions said they experienced good practice.
- Haxby Group offer a telephone consultation service. This is very useful for patients with long term conditions.
- Some practices have a good system for recalling patients for medicine use reviews, asthma checks etc.
- GPs were said to be ok with people with mental health issues in comparison with A&E where the language used was ‘terrible’.
- Text messaging to remind people about appointments is a good service.
- The systems for ordering repeat prescriptions and having medication delivery to their home are very good.
- Patients in Haxby like having the pharmacy next to the surgery and also the extended opening hours the pharmacy offers.
- Clifton/Priory offer open surgeries. Patients were aware of practices in West and East Yorkshire also offering open surgeries.
- In Pocklington there are two doctors on call each day. The receptionist can ring them if necessary and the doctor can then phone the patient to give advice.

- A patient liked the prescription line that used to be available at her practice. This has been stopped now but the patient is happy with the online system set up to replace it.
- The idea of giving older people a named doctor is a good idea in theory but doctors leave so there are changes. One patient had a very good experience of this service but another had to wait 20 days to see the named doctor as the doctor is very popular and also has a teaching commitment.
  Many patients said that they like to see a doctor that they know and who knows them.
- A patient commented that having a welcome poster in many languages might be considered good practice but it discourages people from learning English and integrating. The NHS spends a lot of money on interpreters.
- Email liked by some for receiving test results but not by others especially if the results are not good. If the results are OK then email and text are fine otherwise people would prefer a phone call.
- Having access to own notes would be useful but may not be available. One person knew it was possible and managed to get a copy but it was hard work. One person also knew but had not tried. Most people did not know having a copy of your own notes was possible. This could lead to life-changing effects if a problem was identified.
- No newsletter, not even at the surgery, only questionnaires asking how the surgery and staff were doing.
- Receptionists are generally friendly and good. Trying to contact a Practice Manager (Lavender Grove) proved impossible. This was to ask about help with signposting in relation to loneliness, dementia, etc – this is not the way it should be.
- Automatic booking systems are very good eg contact every six months for diabetic testing. At lavender Grove the medical staff are good and personable. The nurses at Monkgate are nice and friendly.
- Initiated own medicine-use review and the GP was very helpful.
- Reception areas are not private enough.
- GPs have been assigned, not only for those over 75, but have no chance to see them – even over five years.
- The chargeable services are OK especially for information on particular holiday destinations.
- Very good at sending for an annual review of blood pressure (if needed). On a normal visit you may not get results of tests and

you have to phone. One thinks receptionists shouldn't give results - GP should do. Patients need to understand distinction between different roles - nurses/nurse practitioner/GP.

- In the Haxby practice it is the patient's responsibility to contact the surgery for their test results. This may not be made clear in all surgeries, it is important to know who is responsible for contacting the patient about test results.
- Not all GPs are good at looking at results - disappointed in some GPs.
- If you are not happy with any service you receive from the practice then you must complain. Nurses are excellent and receptionists are also excellent. E-mail consultations are difficult - from a GP point of view they can't be sure who is reading the e-mail. E-mail could be used more for general communications. There should be good telephone consultation and more practices should offer NHS Annual Health Checks.

4. Barriers

- It is sometimes hard to book an appointment by phone.
- Some practices offer a phone call with a nurse for people who can’t get to the surgery.
- Home visits seem to be limited to people who are registered as bedridden.
- There are no nominated spaces for wheelchairs.
- Could a wheelchair be provided at all doctors’ surgeries for patients’ use?
- Car parking is hard at some surgeries. There are not many spaces.
- Some surgeries are convenient for bus routes. This is an important factor for many patients.
- A patient asked “Are doctors asking the right questions?”
- Doctors are not offering a holistic approach. They have separate appointment to look at symptoms separately.
- Practices could offer more understanding of mental health, exercise, pain relief, self-medication etc.
- It would be good to have access to information such as leaflets without having to ask for it. It can be embarrassing to ask for some subjects. Make the information visible.
- Some practices have a ‘Health Hub’ to provide information about, for example, medical conditions and support for carers. The staff should promote this more.

- Some practices have good electronic prescription systems but sometimes people struggle. Older people do not realise they have to reorder 14 days before they need the new prescription. People with multiple prescriptions can struggle as their medications are out of line.
- Sometimes there is a wait of 3 or 4 hours for an out-of-hours doctor to come. People don't know what to do in these circumstances.
- Lavender Grove is all on one level but does not have automatic doors. The car park is very small with only one disabled space. The doors are heavy therefore difficult for frail patients. Cornland access is OK.
- Car park space is at a premium. The bike parking space at Monkgate is difficult if cars are parked as well.
- GPs seem to pull out all the stops to prevent home visits. Example of this – offered triage and more pain tablets. Not good.
- It is easier to get an out-of-hours service than a home visit.
- GPs should have a mission statement on looking after carers, there is no support for carers at Monkgate.
- The 28-day prescription service is money-making for GPs and inconvenient for patients who could previously get three month prescriptions. GPs need to be more patient friendly. How universal is this 28-day prescription service? Repeat prescriptions do need regular reviews so that people are not stockpiling or using an incorrect dose.
- Not being listened to by GPs, e.g. articulate patient, looking well, was not listened to. The GP appeared to think the patient was exaggerating. Previous mental health problems appeared to be affecting how the GP looked at the patient. The patient asked for a specific service, the GP said no, so changed GP and the service was given.
- GP choice on 28 day prescribing - people with Long Term Conditions or need for daily drugs may wish for a prescription for a longer period. Most chemists deliver - but this is a pharmacy decision - think this is age related.
- Receptionists can be awkward about getting appointments. Have had to wait 3 weeks - is there a legal maximum time you can ask someone to wait?
- New national GP contract means all will have a named GP

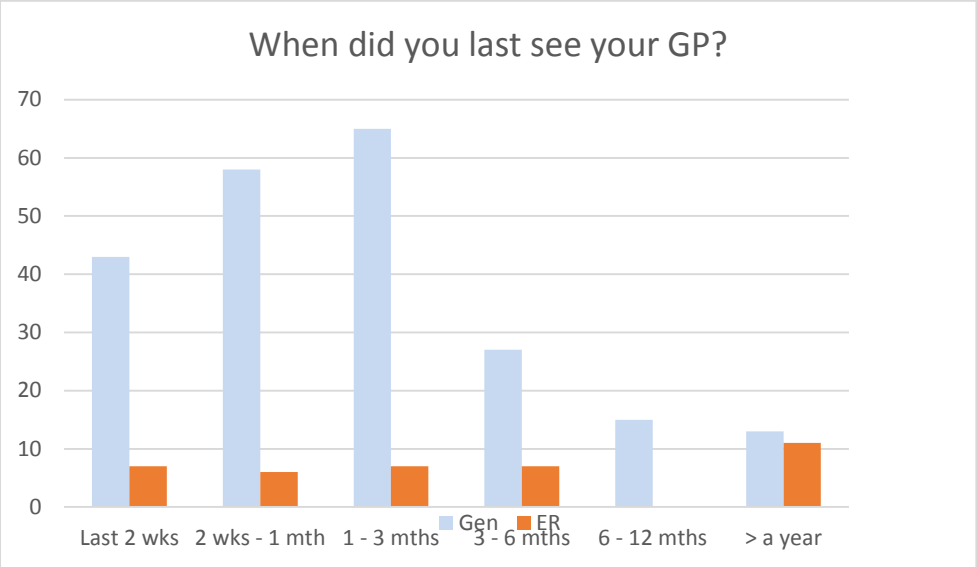
- Not all surgeries have parking - can be an issue in inner city areas. Many surgeries will only have some spaces - not necessarily enough
- Not always listened to by GP. BSL signer can be more difficult to find than an interpreter for a foreign language. PCT used to pay for interpreter services and now the practice has to pay for them.
- In an emergency would struggle for BSL interpreter - for a foreign language could use language line - easier if planned appointments. Hospital have access to interpreters as well.

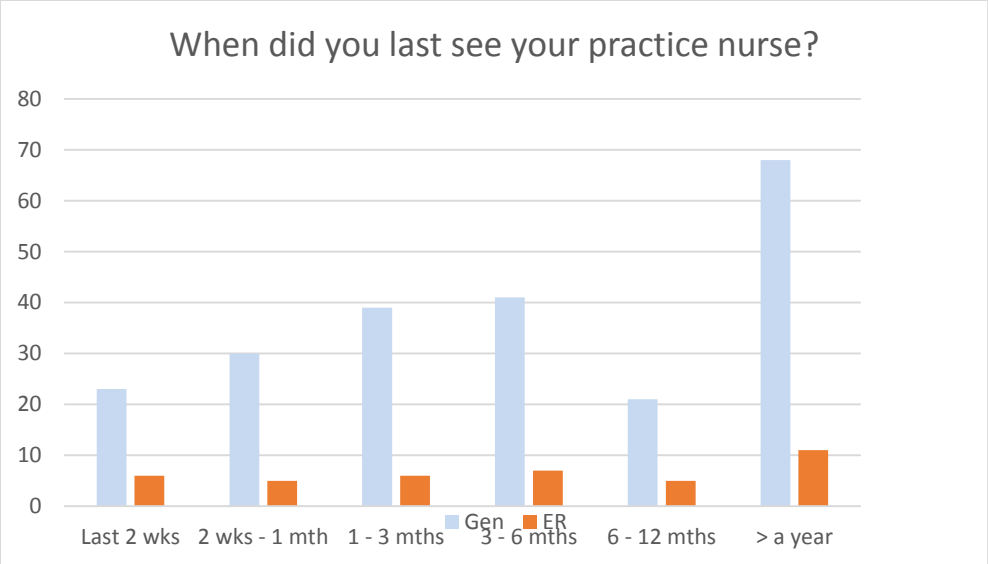
Suggestion for Improvements

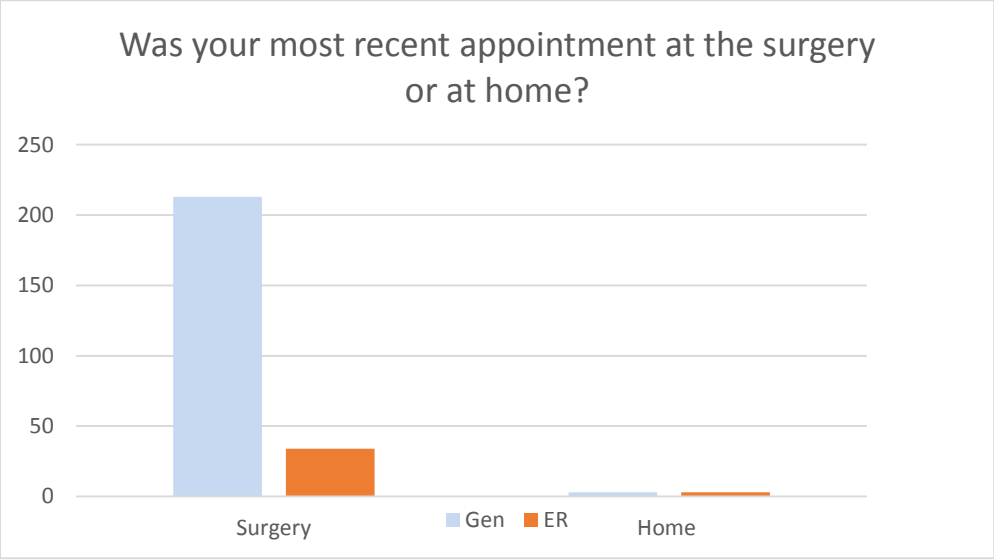
- Extended hours such as evening appointments would be useful for people such as carers as well as people who work.
- It would be easier for patients if practices were more standardised so that people know what is available. They should share best practice.
- More use of social prescribing would reduce doctors' time and decrease patients' isolation.
- Provide more information for patients so they can do more to help themselves. Make the information visible. Promote it more. Make it possible for patients to access information about potentially embarrassing conditions without having to ask.
- Offer support for former carers. This would be a preventative measure to try and reduce ill health in carers when their loved one has gone. Doctors are aware of patients who are in this position and could make an effort to support them.
- Do surgeries have a register of patients who are carers? Could this be on patients' records to alert medical professions of this? It could be linked to the records of the person they care for.
- Do medical records show that a patient is Deaf or has a severe or profound hearing loss? Flagging this up for the medical professional before they see the patient would be helpful to both parties.
- None of the 5 surgeries* have an Equality and Diversity Statement that would suggest them being LGBT friendly. (*surgeries not named)
- Opticians provide a good service to "all people" and are not judgemental. Could surgeries copy this practice? Do our GPs have values that reflect these underlying principles?

