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

**To:** Councillors Steels-Walshaw (Chair), Runciman, Webb and Mason
Siân Balsom – Manager, Healthwatch York
Dr Emma Broughton – Joint Chair of York Health & Care Collaborative
Zoe Campbell – Managing Director, Yorkshire, York & Selby - Tees, Esk & Wear Valleys NHS Foundation Trust
Sarah Coltman-Lovell - York Place Director
Sara Storey – Corporate Director of Adults and Integration, City of York Council
Martin Kelly - Corporate Director of Children's and Education, City of York Council
Simon Morritt - Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust
Mike Padgham – Chair, Independent Care Group
Alison Semmence - Chief Executive, York CVS
Peter Roderick - Director of Public Health, City of York Council
Tim Forber - Chief Constable, North Yorkshire Police

**Date:** Wednesday, 24 July 2024

**Time:** 4.30 pm

**Venue:** West Offices - Station Rise, York YO1 6GA

## A G E N D A

**1. Declarations of Interest** (Pages 1 - 2)
At this point in the meeting, Members and co-opted members are asked to declare any disclosable pecuniary interest, or other registerable interest, they might have in respect of business on

this agenda, if they have not already done so in advance on the Register of Interests. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

*[Please see attached sheet for further guidance for Members].*

**2. Minutes** (Pages 3 - 14)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on **Wednesday, 8th May 2024**.

**3. Public Participation**

At this point in the meeting members of the public who have registered to speak can do so. Members of the public may speak on agenda items or on matters within the remit of the committee.

Please note that our registration deadlines have changed to 2 working days before the meeting. The deadline for registering at this meeting is at **5.00pm** on **Monday 22nd July 2024**.

To register to speak please visit www.york.gov.uk/AttendCouncilMeetings to fill out an online registration form. If you have any questions about the registration form or the meeting please contact the Democracy Officer for the meeting whose details can be found at the foot of the agenda.

**Webcasting of Public Meetings**

Please note that, subject to available resources, this public meeting will be webcast including any registered public speakers who have given their permission. The public meeting can be viewed on demand at www.york.gov.uk/webcasts.

**4. Presentation: Poverty Truth Commission**

"To be treated with kindness, understanding, honesty and respect when accessing services", was chosen by the York Poverty Truth Community Commissioners as the issue that would make the most difference to them whilst experiencing poverty.

As a result the Commission produced a Charter containing a set of four organisational standards that would ensure the above. Some of our Community Commissioners will talk through how the standards came about based on their own experiences.'

**5. Better Care Fund** (Pages 15 - 64)

The purpose of this report is to inform the Health and Wellbeing Board of the recent Better Care Fund (BCF) planning submission which is a national requirement.

It also includes detail on how City of York Council and NHS Humber and North Yorkshire Integrated Care Board (ICB) will work together to further join up commissioning and develop the care market.

**6. Report of the Chair of the Health and Wellbeing Board** (Pages 65 - 72)

This paper is designed to summarise key issues and progress which has happened in between meetings of the Health and Wellbeing Board, giving Board members a concise update on a broad range of relevant topics which would otherwise entail separate papers.

**7. Report of the York Health and Care Partnership** (Pages 73 - 130)

This report provides an update to the Health and Wellbeing Board regarding the work of the York Health and Care Partnership, progress to date and next steps.

**8. Healthwatch York Annual Report & Update on Recommendations from Previous Reports** (Pages 131 - 246)

This report is for information, sharing details about the activities of Healthwatch York in 2023/24 with the Health and Wellbeing Board.

**9. Update on Goals 8 & 9 of the Joint Health and Wellbeing Strategy 2022-2032** (Pages 247 - 258)

This paper provides the Health and Wellbeing Board with an update on the implementation and delivery of two of the ten big

goals within the Local Joint Health and Wellbeing Strategy 2022-2032. It also includes information on performance monitoring.