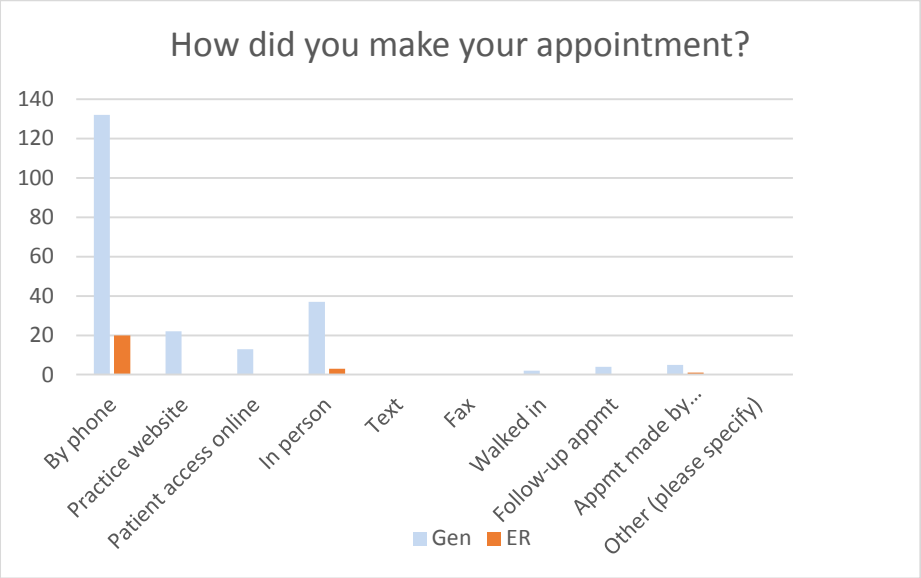
- A patient commented that a Scottish practice was really good. No prior appointments were made. All appointments were made on the day and people were given an interview by phone.
- FAX is good for Deaf people
- Need Deaf awareness training for all staff including receptionists
- Best solution for Deaf people is to establish a relationship with a particular doctor and try to always see that doctor. They can work out how best to communicate – mixture of writing things down, gestures etc. But it can be tricky to get an appointment with the doctor they want, at the time they want.
- Beech Grove has no newsletter
- Healthwatch York to work with patients to produce a top ten tips guide for GP's and Receptionists working with Deaf patients, including
    - Use clear language
    - No phones
    - Don't rush people
- There should be music played outside consultation rooms, so that people passing outside can't hear what's being said inside.
- Referral letters should be by email, and consultants' letters could be emailed. (comment: Private Consultants do everything by letter.)

Appendix D – Quantitative data from the GP Survey








How did you make your appointment?
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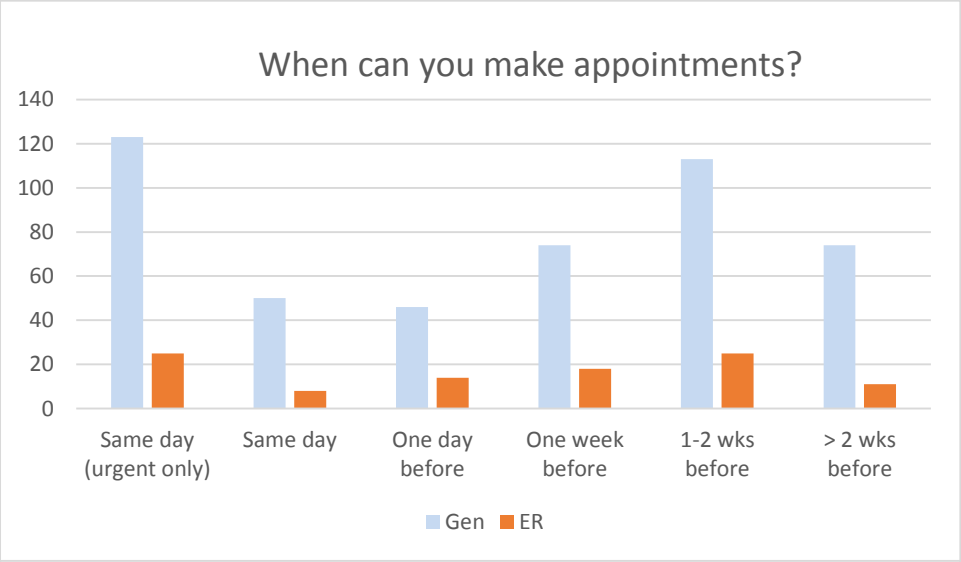
120
100
80
60
40
20
0
By phone
Practice website
Patient access online
In person
Text
Fax
Walked in
Follow-up appmt
Appmt made by...
Other (please specify)
Gen
ER


When can you make appointments?
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100
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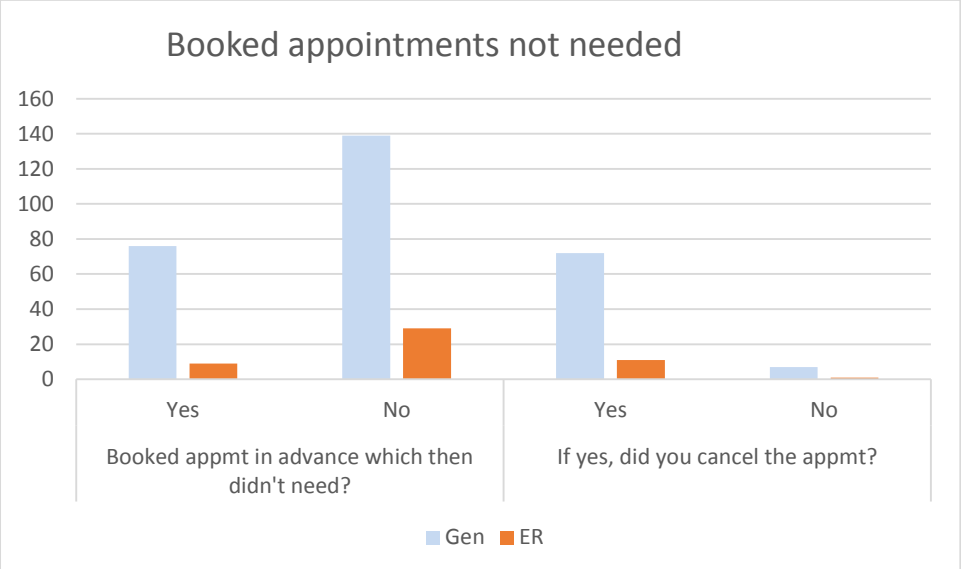
Same day (urgent only)
Same day
One day before
One week before
1-2 wks before
> 2 wks before
Gen
ER


Booked appointments not needed
160
140
120
100
80
60
40
20
0
Yes
No
Booked appmt in advance which then didn't need?
Yes
No
If yes, did you cancel the appmt?
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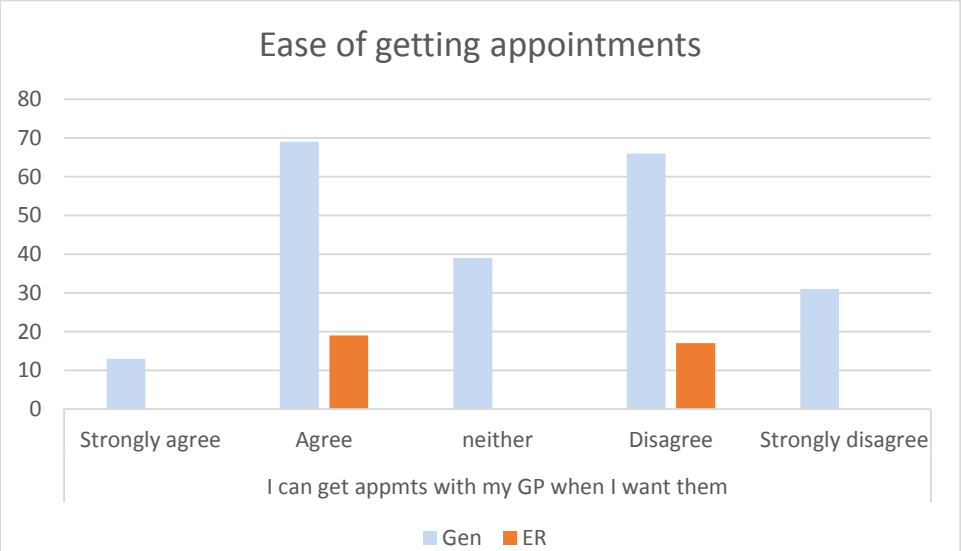
Ease of getting appointments
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Strongly agree
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Disagree
Strongly disagree
I can get appmts with my GP when I want them
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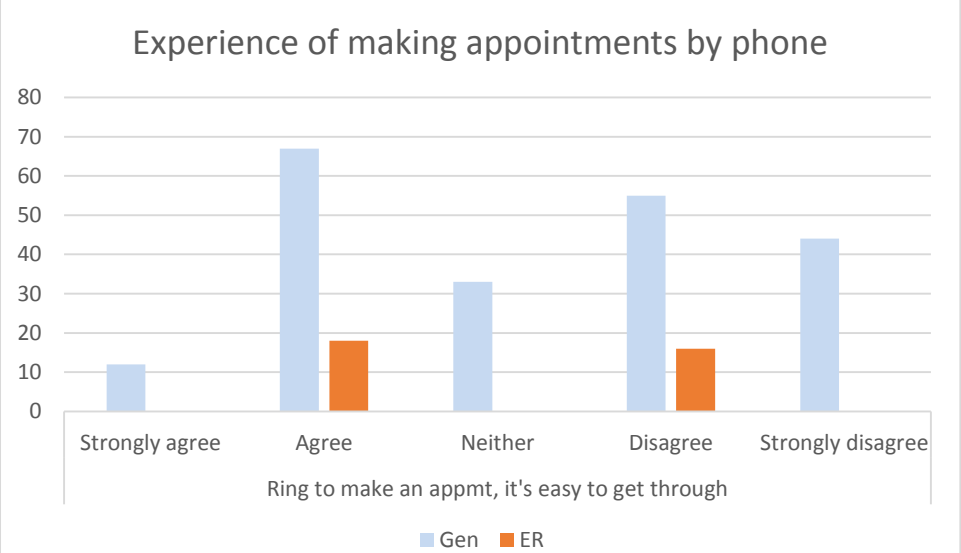
Experience of making appointments by phone
80
70
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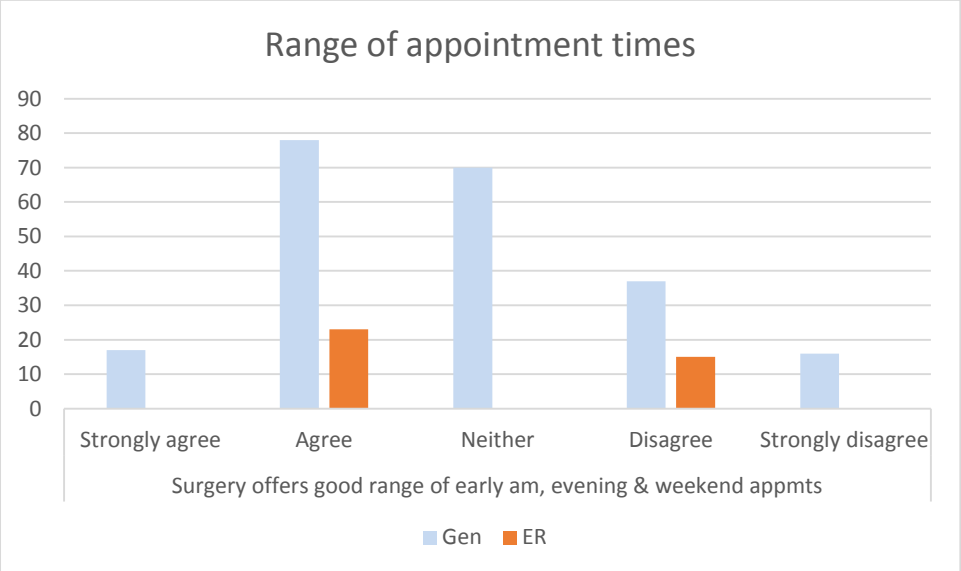
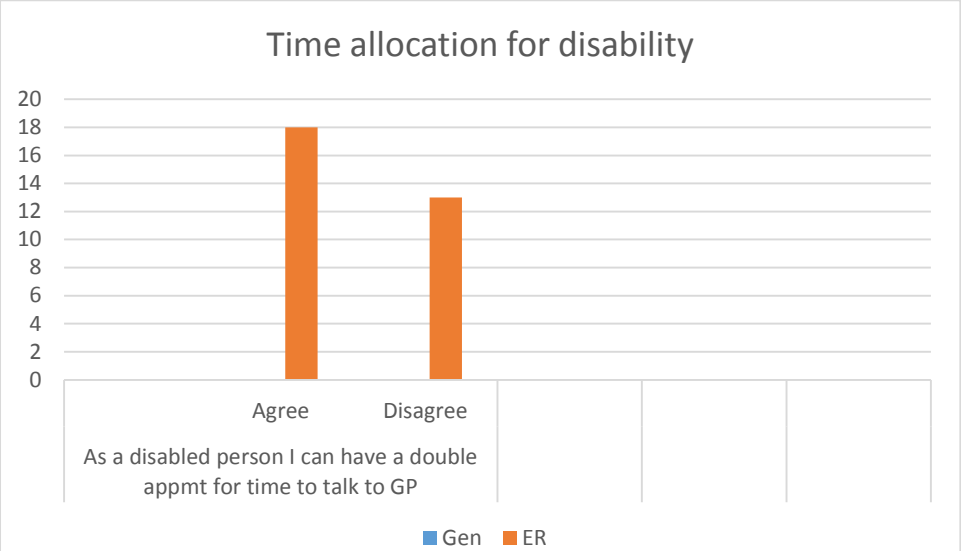
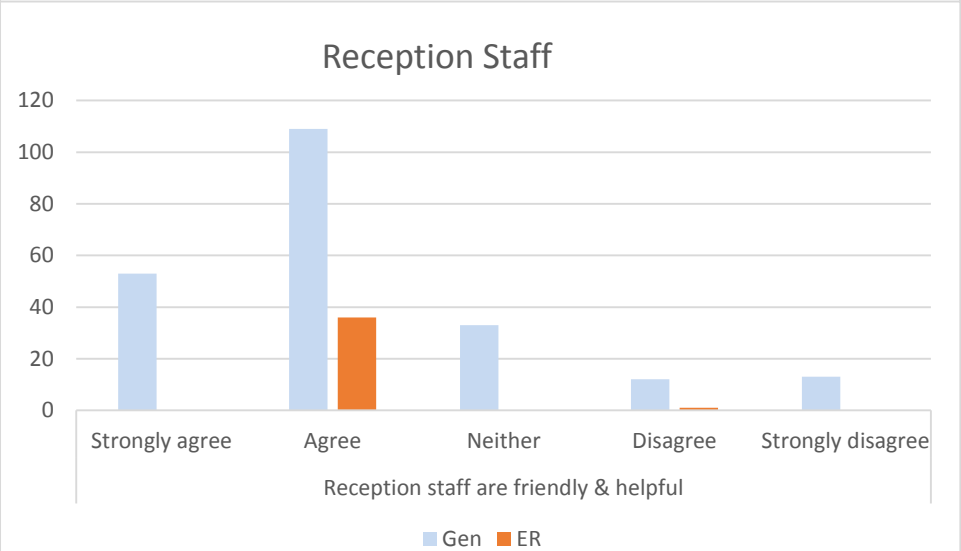
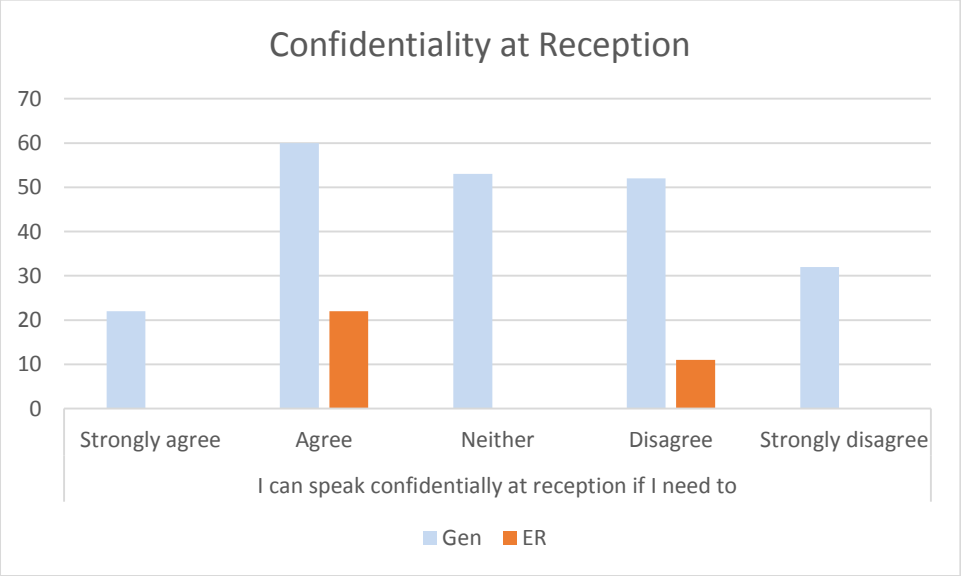
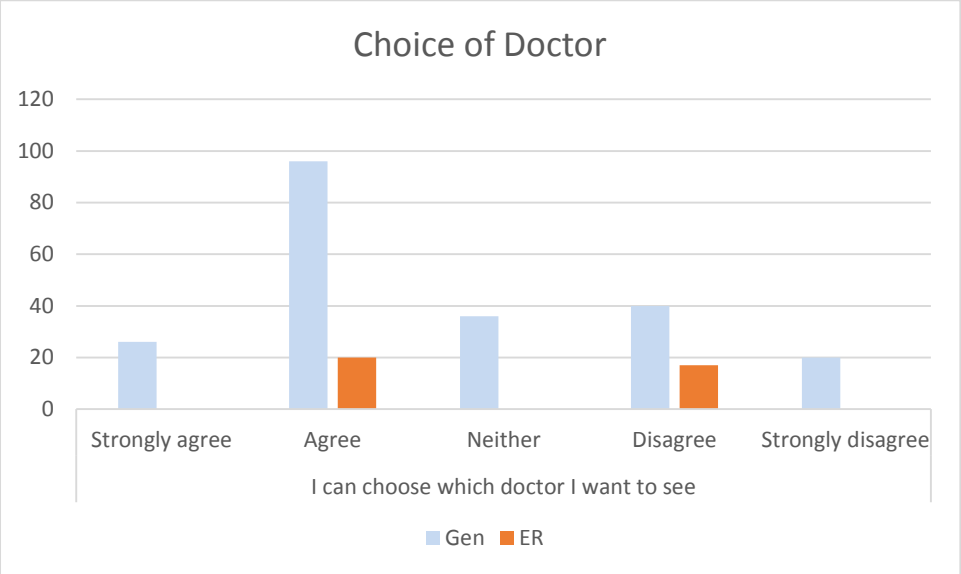
Strongly agree
Agree
Neither
Disagree
Strongly disagree
Ring to make an appmt, it's easy to get through
Gen
ER

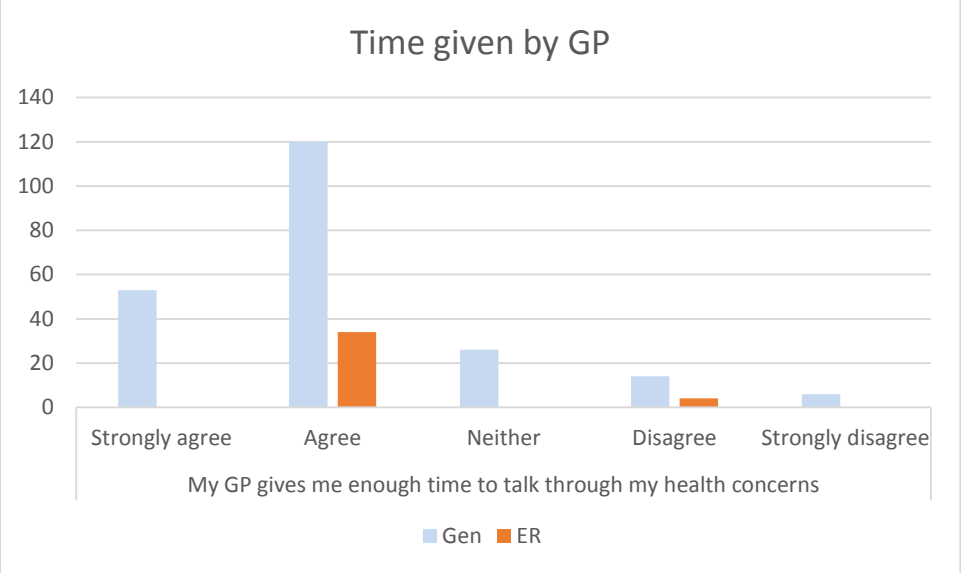

Range of appointment times
90
80
70
60
50
40
30
20
10
0
Strongly agree
Agree
Neither
Disagree
Strongly disagree
Surgery offers good range of early am, evening & weekend appmts
Gen
ER

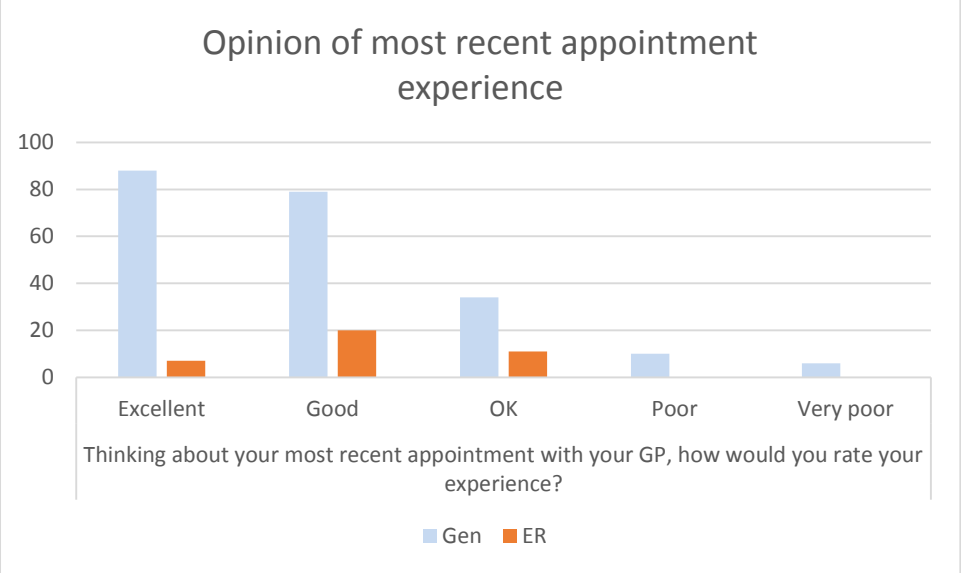

Time allocation for disability
20
18
16
14
12
10
8
6
4
2
0
Agree
Disagree
As a disabled person I can have a double appmt for time to talk to GP
Gen
ER

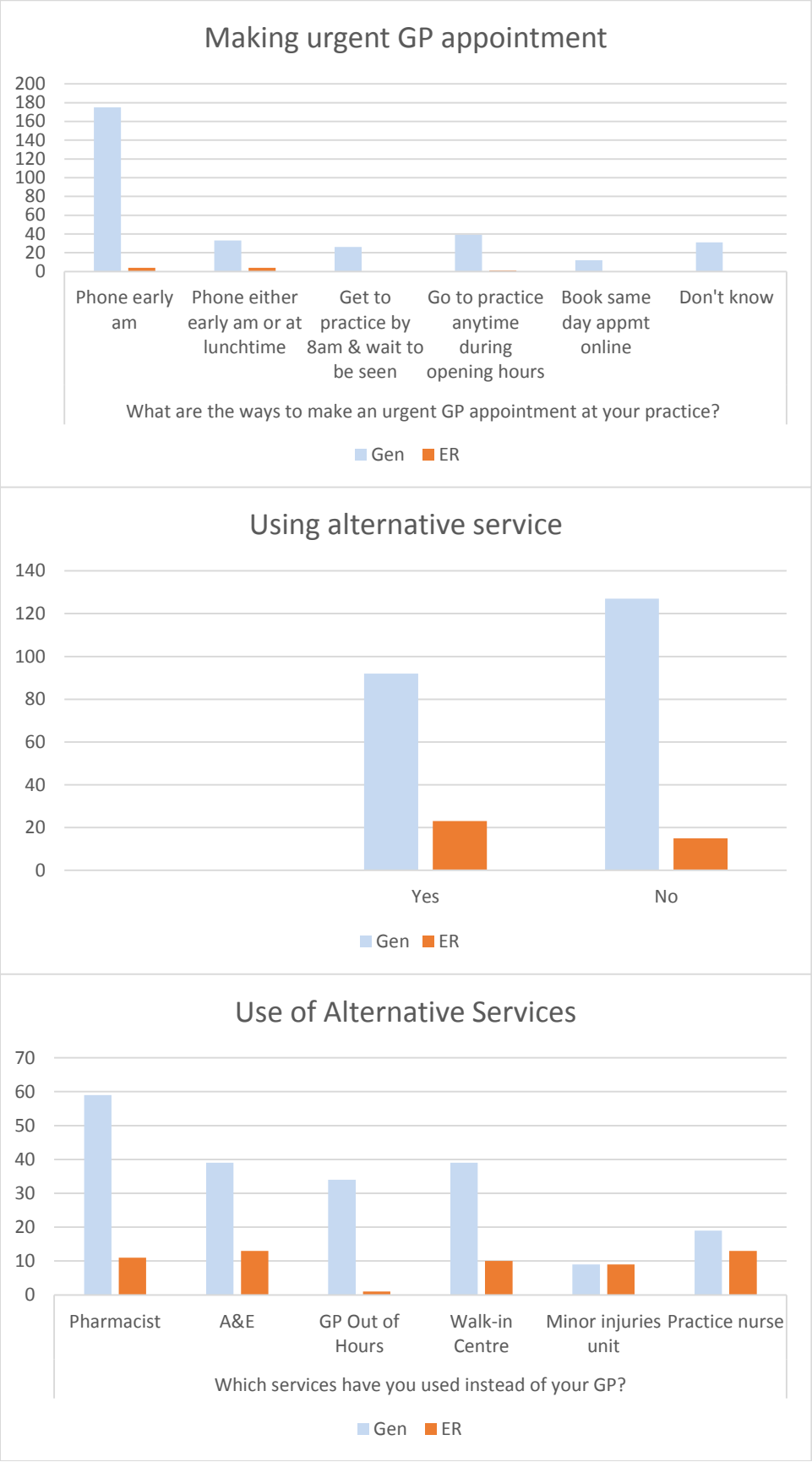

Reception Staff
120
100
80
60
40
20
0
Strongly agree
Agree
Neither
Disagree
Strongly disagree
Reception staff are friendly & helpful
Gen
ER