**10. Urgent Business**

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

**Democratic Services Officer**

Ben Jewitt
Telephone: (01904) 553073
Email: benjamin.jewitt@york.gov.uk

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

- Registering to speak
- Written Representations
- Business of the meeting
- Any special arrangements
- Copies of reports

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**We can also translate into the following languages:**

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)**

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Agenda Item 1

**Agenda Item 1**

## Declarations of Interest – guidance for Members

(1) Members must consider their interests, and act according to the following:

| **Type of Interest** | **You must** |
|---|---|
| Disclosable Pecuniary Interests | Disclose the interest, not participate in the discussion or vote, and leave the meeting unless you have a dispensation. |
| Other Registrable Interests (Directly Related)<br>**OR**<br>Non-Registrable Interests (Directly Related) | Disclose the interest; speak on the item only if the public are also allowed to speak, but otherwise not participate in the discussion or vote, and leave the meeting unless you have a dispensation. |
| Other Registrable Interests (Affects)<br>**OR**<br>Non-Registrable Interests (Affects) | Disclose the interest; remain in the meeting, participate and vote unless the matter affects the financial interest or well-being:<br>(a) to a greater extent than it affects the financial interest or well-being of a majority of inhabitants of the affected ward; and<br>(b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.<br>In which case, speak on the item only if the public are also allowed to speak, but otherwise do not participate in the discussion or vote, and leave the meeting unless you have a dispensation. |

(2) Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(3) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

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| City of York Council | Committee Minutes |
|---|---|
| Meeting | Health and Wellbeing Board |
| Date | 8 May 2024 |
| Present | Councillors Coles (Chair), Runciman, Webb and Mason (from 5:22pm)<br>Sarah Coltman-Lovell – York Place Director<br>Siân Balsom – Manager, Healthwatch York<br>Brian Cranna - Director of Operations and Transformation, Tees, Esk and Wear Valleys NHS Foundation Trust (Substitute for Zoe Campbell)<br>Sara Storey – Corporate Director Adult Social Care and Integration, City of York Council<br>Martin Kelly – Corporate Director of Children's and Education Services, City of York Council<br>John Pattinson – Chief Executive, Independent Care Group (Substitute for Mike Padgham)<br>Alison Semmence – Chief Executive, York CVS<br>Peter Roderick - Director of Public Health, City of York Council<br>Simon Morritt – Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust |
| Apologies | Zoe Campbell – Managing Director, Yorkshire, York and Selby - Tees, Esk and Wear Valleys NHS Foundation Trust<br>Dr Emma Broughton – Joint Chair of York Health and Care Collaborative<br>Mike Padgham - Chair, Independent Care Group<br>Tim Forber - Chief Constable, North Yorkshire Police |

**187. Declarations of Interest (4:38pm)**

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. None were declared.

**188. Minutes (4:38pm)**

Resolved: That the minutes of the Health and Wellbeing Board meeting on 20 March 2024 be approved as a correct record.

**189. Public Participation (4:38pm)**

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

James Cannon spoke on the topic of participation among York's older residents. He advised the board that older residents in York had not been consulted or invited to a symposium on age-related matters, which had recently been discussed by the Chair of Humber and North Yorkshire Integrated Care System (ICS) in her blog.

He stressed that he and other older citizens in York were always willing to participate when given the opportunity to do so, noting that such meetings were open to public participation in other ICS areas such as South Yorkshire and Cumbria.

He noted that the Humber and North Yorkshire ICS otherwise has a patient-centred approach, but there was a lack of wider advertised publicity before or after this symposium and urged the ICS to tell people about such events.

**190. Report of the Chair of the Health and Wellbeing Board (4:43pm)**

The Chair presented the report.

It was noted that the Schools Health and Wellbeing survey link in point 3 did not take users to the most up to date set of results on the website.

The Director of Public Health explained that a survey was completed two weeks prior to the date of this meeting and was currently being circulated to Senior Leadership Teams at schools within the authority area, as well as the York Safeguarding Children Partnership.

The results had not been updated prior to this meeting for technical reasons, as they were published on the homepage for Joint Strategic Needs Assessments (JSNA) in York which, as mentioned at the March meeting of the Board, was in a transitional period between iterations of their website. The Director of Public Health assured the Board that the current results of this survey would be updated and published when the new JSNA website went live.

The chair noted key statistics of concern regarding health and meals in schools from the current data – firstly that 7% of primary school children had missed school in the past month due to tooth pain; secondly that significant numbers of children reported being hungry in secondary schools (25% reported not eating breakfast, 10% also reported not eating anything at lunchtime, 37% of secondary children believed school food was too expensive).

The chair raised two further points from the survey, namely the issue that a fifth of all children reported using the internet for more than six hours on an average school day and 23% of school age children reported self-harming in the past year.

The board agreed that it was appropriate for the results of this survey to form an item at the next meeting of the Board, allowing all partners to digest the report once fully circulated.

It was noted that a feasibility study, hearing the voices of children and supporting many of the issues raised by this survey, was being undertaken with a view to creating a Poverty Truth Commission for children.

Resolved: That the Health and Wellbeing Board noted the report.

Reason: So that the Board were kept up to date on: Board business, local updates, national updates, and actions on recommendations from recent Healthwatch reports.

**191. Report of the York Health and Care Partnership (4:49pm)**

The York Place Director presented this report which included an update on the Annual Report. She stated that the March

meeting of the York Health Care Partnership (YHCP) reflected on the past 12 months and reassessed priorities. The report had not been finalised at the time of this meeting and will therefore be brought to the Health and Wellbeing Board in July.

It was noted that the YHCP Reported into this Board and also to the Chief Executive for the Integrated Care Board (ICB); and that it delivered both the Humber and North Yorkshire Integrated Care System and York Health and Wellbeing Board Strategies.

**She noted that the YHCP had agreed to maintain the following six priorities in 2024-25:**

1. To strengthen York's integrated community offer.
2. To implement an integrated Urgent and Emergency Care offer for York.
3. To further develop Primary/Secondary shared-care models.
4. To embed an integrated prevention and early intervention model.
5. To develop a partnership based, inclusive model for children, young people, and families.
6. To drive social and economic development.

She also acknowledged that the Partnership had signed off health and inequalities funding, which was ring fenced by the ICB.

On discussion of the report the following comments were made:

- The Director of Operations and Transformation, TEWV NHS Foundation Trust clarified that the Mental Health Hub was for adults not children.

- The board asked what had been done by ICB to advance point 5 specifically. Director of Place advised that a full update will follow at the next meeting – the things done in partnership are things done together not just by the ICB.

- The Corporate Director of Childrens and Education noted that Early Talk for York would be discussed in item 7, but specifically referred to core 20 – the 20% of population living in more deprived areas. He advised that these groups faced special difficulties when it comes to

equalities. We need to reflect these and this included Romany/gypsy/trans/veterans.

- With regard to the points raised in Public Participation the board asked how do we get people more involved to create something that gives clear communication at all levels within the ICS.

- The board discussed the Child and Adolescent Mental Health Service (CAMHS) out of hours emergency response for young people across York and North Yorkshire. A trauma informed approach to working was discussed, as well as the 24/7 crisis line. The existing challenges to recruitment were discussed. Director of Place responded that there are trauma informed networks for people experiencing multiple disadvantage.

Resolved: That the Board note the report of the YHCP.

Reason: So that the Board were kept up to date on the work of the YHCP, progress to date and next steps.

**192. Update on Goal 7 of the Joint Health and Wellbeing Strategy 2022-2032: 'Reduce both the suicide rate and the self-harm rate in the city by 20%' (5:23pm)**

The Director of Public Health and Public Health Specialist Practitioner Advanced Partnerships and Early Intervention presented an update on Goal 7 of the Joint Health and Wellbeing Strategy 2022-2032: “Reduce both the suicide rate and the self-harm rate in the city by 20%”.

The Director of Public Health introduced the item, stating that Goal 7 and therefore this report, addressed actions 16, 17 and 18 of the action plan. He noted that action 17 was being delivered by the York Centre for Voluntary Service (CVS) and invited the Chief Executive of York CVS to contribute in addition to the two presenters. He also stated that the first year action was around the audit and the second year would be around refreshing and relaunching the Suicide Safer Community Strategy. He noted that a year into the Joint Health and Wellbeing Strategy we are on course but are not fully making an impact yet; Childrens Mental Health, Alcohol and Suicide

indicators within the JSNA which should typically show green, were currently showing yellow or red and these should remain a priority for partners.

Public Health Specialist Practitioner Advanced Partnerships and Early Intervention presented the update on actions noting that goal 7 suicide data was discussed on pages 42-43 of the report, and this showed reductions of just under 20% which while not statistically significant, were moving in the right direction.

She acknowledged that some typographical errors remained in the suicide audit - action 16 - which would be amended before this was published online.

She stated that this was deliberately a retrospective report, hence the figures dating from 2021-22. The reason for this was the need to look at situations specifically confirmed as suicides post-coronial report and not speculating whether or not any particular instance might be considered suicide. While the data may not seem that current she confirmed that these statistics reflected suicide figures post-covid.

She advised that the authority previously had one steering group for suicide and mental health, and that this had now been split. She also stated that work was being undertaken across North Yorkshire and the City of York, offering a combined approach which gave a broader holistic picture.

She also credited Menfulness, Healthwatch York and York MIND for their work on actions 16 and 18 and indicated that the intention was to assemble a tangible action plan going forwards.