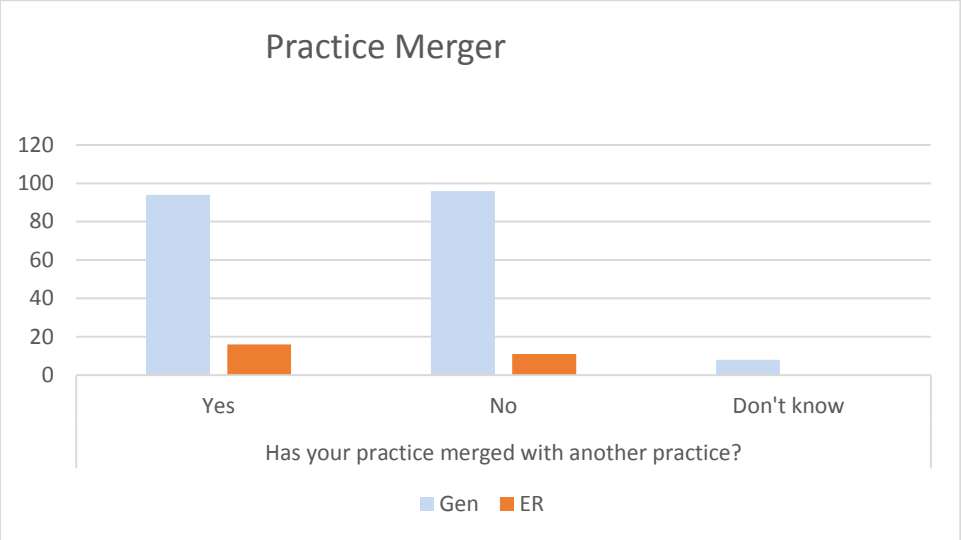

Confidentiality at Reception
70
60
50
40
30
20
10
0
Strongly agree
Agree
Neither
Disagree
Strongly disagree
I can speak confidentially at reception if I need to
Gen
ER

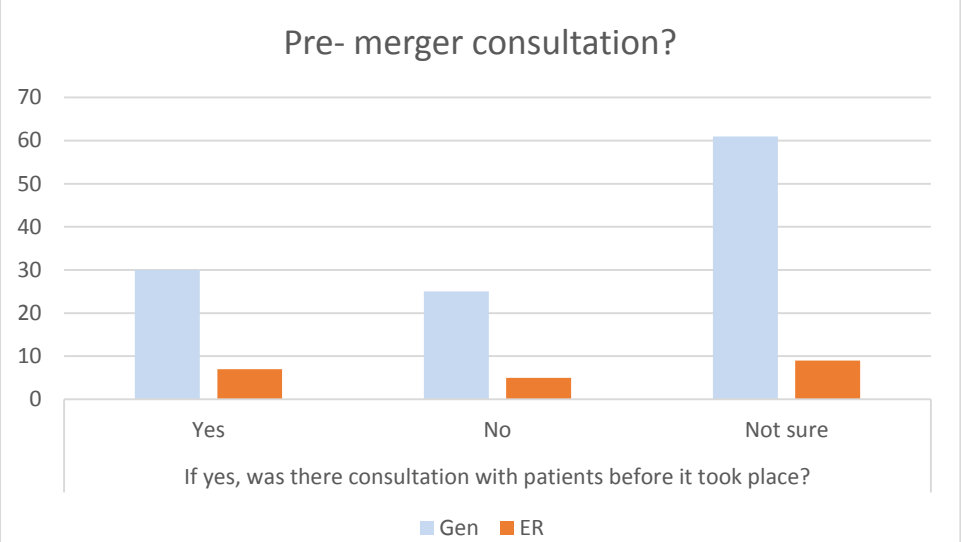

Choice of Doctor
120
100
80
60
40
20
0
Strongly agree
Agree
Neither
Disagree
Strongly disagree
I can choose which doctor I want to see
Gen
ER

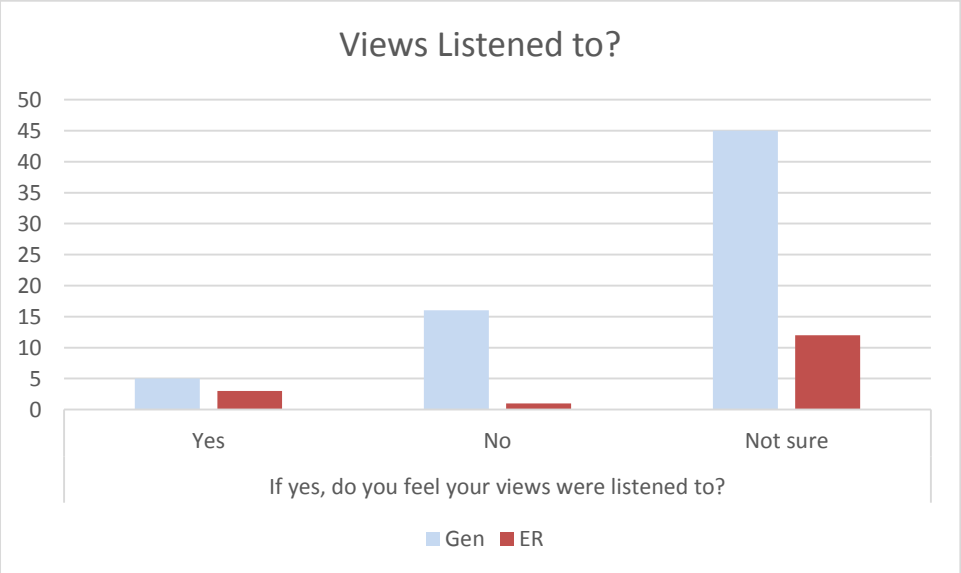

Time given by GP
140
120
100
80
60
40
20
0
Strongly agree
Agree
Neither
Disagree
Strongly disagree
My GP gives me enough time to talk through my health concerns
Gen
ER

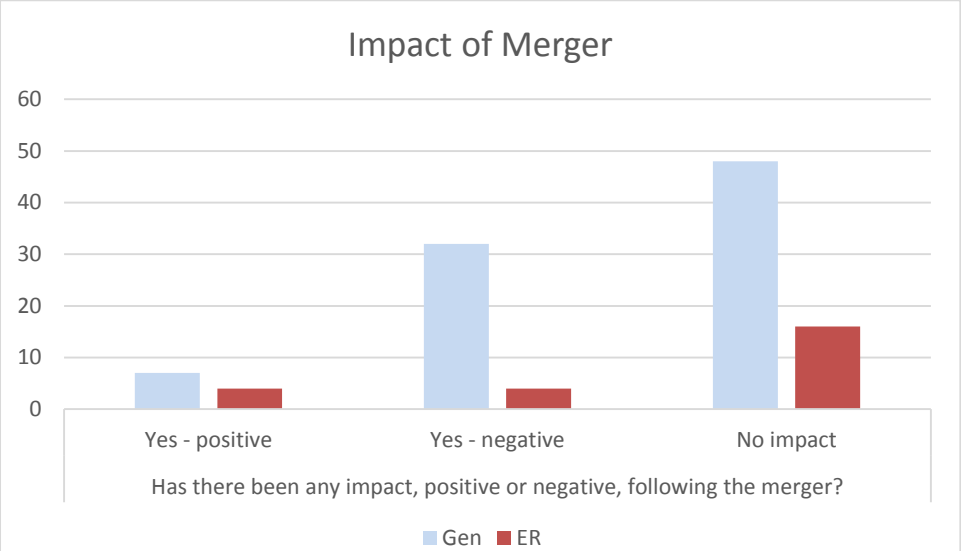

Opinion of most recent appointment experience
100
80
60
40
20
0
Excellent
Good
OK
Poor
Very poor
Thinking about your most recent appointment with your GP, how would you rate your experience?
Gen
ER

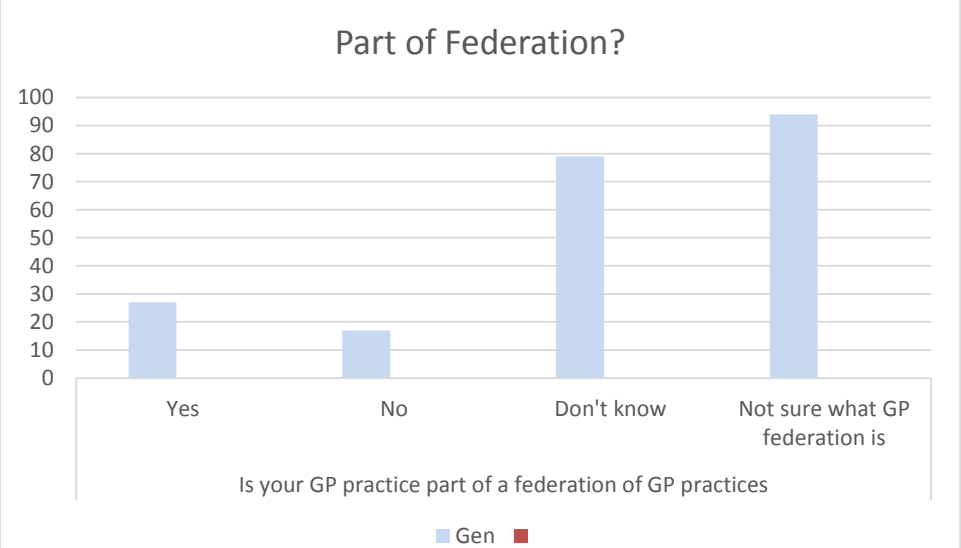

Making urgent GP appointment
200
180
160
140
120
100
80
60
40
20
0
Phone early am
Phone either early am or at lunchtime
Get to practice by 8am & wait to be seen
Go to practice anytime during opening hours
Book same day appmt online
Don't know
What are the ways to make an urgent GP appointment at your practice?
Gen
ER
Using alternative service
140
120
100
80
60
40
20
0
Yes
No
Gen
ER
Use of Alternative Services
70
60
50
40
30
20
10
0
Pharmacist
A&E
GP Out of Hours
Walk-in Centre
Minor injuries unit
Practice nurse
Which services have you used instead of your GP?
Gen
ER

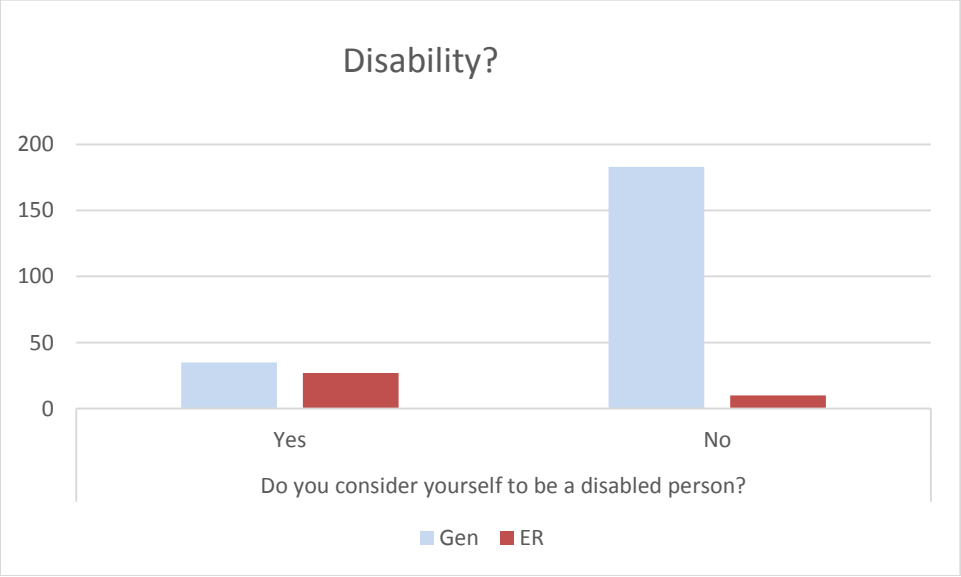

Practice Merger
120
100
80
60
40
20
0
Yes
No
Don't know
Has your practice merged with another practice?
Gen
ER