She introduced the Yes Project (Action 17) conducted together with York CVS, as part of the forward strategy to reduce stigma and bring good mental health into the city.

The Chief Executive, York CVS further discussed the Yes Project, stating that it was about good mental health, and that a film (“The WHY film” www.WhySuicidePrevention.co.uk) had been made by champions with the message that talking about suicide saves lives. She urged partners to get in touch if they would like CVS to present the film for them.

The board asked for clarification about whether references to those in the report contacting their GP around the time of

suicide represented a statistically significant/higher than average level of contact with GP.

The Public Health Specialist Practitioner Advanced Partnerships and Early Intervention stated that the audit sought to source markers and flags from the coronial report or police report – and whether someone had recently attended a Mental Health appointment counted as one of these; this was why this data was included. She conceded that the published data did not distinguish whether the GP attendance related to a Mental Health issue or any other (possibly unrelated) health issue and as such this should be considered a correlative rather than causative factor.

The board asked whether there should be a content warning on the audit before wider publication, and also signposting for bereavement support and to organisations such as Samaritans. The Public Health Specialist Practitioner Advanced Partnerships and Early Intervention advised that while there was already a general warning note within the report, some editorial alterations were already required and she would be more than happy to make the requested additions and to take guidance from partners regarding the wording.

The board asked whether more young people contemplating suicide had come forward for help specifically during the pandemic, and if so had the impact of Covid now lessened or ended? The Public Health Specialist Practitioner Advanced Partnerships and Early Intervention deferred to front-end responders, stating that she did not personally have this data. The Director of Operations and Transformation, TEWV NHS Foundation Trust responded that within the general population the majority of people who attempted suicide had not had recent contact with Mental Health Services, and it was really more about education and prevention. The Director of Public Health noted the lag due to retrospective nature of the audit needing to take into account the coronial report, meant that it was difficult to fully appreciate where we stand regarding statistics and people’s Mental Health post-pandemic.

The board asked whether the authority was still training people in Mental Health First Aid: The Chief Executive, York CVS responded that CVS was undertaking these and also ASIST training for the voluntary sector due to the work they undertake. The Director of Public Health added that suicide prevention

training, ASIST (the full course) and SafeTALK (the shorter version) are still conveyed by York Mind but unfortunately they were no longer funded programmes.

The board raised concerns about young people's mental health deteriorating over the past decade and how this may become a concern as these young people turn 18. The Director of Public Health advised that 2000s figures were 800,000 - 900,000 2010s up towards 1,000,000.

Addressing several points raised, the Director of Public Health clarified:

- It was generally understood to be incorrect that people taking their life are at an acute point in a mental health crisis being seen regularly, and only 1 in 4 are under secondary mental health care (although a greater number may be on the primary care register).
- 41% of these people had seen their GP recently, but of the general population, many people see their GP regularly and it was important to distinguish causality vs correlation.
- Income and background were significant contributory factors; suicidality increased the further down the income spectrum one was and ending stigma should be a focus here; communities such as Autism/ADHD spectrum and LGBTQ+ were also statistically more likely to commit suicide.

The board noted the Director of Public Health's comments regarding the significant increase in neurodiversity among the population, particularly young people. The Corporate Director, Childrens and Education advised that the audit would be used to inform his team's trauma informed practice.

The board asked whether there were any more predictive powers within the data in terms of looking at frequency of use of these services. The Director of Public Health stated that trying to predict here was not easy as suicide was an area where there are a lot of false positives; instead systems such as SafeTALK and ASIST engender a culture in which professionals have courage to talk. He highlighted that this was not just healthcare/medical professionals but also organisations such as Network Rail who do an exceptional job of training staff to talk to people. The Public Health Specialist Practitioner Advanced

Partnerships and Early Intervention added that she was working with Network Rail and factoring their data into statistics.

Resolved: That the Health and Wellbeing Board noted and commented on the updates provided within this report and its associated annexes.

Reason: To ensure that the Health and Wellbeing Board fulfilled its' statutory duty to deliver on one of the ten big goals within the Joint Local Health and Wellbeing Strategy 2022-2032.

**193. Learning From Early Talk for York (5:54pm)**

The report was presented by the Social Mobility Project Lead and the Corporate Director, Children's and Education Services; discussing the factors that had made Early Talk for York so successful.

The Social Mobility Project Lead summarised the pilot, stating that it had started small, which allowed them to get the right approach and prioritise relationships. He stated that Early Talk for York positively exemplified the concept of "Waiting Well" and made positive progress in addressing inequalities.