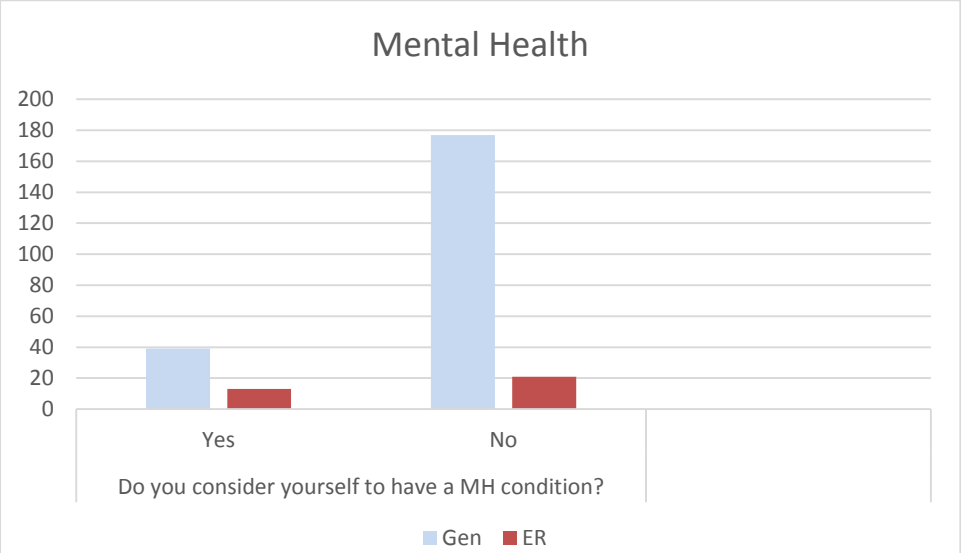

Pre- merger consultation?
70
60
50
40
30
20
10
0
Yes
No
Not sure
If yes, was there consultation with patients before it took place?
Gen
ER

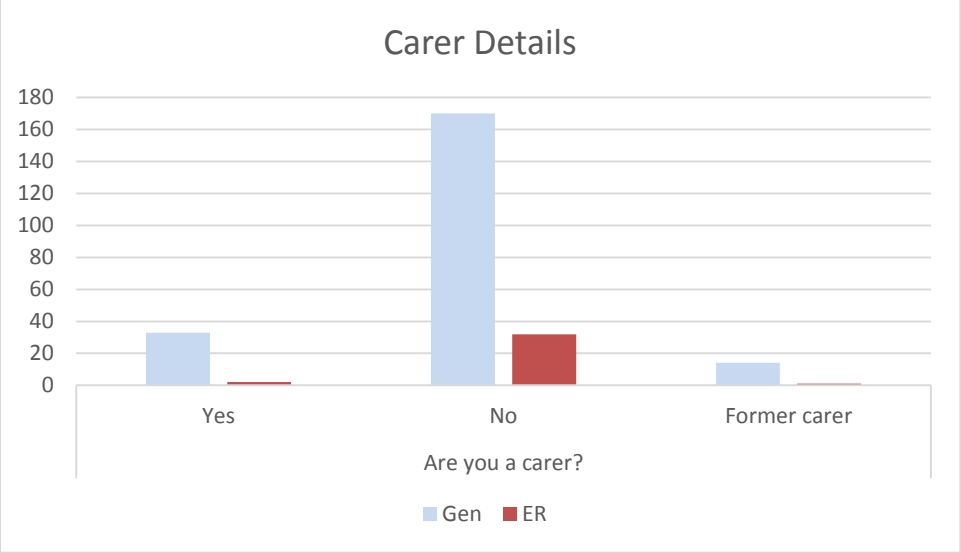

Views Listened to?
50
45
40
35
30
25
20
15
10
5
0
Yes
No
Not sure
If yes, do you feel your views were listened to?
Gen
ER

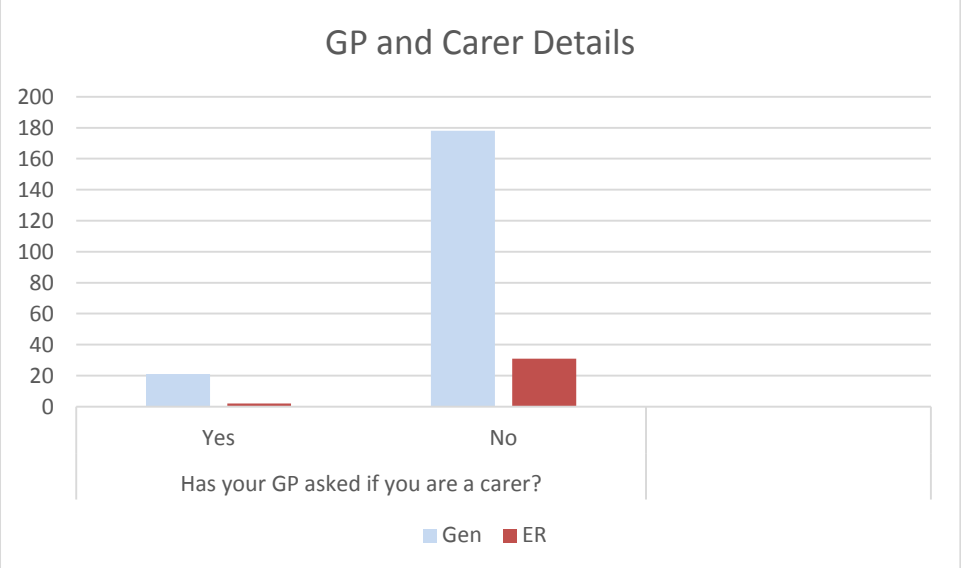

Impact of Merger
60
50
40
30
20
10
0
Yes - positive
Yes - negative
No impact
Has there been any impact, positive or negative, following the merger?
Gen
ER

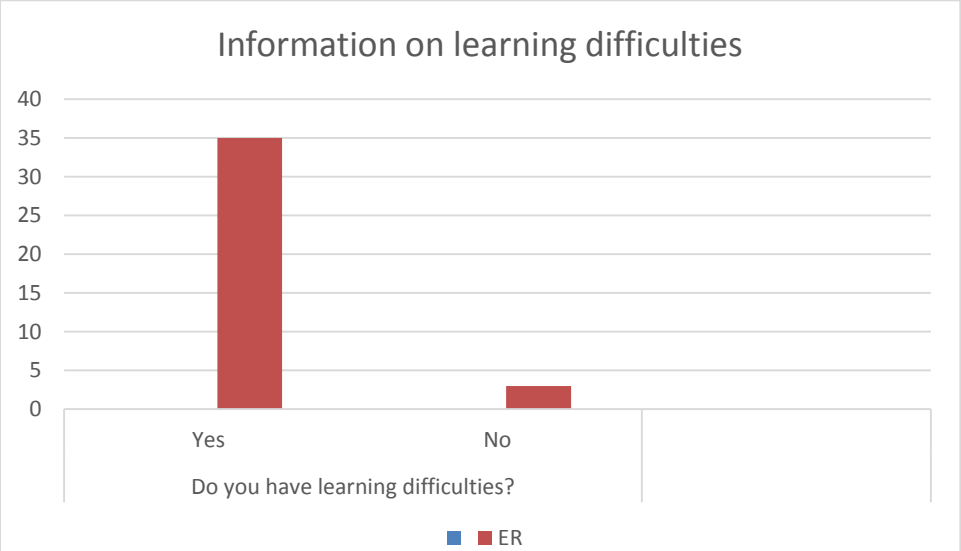

Part of Federation?
100
90
80
70
60
50
40
30
20
10
0
Yes
No
Don't know
Not sure what GP federation is
Is your GP practice part of a federation of GP practices
Gen

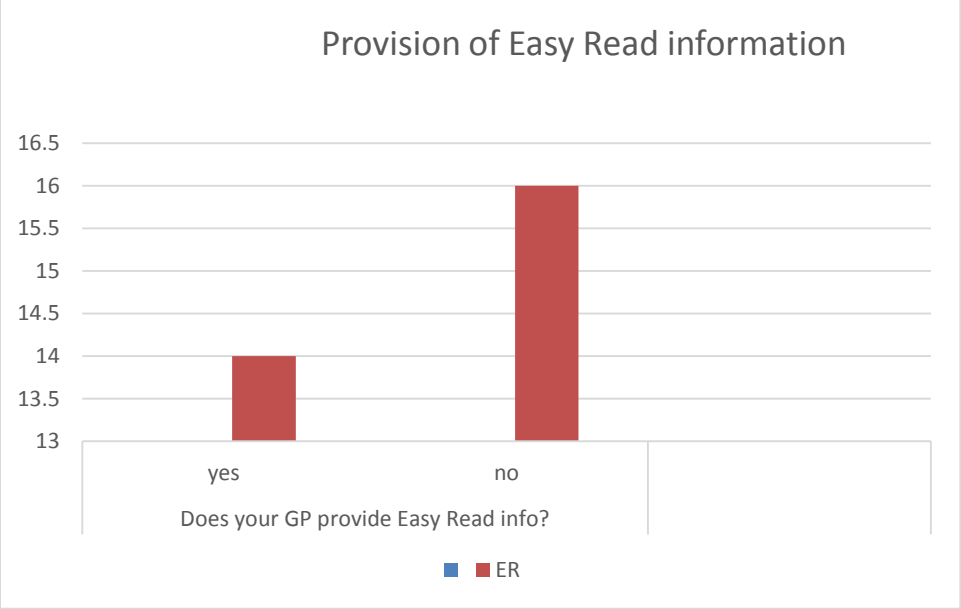

Disability?
200
150
100
50
0
Yes
No
Do you consider yourself to be a disabled person?
Gen
ER

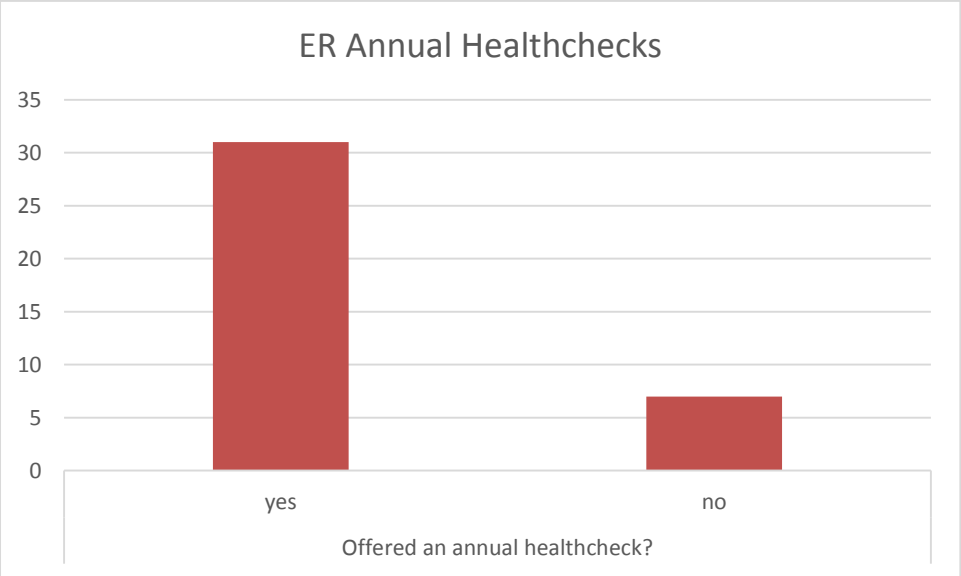

Mental Health
200
180
160
140
120
100
80
60
40
20
0
Yes
No
Do you consider yourself to have a MH condition?
Gen
ER

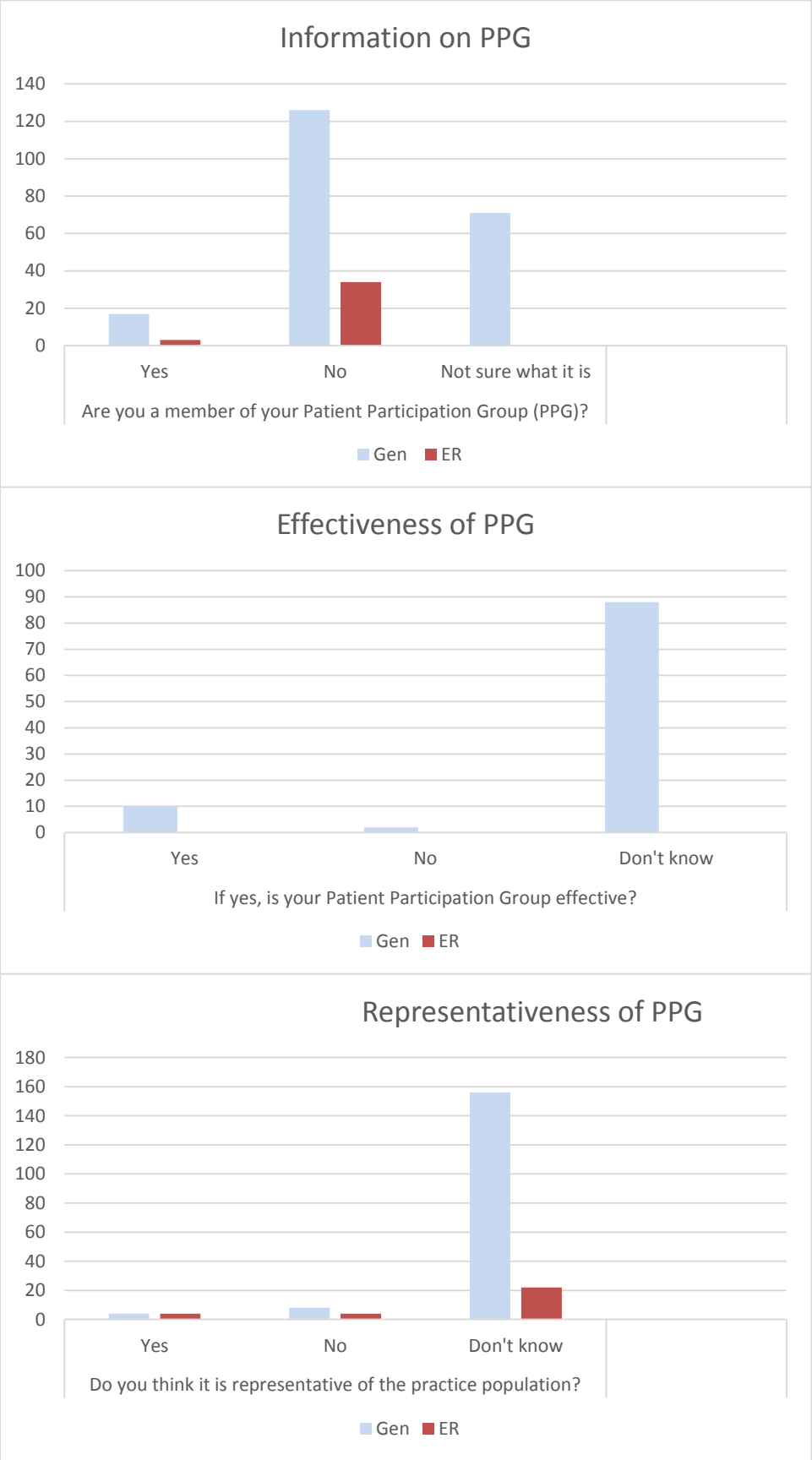

Carer Details
180
160
140
120
100
80
60
40
20
0
Yes
No
Former carer
Are you a carer?
Gen
ER

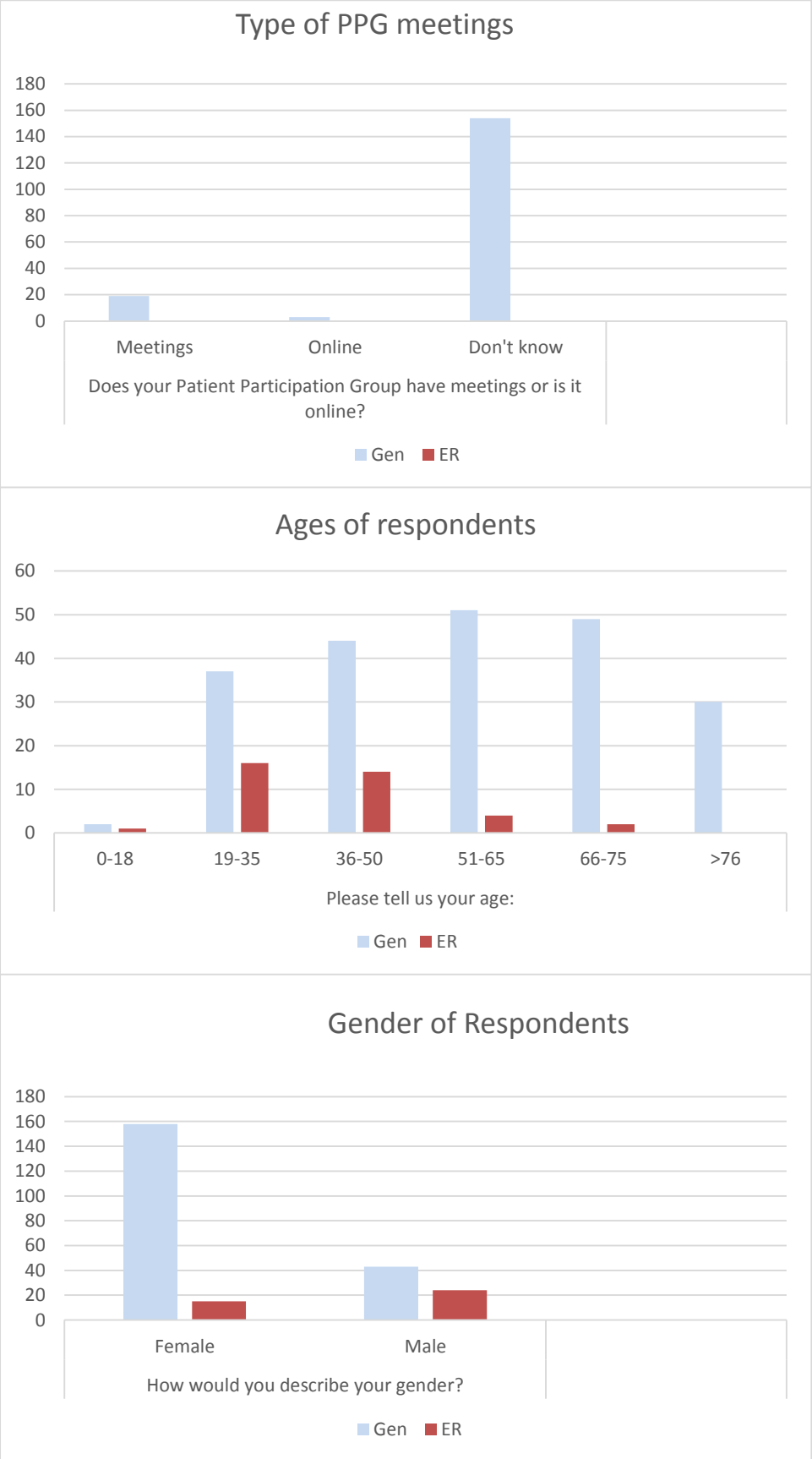

GP and Carer Details
200
180
160
140
120
100
80
60
40
20
0
Yes
No
Has your GP asked if you are a carer?
Gen
ER

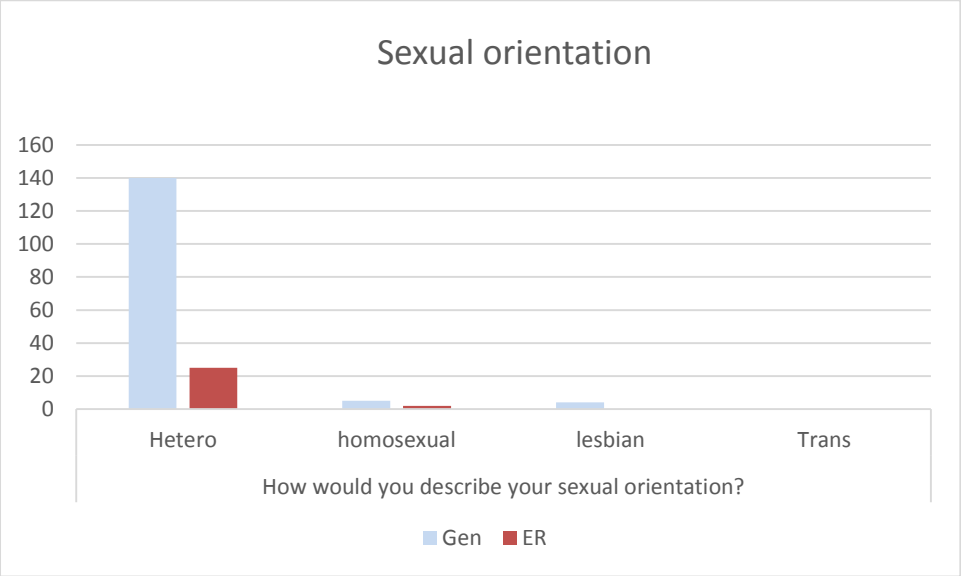

Information on learning difficulties
40
35
30
25
20
15
10
5
0
Yes
No
Do you have learning difficulties?
ER


Provision of Easy Read information
16.5
16
15.5
15
14.5
14
13.5
13
yes
no
Does your GP provide Easy Read info?
ER


ER Annual Healthchecks
35
30
25
20
15
10
5
0
yes
no
Offered an annual healthcheck?


Information on PPG
140
120
100
80
60
40
20
0
Yes
No
Not sure what it is
Are you a member of your Patient Participation Group (PPG)?
Gen
ER
Effectiveness of PPG
100
90
80
70
60
50
40
30
20
10
0
Yes
No
Don't know
If yes, is your Patient Participation Group effective?
Gen
ER
Representativeness of PPG
180
160
140
120
100
80
60
40
20
0
Yes
No
Don't know
Do you think it is representative of the practice population?
Gen
ER


Type of PPG meetings
180
160
140
120
100
80
60
40
20
0
Meetings
Online
Don't know
Does your Patient Participation Group have meetings or is it online?
Gen
ER
Ages of respondents
60
50
40
30
20
10
0
0-18
19-35
36-50
51-65
66-75
>76
Please tell us your age:
Gen
ER
Gender of Respondents
180
160
140
120
100
80
60
40
20
0
Female
Male
How would you describe your gender?
Gen
ER


Sexual orientation
160
140
120
100
80
60
40
20
0
Hetero
homosexual
lesbian
Trans
How would you describe your sexual orientation?
Gen
ER

Appendix E - Notes from York Racial Equality Network (YREN) Open Forum April 2016

Access to GP Services

- There are issues for Muslim, African and Asian women particularly, but women generally, wishing to see a female GP:
    - Not confident to complain, navigate the receptionist
    - So struggle to get the appointments they want
    - They feel they sometimes face confrontation and challenge at reception

The issues are the same for men who wish to see a male GP

- Ringing the GP at 8.00 am to get an appointment is a challenge – it causes sleeplessness as people are anxious about having to call back, and are often faced with an engaged line.
- Difficulties in communication can lead to people for whom English is a second language stockpiling medication if they have auto repeat prescriptions.
- Only 20% of Open Forum attendees were aware of GP Patient Participation Groups (PPGs).
- There is currently confusion over the role and relocation of the Walk-In Centre; access to urgent care is now through A&E at York Hospital, not Monkgate. There was felt to be a lack of accessible information for the community about the changes and how best to use the services.
- There is a lack of awareness of the possibility of GPs ringing patients to triage them or discuss their issues.

Communication

- Few people are aware of interpreting services – it's a barrier to accessing services alone
- There are cultural barriers around people understanding their rights
- Children are used inappropriately for interpreting, this can lead to a child becoming a 'communication carer', and parents being reluctant to reveal intimate details of their condition.
- There are issues around using close community and/or family members to interpret – this may compromise a patient's medical privacy and prevent a patient from seeking help.

- There needs to be increased awareness of options for interpretation. The patient should be able to choose:
    - Language line
    - Parent/family member/partner
    - Friend

  However, it should not be assumed that patients will have to use parent/family member/partner/friend; in the first instance, it is a Health Services responsibility.
- Sometimes there is a problem with receptionists understanding peoples' accents – this can lead to misunderstandings
- When there are difficulties in continuity - not seeing the same doctor – it's hard having to start all over again. This adds to the tensions and barriers which already exist
- It's good that NHS 111 is not automated, it's easier than 101

Knowing what your rights and options are

- Organisations should use groups like YREN to get messages out – but the information provided needs to be useful – and useable
- There is potential for Healthwatch York to work with YREN and other partner organisations to develop Community Health Champions – the go-to person for health questions. The Community Health Champions could use Healthwatch York to get answers if they don't know them. We could pilot this with one place and see if it could grow.

Other issues

There are issues with

- Dentists
- Opticians
- Hospital access – there is a hope/expectation that we will see the named consultant
- Exercise, diet, smoking – we need to have better access to public health information.
- Mental Health – being able to identify with a physical buildings is important in helping people relate to mental health services
- Antenatal services – a significant proportion of BME people have no internet access and they are not told of other options.

- **Hospital complaints** – Do we have a breakdown of data by ethnicity?