The Corporate Director, Children's and Education further discussed this topic stating that Early Talk for York was a tremendous example of how something different and innovative could be created, which allowed intervention to take place while young people were still on a waiting list. He suggested this model could be further deployed in other areas of practice.

The board asked whether there any longitudinal work being undertaken to see if those coming off the waiting list were staying off it – with specific regard to paragraph 19. The Social Mobility Project Lead conceded that this was difficult to evaluate, but a number of academic institutions were offering to help and a bid had been put into a national funder that would allow for robust independent evaluation.

The board acknowledged that better speech and language can lead to better outcomes for young people, and asked partners which other areas they felt could benefit from a similar people-based approach.

The board acknowledged that while this method was resource intensive it had demonstrably delivered results.

The Director of Public Health discussed that another area that may benefit from this model would be Family Hub; for example its role in young people's nutrition and the goal of living to a healthy weight. The Director of Nursing and Quality explained that children with conditions such as epilepsy, diabetes, asthma, as well as Complications of Excessive Weight (CEW) were presently referred to regional tertiary centres and therefore a preventative solution would be far preferable.

The Corporate Director of Childrens and Education suggested Mental Health – in terms of having a medicalised rather than a social approach; and cited the present preoccupation with assessing conditions such as autism rather than intervention and actually working with those seeking help.

The board also asked who Early Talk For York is currently working with – in terms of numbers and how children are identified, and what are the long term views on opening up the pilot and parents referring their children. The Social Mobility Project Lead answered that the scheme's referrals predominantly came from early childhood education and care (ECEC) settings and in terms of the numbers there were between 4000-5000 children across the city impacted by Early Talk for York and the Full Approach is in approximately 50 schools and settings impacting approximately 2000 children. The initial rollout was somewhat impacted by the pandemic. The Corporate Director Children's and Education said that full rollout to parents would need to be carefully managed as there would likely be high demand.

Resolved: That the Health and Wellbeing Board noted and commented on the contents and implications of the report.

Reason: To provide the Health and Wellbeing Board with an update on learning from Early Talk for York.

**194. Developing a Corporate Parent approach to support the Health and Wellbeing of Care Leavers (6:16pm)**

The Director of Nursing & Quality, NHS Humber & North Yorkshire Health and Care Partnership and Corporate Director,

Childrens and Education Services presented the report on a Corporate Parent approach to support the Health and Wellbeing of Care Leavers.

The Corporate Director, Children's and Education introduced the report, detailing discussion with a national advisor about areas or strength and improvement. He stated that young people in care and care leavers were twice as likely to leave home at 18 and need Corporate Parenting support around them.

The Director of Nursing & Quality, NHS Humber & North Yorkshire Health and Care Partnership clarified that the official legal definition of a care leaver is someone who has spent 13 weeks under care of the Local Authority before their 16th birthday but the Care Leavers Association definition is more nuanced, specifying any child who has been in care – voluntarily or via Court Order – and in the various ways we understand that – fostering and residential care.

She confirmed that the Integrated Care Board's Children's and Young People's Board was established in January and it was determined that there was good reason to protect care leavers, with some action having been taken already.

She stated that adults that had spent time as Children in Care between 1971 and 2001 had lower prospects, lower employment, and the York Trust had supported those who wish to pursue a career in Mental Health. She confirmed that having studied feasibility and costs, free prescriptions for care leavers would currently impact just four young people across the authority area. Dental care, and glasses were still proving a challenge to progress.

The board asked whether this strategy constituted part of the care leavers covenant, and how the local authority ensured care leavers prospects were improved.

The Corporate Director of Childrens and Education responded by explaining that all Local Authorities had a Local Offer, and City of York Council ensured that care leavers went into the gold band and additionally that the houses provided had white goods. He also explained that the Council were working with local businesses towards not only a prioritised interview but also developing a gold/silver/bronze banding of partner employers to

improve understanding of the demands of working with young people who have been in care.

While the Director of Nursing & Quality, NHS Humber & North Yorkshire Health and Care Partnership did not have specific statistics about costings for glasses and dental care for Children in Care/Care Leavers, she did not believe this amounted to a substantial sum and suggested the authority might be able to subsidise this internally. Councillor Mason felt he may have a solution regarding eyecare and offered to personally pursue this issue.

The Director of Nursing & Quality, NHS Humber & North Yorkshire Health and Care Partnership said that there were currently no young people on the steering group and she definitely felt this should be a priority going forwards. Corporate Director Children's and Education said there was more work to do but that this would be in the local offer.