- **Religion** – this is recorded on admission at hospital - is this routinely notified to the Chaplain? If not, why is it recorded?

- **Nutrition in hospital** – How culturally aware are the catering team? Has there been any additional training for staff over the last 2 years?

- **Importance of Health Passports** – it's really hard to have to keep explaining things – but if doctors and nurses take note of the passport it helps; especially for hidden impairments.

Appendix F – Report by Citizens Advice York on impact of GP's Charging for Medical Evidence

This report has been completed by Citizens Advice York: an advice provider in York offering free, independent, impartial, confidential legal advice in areas of welfare benefits, debt, consumer, housing and employment.

In 2015/16 Citizens Advice York have seen 5,593 clients with 16,425 issues. Unfortunately our Advice Issue Codes do not include issues around access to GP services and in particular GPs charging for medical evidence so we do not have comprehensive data of the extent of this problem. Nevertheless we have many issues that have been raised, some qualitative examples from 2015/2016 are below:

- A client on a low income with health problems was charged £29.50 for a tick box form and signature needed to renew their bus pass. The client decided not to pay full fare and wait a few months until they was eligible for the older person's bus pass.

- A client who is appealing the DWP's decision not to award enhanced rate mobility for Personal Independence Payment (PIP) was told that a letter to evidence their condition would cost between £50 - £70.

- Another client appealing the DWP's decision not to award Employment Support Allowance (ESA) would be charged either £20 or a £70 fee depending on the type of letter.

- A client appealing the DWP's decision not to award PIP is unable to afford the £20 charge for medical evidence letter from the GP.

- Another client appealing a PIP decision would incur a charge of up to £85 which they cannot afford and if the tribunal hearing went

ahead without medical evidence this could potentially hinder the case.

- Another charge was £42 for a client who was appealing DWP's decision not to award ESA.

- A client who has mental health problems and has experienced domestic abuse needs to provide medical evidence from the GP for her ESA application. This costs £20 which the client is unable to afford.

- In some cases a GP letter is practically demanded by DWP, e.g. to prove that a client's condition has worsened or that they require a home assessment, but DWP are still not prepared to request it.

In many of these cases (where there is enough time) Citizens Advice York are using resources to make applications for charitable assistance to help with these charges. Charities are increasingly overstretched and the stigma of having to rely on charity is also having a negative effect on clients.

The above cases are of significant concern to us, particularly due to the high level of successful ESA and PIP appeals demonstrating incorrect decisions made following the assessment and/or possible new evidence presented at the appeal stage. From our statistics, 62% of known outcomes for PIP appeals were successful and 44% of known ESA appeals were successful. Statistics from the Ministry of Justice also shows that in Quarter 4 of 2015/16, 63% of PIP appeals were successful and 58% of ESA appeals were successful[xv].

The charges for GP medical evidence have a significant impact on a client's ability to obtain this important evidence, as well as those residents who do not come to Citizens Advice for help. Although the NHS is under significant financial constraints, it cannot be fair to charge people who are often on a low or limited income, who have reduced capability for increasing that income through work due to the very nature of having a health problem or a disability. The idea of having to rely on charity causes distress for many clients, and is not guaranteed to be successful, and again this is for clients who approach Citizens Advice for assistance. We have no data on how many residents may have been dissuaded from appealing a DWP decision due the charges associated with medical evidence. Furthermore, it does not fit with the Health and

Wellbeing's aims of reducing health, and wider, inequalities and to reduce financial and social exclusion.

Possible recommendations for consideration of the Health and Wellbeing Board:

- Waive the cost of GPs medical evidence for those receiving means-tested benefits
- Reclaim the cost of GPs medical evidence from DWP
- Provide evidence to the DWP of the negative impact of GP charges and request that the onus should be on the DWP to request medical evidence, rather than the claimant.
- On the occasion where a client seems to be in need of a GP letter or other medical evidence, Healthwatch could write to the DWP requesting that the DWP pay the cost of the GP's letter or confirm the need for a letter.

Thank you for considering our report.

Kind regards

Beth Hurrell

Research and Campaigning Coordinator
Citizens Advice York

References

[i] BMA Press Briefing titled General Practice In The UK July 2014

[ii] http://www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/nhs-spend-on-general-practice-falls-to-72-from-april-despite-uplift/20031234.fullarticle

[iii] For example, http://www.pulsetoday.co.uk/home/finance-and-practice-life-news/gp-morale-continues-to-plummet-bma-survey-reveals/20008699.fullarticle

[iv] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf

[v] https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-surveys/future-of-general-practice-week-1

[vi] http://www.mirror.co.uk/news/uk-news/gp-recruitment-crisis-40-trainee-7075360

[vii] https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-surveys/future-of-general-practice-week-2

[viii] http://www.kingsfund.org.uk/press/press-releases/causes-gp-crisis-revealed-new-analysis

[ix] See for examples:
https://www.theguardian.com/healthcare-network/2015/jun/17/small-local-spelt-end-gp-surgery
http://www.coastalmedicalgroup.co.uk/website/Y01008/files/Bay%20Medical%20Merger%20Newsletter%20May%202016.pdf

[x] http://www.healthwatcheastridingofyorkshire.co.uk/sites/default/files/gp_appointments_systems_follow_up_report_web_version.pdf

[xi] http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/primary_care_a_review_of_local_healthwatch_reports.pdf

[xii] http://www.publications.parliament.uk/pa/cm201516/cmselect/cmhealth/408/40802.htm

[xiii] https://www.simplyhealth.co.uk/sh/pages/healthy-you/yougov-everyday-health-tracker-two.jsp

[xiv] http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf

[xv] https://www.gov.uk/government/statistics/tribunals-and-gender-recognition-certificate-statistics-quarterly-january-to-march-2016

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Facebook: Like us on Facebook

Web: www.healthwatchyork.co.uk

York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York. York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This report

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

Paper copies are available from the Healthwatch York office

If you would like this report in any other format, please contact the Healthwatch York office

Health and Wellbeing Board 20 July 2016

Report of Director of Adult Social Care, City of York Council.

Progress in York with implementation of the Care Act 2014

Summary

1. This paper aims to update the Health and Wellbeing Board on York's implementation of the Care Act 2014. An earlier report submitted to the Health and Wellbeing Board meeting on 22 October 2014 (Agenda Item 11 of that meeting) set out the key elements of the Care Act and highlighted the new duties and responsibilities for local authorities and their partners.

2. Work to implement the Care Act in York began in 2014 and has continued since the Act took effect in April 2015. This paper describes areas where progress is being made as well as areas where further work is required. It also notes the principal changes that have occurred nationally since April 2015.

Background

3. The report submitted to the Health and Wellbeing Board in October 2014 described some of the main requirements of the first phase of the Care Act from April 2015:

- a duty to provide universal information and advice
- requirements for assessments of need
- a national eligibility criteria
- requirements for support planning
- the right to direct payments
- carers will be on the same footing as those whom they care for
- responsibility to provide support to prisoners with eligible needs
- market shaping – preparation to sustain a robust provider market which promotes choice and control and manages market failure.

In addition to these requirements, the Care Act also imposes a duty on local authorities to reduce, prevent or delay needs for care and support among adults in their areas.

4. The second phase of the Care Act will require the development and implementation of:

    - The "care cap" – a limit on the amount of money an individual will be required to contribute to the cost of his or her care over a lifetime and

    - A "care account" – an individual account that will track the financial contribution made by an individual to pay for his or her care.

    As part of phase two, the "capital threshold" is to be lifted from its current level of £23,250. This is the savings that an individual receiving care in a registered care home can retain; above this threshold the individual pays the full cost of care.

5. Phase two of the Care Act was scheduled to be implemented in April 2016. In July 2015 the government announced that implementation had been deferred to 2020.

6. Statutory guidance to accompany the Care Act was issued in October 2014. A refreshed edition of this guidance was issued on 10 March 2016. Many of the amendments to the original guidance are described as "minor detail amendments/clarification only" but more substantial amendments have been made e.g. to reflect postponement of the funding reform and new legislation in relation to domestic abuse. Many of the substantial changes are to Chapter 14 on Safeguarding.

    The statutory guidance will continue to be updated online and is available at https://www.gov.uk/guidance/care-and-support-statutory-guidance

Main/Key Issues to be considered

7. The October 2014 report to the Health and Wellbeing Board recommended that the Board:

    - Advocate and strengthen the joint working arrangements across York.

- Promote and engage fully in the development and implementation of the legislative requirements.

- Support the protection of care and the implications of the Care Act through the Better Care Fund programme.

8. All three of these recommendations remain relevant in July 2016. In particular – in relation to the first recommendation - it is important to recognise that the title of the legislation is the Care Act, not the *Social* Care Act. Its relevance to other organisations is clear from the structure of the Act itself:

    - Part 2 is about care standards, including those in the NHS

    - Part 3 is about Health, including Health Education and the Health Research Authority

    - Part 4 is about health and social care and in particular integration of the two

9. Part 1 of the Care Act – entitled *Care and Support* and starting with a section on *General responsibilities of local authorities* - includes two section (6 and 7) that impose duties on local authorities and their partners to cooperate with each other.

10. Progress with the implementation of the Care Act has been monitored through a series of six stocktakes (three before the implementation of the Act itself in April 2015 and three since then). The most recent stocktake, number 6, was issued on 20 June 2016 with a required response date of 15 July. Stocktake 6 addresses a number of areas related to the implementation of the Care Act. This is discussed in the Analysis Section below.

11. As noted above (paragraph 5), the implementation of the financial changes introduced by the Care Act was deferred in July 2015 from April 2016 to 2020. The two stocktakes since then have focused on Part I of the Care Act implemented in April 2015.

12. As part of a review of our implementation of the Care Act in York, a high-level action plan has been developed to ensure that progress is maintained. This includes:

    - Lead managers have been designated for key areas of Care Act implementation.

- A governance structure has been implemented whereby regular time is set aside in Departmental Management Team meetings for reports from the lead managers.

- Workshops with staff are being planned for the autumn to review the first 18 months of the Act and refresh understanding of the requirements of the legislation including the updated statutory guidance.

Consultation

13. There has been ongoing consultation with and involvement of partners within and outside of City of York Council.

Options

14. The analysis below shows that good progress has been made to ensure compliance with the detail of the Act. Inevitably, given the scale of change associated with the Act, there is progress to be made, not only to achieve compliance with the detail of the legislation, but also to embed the spirit of the Act in the way we operate.

15. Increasingly the relevance of the Act in shaping our work will be on ensuring the outcomes intended are fully seen by York's residents and that the approach, culture and behaviours of our workforce promote these outcomes. To this end, it is suggested that the Care Act now be considered to be a fully integral part of how we operate across the system and not seen as a separate project. Progress will be seen and monitored through the component directorate and service plans within agencies, and as part of the overall monitoring across the Health and Wellbeing Strategy

16. Alternatively, the Health and Wellbeing Board may wish to request continued updates specifically related to compliance with the Act. This is not recommended, however, as it would present compliance as something separate to our key objectives and operating principles.

Analysis

17. Stocktake 6 is intended to be the final national review of progress towards implementation. It is expected that the Stocktake process will be re-started if Phase 2 of the Act is to be implemented in 2020.

18. At the time of writing, work is still underway to complete this Stocktake. However, several key points have emerged to date:

    a. Overall confidence in embedding the statutory requirements in business processes.

    b. Recognition that there remains work to do to embed the practice and culture that underpins the spirit of the Act.

    c. That there has been a marginal increase in the number of assessments reaching the eligibility threshold.

    d. Prevention, including information and advice, is generally effective, but could be better coordinated and joined up across the organisation and with partners.

    e. Partnership and Integration arrangements are developing but this has yet to produce a range of jointly commissioned and delivered services.

19. These key findings support a view that much has been achieved, but we are still to realise the full benefits of the approach which the Care Act enshrines in legislation.

Strategic/Operational Plans

20. Across the health and social care system, the Care Act now represents a significant part of the strategic and operating framework, relevant to the work of all contributing organisations. For this reason, it should be reflected in the performance monitoring arrangements in each organisation and in the system-wide strategies, namely the Health and Wellbeing Strategy and Sustainability and Transformation Plan.

21. The Adult Social Care strategy and directorate plan has recently been redrafted, setting out the high-level principles for the directorate to work to. These directly read across to the Care Act, describing our key objectives as Preventing, Reducing and Delaying the need for care, and those who require ongoing support, managing it in a person-centred way.

22. By directly referencing the language of the Care Act, these strategic documents will continue to support its implementation and the realisation of the better outcomes it identifies.

Implications

23. There are no direct implications as a result of the recommendations in this paper, although as a key piece of legislation, the Care Act will continue to provide the parameters for our work in these areas.

- **Financial** – no direct implications
- **Human Resources (HR)** – no direct implications
- **Equalities** – no direct implications
- **Legal**– no direct implications
- **Crime and Disorder** – no direct implications
- **Information Technology (IT)** – no direct implications
- **Property**– no direct implications

Risk Management

24. As implementation of the requirements of the Act has progressed, the risk of non-compliance has been replaced with general operational risks around the delivery of services. For this reason, the risks related to the Care Act will be mainstreamed into the risk management approach across the service.

25. There remains an outstanding financial risk in respect of phase 2 of the Care Act, should it be implemented in 2020. By placing a cap on the costs of care incurred by an individual, a greater burden may be placed on local authorities for people whose costs go beyond this level. As a city with a higher than average proportion of self funders (those who pay for their own care), there is potential for a significant increase in costs over the years following the implementation as people who wouldn't previously been financially eligible for support reach the care cap threshold. The Council will continue to monitor the Government's policy approach to this and will highlight to the Health and Wellbeing Board (in addition to Executive) an assessment of the impact.

Recommendations

26. The Health and Wellbeing Board are asked to:

- Agree to the future monitoring of progress through the performance management arrangements across the health and social care system.

Reason: To ensure the Act is considered a fundamental part of our system's approach to care in both detail and spirit of the Act.

- Receive a further report at the point that Phase 2 is confirmed to be implemented, highlighting the potential impact.

Reason: To allow the Health and Wellbeing Board to understand the impact of Phase 2 across the health and social care system.

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Report Approved [*X*] **Date** *06/07/16*

Wards Affected: **All** [X]

For further information please contact the author of the report

Background Papers: None

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CITY OF YORK COUNCIL

NHS
Vale of York
Clinical Commissioning Group

Health and Wellbeing Board **20th July 2016**

Joint Report of the Director of Adult Social Care, City of York Council and the Chief Operating Officer, NHS Vale of York Clinical Commissioning Group.

Better Care Fund Submission 2016/17

Summary

1. The purpose of the report is to update the Health and Wellbeing Board (HWBB) on progress to finalise a submission for the Better Care Fund (BCF) in 2016/17 and beyond.

2. Negotiations between the Council and the CCG have continued since April and a joint spending plan and narrative are in draft form awaiting final agreement.

3. To consider and comment on progress to date to agree the spending plan and narrative, subject to final agreement being reached between Officers of the Council and the Clinical Commissioning Group after the meeting.

4. To renew the delegated authority to jointly sign off the BCF plan and submission prior to 29th July 2016 deadline which was previously granted to both the Chair of the City of York Council's Health and Well-being Board and the Chair of NHS Vale of York Clinical Commissioning Group's Governing Body.

Background

5. The BCF was introduced as a tool to encourage and speed up the integration of health and social care, and prompt local authorities and Clinical Commissioning Groups to develop transformational

projects through the use of pooled budgets and integrated spending plans. A series of national conditions were specified, governing the development of detailed plans. The BCF did not however result in an allocation of any additional funding; instead the challenge was how to use existing resources in a more imaginative and joined up way to integrate services around the customer.

6. In 2015-16, the Government earmarked £3.8 billion against the BCF with local areas contributing an additional £1.5 billion, taking the total spending power of the BCF to £5.3 billion. Locally, this equated to a BCF budget for York of £12.2 million. Plans for how this budget was to be spent in 15/16 were agreed between the CCG and City of York Council and were signed off by the HWBB in April 2015.

7. In 2016/17 the BCF is being increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and CCGs. The local flexibility to pool more than the mandatory amount will remain. Locally, this will equate to a minimum pooled BCF budget for York of £12.2 million.

8. The HWBB received a progress report at its last meeting setting out the main aims of the 2016/17 plan and the projects that made up the programme. Officers of the Council and CCG have followed national guidance for preparing and submitting the BCF joint spending plan for 2016/17 by using the 2015/16 plan as a starting point.

9. Due to the failure to submit a balanced plan by the previous deadlines senior officers were invited to an NHS England Escalation Panel in London on 7th June 2016. The Panel recognised the confidence the CCG and CYC had in jointly concluding matters in a way that puts in place the building blocks for a realistic solution not just for the immediate term in respect of the BCF but for the broader care and health economy going forward.

Deadline for submission

10. York has to submit a final BCF plan for 2016/17 to NHS England by 29th July 2016, an extended deadline agreed following an

Escalation Panel meeting on 7th June 2016 in London. National Conditions require the joint spending plan and narrative for our submission to be approved and signed off by the Health and Wellbeing Board, the Council and the CCG.

11. Three previous deadlines, for the submission of draft plans for 2016/17, have already been missed, although the CCG and local authority did agree a holding response in April that articulated the work being undertaken to close discussions.

12. The financial context of the CCG/CYC and the under-performance of the 2015/16 programme are the two issues that have proven difficult in reaching agreement about the BCF plan for 2016/17.

13. Officers from both the CYC and CCG are working exceptionally hard to finalise and approve the plans to meet the extended deadline of 29th July 2016.

Approach to developing a plan

14. The Council and CCG have formally met on numerous occasions since the technical guidance for the current submission round was published on 23rd February 2016 by NHS England, with a deadline of 2nd March for the first draft submission. Work on the BCF has been taking priority over other issues.

15. Members of the Board will be aware of the financial context in which the CCG and the Council is operating. The 2015/16 BCF Plan failed to achieve the level of savings and efficiencies originally envisaged, potentially worsening the deficit and increasing pressures on CCG and Council budgets.

16. Recognising these issues officers from the CCG and the Council agreed a pragmatic way forward, a three stage approach which would involve:

- Reviewing confidence levels in 2015/16 projects submitted by CCG/CYC and agreeing schemes for inclusion in 2016/17. This has involved reviewing purpose, outputs, implementation problems and fit with overall direction of travel.
- Identifying other projects, funding streams and ‘pathways’ that would complement and could later be added to the agreed

programme to help realise additional efficiencies and desired outcomes

- A look at the whole system and totality of funding to fit with the emerging vision for health and social care in York.

17. Although good progress was made it was not possible to submit draft plans on 2nd March, 21st March or in May because of difficulties described above. It also became increasingly apparent that some of the assumptions in the 2015/16 plan were over optimistic, affecting our ability to collectively achieve the scale of financial efficiencies required from a programme of this size.

18. Further progress has subsequently been made with all of the expenditure agreed between the local authority and the CCG giving the York health and social care system a balanced BCF financial plan.

Next Steps

19. There is still some work to be done to make this final deadline and we remain hopeful that the Health and Well-being Board are now supportive of the balanced draft spending plan and narrative presented for this meeting. The current position is that:

- The total cost of schemes subject to final negotiation has been agreed as £12.2million.
- Senior Managers from the CCG and the Council have jointly written a draft narrative to accompany the plan.
- These discussions now also need to conclude with an agreement about how risk will be managed to include a set of principles governing our risk management approach for inclusion in the S.75 agreement.
- Although discussions have taken place regarding where System Resilience Group (SRG) funded schemes fit with the wider integration agenda, they are not included in the BCF. It is important that the HWB are aware that the SRG schemes are a pressure on the CCG's core budget. To ensure that HWBB are fully informed of the SRG schemes we would suggest that they are reported to the HWB via the ITB and that the ITB is now asked to have oversight of how it reviews and prioritises these SRG schemes.

20. Engagement with all stakeholders has not been as thorough as we would have liked given the timescales we have had to work to. Numerous individual conversations have taken place but at some point going forward this should be more of a collective discussion regarding the future ownership and direction of the BCF Plan for York. We would propose the HWB inviting the Integration and Transformation Board to take collective ownership of the BCF from hereonin and through this mechanism the HWB would expect the health and social care system to establish formal mechanisms so that, in future, the responsibility for BCF sits at the heart of our governance arrangements for transforming our system.

21. To this end the ITB is asked to now start developing the system's approach to the BCF for 2017/18 ensuring it underpins our longer terms direction for integration of health and social care.

Strategic/Operational Plans

22. The BCF does not sit in isolation and is an integral enabler that supports numerous operational and strategic planning frameworks. Although the detail of where BCF resources will be focused in 16/17 is still to be finalised, there are clear links to the CCG Operational Plan, the council Plan and the Sustainability and Transformation Plan. Addressing the key health and social care drivers and inequalities highlighted in the Joint Strategic Needs Assessment (JSNA) are also the focus of BCF planning.

Implications

23. The following implications have been addressed in this report

- **Financial –** The financial pressures faced by all organisations across the system are one of the key drivers behind the refreshed approach to BCF planning and delivery. Senior leaders are committed to ensuring that addressing financial pressure in one part of the system does not create additional pressures in other parts. This is a significant move towards a more integrated and whole system approach and will require strong leadership and buy in to succeed.

- **Human Resources (HR) -** There are no specific HR implications at this stage of the planning process

- **Equalities –** Equalities are continuously addressed through the engagement and consultation approach and recognised methods of assessing this through Equality Impact Assessments are followed

- **Legal –** There are no specific legal implications at this stage of the planning process

- **Crime and Disorder –** There are no specific crime and disorder implications at this stage of the planning process

- **Information Technology (IT) –** Progress towards a more joined up approach to IT is being addressed through the Digital Roadmap, progress on which is outside the scope of this report

- **Property –** There are no specific property implications at this stage of the planning process.

Risk Management

24. The whole system approach to BCF planning for 16/17 is not without risk, primarily that pressures in specific parts of the system will force organisations to take and inward facing approach to addressing these, rather than how these pressures can be managed across the system.

Recommendations

25. The Health and Wellbeing Board are requested to note and comment on the intensive drive to deliver a balanced plan.

26. Subject to agreement reached between senior managers from the Council and the Clinical Commissioning Group ahead of the meeting, consider the draft spending plan for submission to NHS England on 29th July 2016.

27. Provide delegated joint authority for the Chair of HWBB and Chair of the CCG Governing Body to authorise any final alterations to the narrative part of the submission, after receiving comments from members of the Board.

28. The Chief Operating Officer and Director of Adult Social Care to report agreement to their respective executive management teams.

Reason: To keep the HWBB abreast of progress and to seek a decision from the Board in relation to a joint spending plan for 2016/17 and advise of the intention to submit the BCF documentation subject to local authorisation by delegated parties by the required deadline.

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	Report Approved ✓ **Date** *19.07.2016*

Specialist Implications Officer(s) *List information for all i.e* Finance Officers within different organisations

Wards Affected: **All** ☐

For further information please contact the author of the report

Background Papers:
Report to the Health and Wellbeing Board on 9th March 2016
http://modgov.york.gov.uk/ieListDocuments.aspx?CId=763&MId=8771&Ver=4

Report to the Health and Well-being Board on 20th April 2016
http://democracy.york.gov.uk/ieListDocuments.aspx?CId=763&MId=9645&Ver=4

Abbreviations used in the Report:
A&E- Accident and Emergency
BCF- Better Care Fund
CCG- Clinical Commissioning Group
CYC- City of York Council
HR- Human Resources
HWBB- Health and Wellbeing Board
IT- Information Technology
JSNA- Joint Strategic Needs Assessment
NHS- National Health Service

DRAFT - Health and Wellbeing Board Forward Plan 2015/16 and 2016/17

Date	Item
20th July 2016	**Governance**
	Appointments to the Health and Wellbeing Board
	Older People's Focused Meeting
	Report from the Independent Care Group
	Older People's Survey
	Older People's Mental Health
	Other Business
	Report of Adults Safeguarding Board
	Performance Management Framework
	Sustainability & Transformation Plans
	Healthwatch York Report – Access to GP Services
	One Year on – Review of Implementation of Care Act
	Update on Better Care Fund
7th September 2016	**Mental Health Focused Meeting**
	Action taken to address the key issues highlighted in the Higher York report [Everybody's Business Conference]
	Report from CAMHS Executive on the Local Transformation Plan/Future in Mind
	Report from TEWV – Rehabilitation and Recovery in Working Age Adults
	Report from TEWV – Mental Health In-Patient Facilities for York
	Other Business
	Update from the JSNA/Joint Health and Wellbeing Strategy Steering Group (including strategy renewal)
	Annual Report on Health Protection 2015/16
	Update from Integration and Transformation Board
	Alcohol Strategy for York

DRAFT - Health and Wellbeing Board Forward Plan 2015/16 and 2016/17

Date	Item
23rd November 2016	**Children & Young People Focused Meeting**
	Update on Better Care Fund
	Healthy Child Service
	Report of Children's Safeguarding Board
	Other Business
	Healthwatch York Report (topic to be confirmed)
	Draft New Joint Health and Wellbeing Strategy
18th January 2017	Annual Report of the YorOK Board
	Performance & Monitoring (to include Health and Wellbeing Board Indicators, Better Care Fund and Futures in Mind)
	Update from Integration and Transformation Board
	Launch of the New Joint Health and Wellbeing Strategy
8th March 2017	Annual Report of the Mental Health and Learning Disabilities Partnership Board
	Draft Mental Health Strategy for Vale of York
17th May 2017	Healthwatch York Report (topic to be confirmed)
	Update from Integration and Transformation Board

To add (dates tbc)

One Planet York

Managing Performance and Monitoring

PNA 2017/18