The board acknowledged the national debate over care leavers having protected characteristics and that national government had yet to offer protected status to this cohort, but that a lot of authorities had addressed this locally at a council level.

Resolved: That the Health and Wellbeing Board noted and commented on the contents and implications of the report.

Reason: To provide the Health and Wellbeing Board with an update on Developing a Corporate Parent Approach to support the Health and Wellbeing of Care Leavers.

Cllr Jo Coles, Chair
[The meeting started at 4.36 pm and finished at 6.37 pm].

**Health and Wellbeing Board** 24 July 2024

**Report of the Better Care Fund Planning Submission and Update**

## Summary

1. The purpose of this report is to inform the Health and Wellbeing Board of the recent Better Care Fund (BCF) planning submission which is a national requirement. The planning submission template collects data on the use of BCF funding and ambitions for performance on BCF metrics (performance objectives) and activity to achieve these as well as on capacity and demand planning.

2. We are also required to provide a summary of the strategic approach to integration of health and social care to support further improvement of outcomes for people with care and support needs. Included in this we provide narrative on specific schemes, outcomes and what they are trying to achieve.

3. Acknowledging the current direction of travel and the shift towards a more joined up approach to commissioning, we have also included detail on how City of York Council and NHS Humber and North Yorkshire Integrated Care Board (ICB) will work together to further join up commissioning and develop the care market.

## Background

4. The Better Care Fund Policy Framework sets out the Government's priorities for 2023-25, including, but not limited to, improving discharge, admission avoidance, reducing the pressure on Urgent and Emergency Care and social care, and supporting intermediate care.

5. City of York Council and the ICB collectively oversee £25.3m spend across Health and Social Care to support system flow, maintain independence, reduce hospital delays and admissions.

6. The vision for the BCF over 2023-25 is to support people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by a set of core principles, objectives, and national conditions including a requirement for plans to be jointly signed off by ICBs and local authorities, enabling people to stay well, safe, and independent at home for longer and providing the right care, in the right place, at the right time.

7. We have developed this submission alongside the BCF Policy Framework and BCF Planning Requirements for 2023/25. All schemes within the BCF support and embed the Home First approach, support admission avoidance, enhance personalisation, and reduce health inequalities.

**Jointly Commissioned Services**

8. Through the BCF we have several jointly commissioned services such as equipment, carers, and reablement amongst others. The Council has a senior commissioning team that works closely with NHS colleagues on the planning and delivery of various joint commissions and contractual arrangements. This approach was further developed when the Council moved to an all-age approach to commissioning through a dedicated team working together with health, housing, children's services, public health, and transformation colleagues.

9. Our jointly commissioned BCF services continue to:

    - reduce length of stay within a hospital setting through enhancing rapid response services and in reach integrated teams.

    - Reduce waiting times for people contacting social care.

- Reduce the need for ongoing support through social care, promoting independence and control.
- Enhance our Voluntary and Community and utilise resources to promote early intervention and prevention approaches.
- Build on the strength of local communities and provide services that build on people's own abilities and strengths.
- Enhance personalised care and support through commissioning tailored support through personal budgets.
- Enhance mental health and wellbeing services building on the mental health hub and the connecting our city programme.

10. The focus of our BCF services remain in line with the BCF policy objectives and national priorities. We will continue to build on the schemes that are supporting the delivery of good outcomes.

**Performance Objectives**

**Preventing admission to hospital or long-term residential care**

11. We are committed to early intervention and preventative approaches, supporting early discharge of people who require hospital admission and providing support for people to remain at home for longer. Working together we are further developing strength-based approaches, supporting people and communities to build on their strengths, introducing self-care models of care and support building resilience and independence. Through partnership working we are developing stronger healthier communities by listening to what matters to our citizens and codeveloping services to meet needs.

12. There are number of schemes that are explicitly supporting admission avoidance, some of which are outwardly facing and take place within community settings such as Urgent Care Practitioners who treat people on scene which avoids a conveyance and potential admission as well as the York Integrated Care Team who

promote anticipatory care, providing short term support for patients, working off an existing caseload.

13. In parallel with this, we have several schemes that are inward facing including the Rapid Assessment and Therapy Service which is ED based with a focus on turning patients around quickly who do not need emergency interventions. Running alongside this, we also have an in-reach model that pulls patients out of other areas within the acute footprint and supports people to return to their usual place of residence within 2 hours for a further assessment of their needs.

**Improving hospital discharges**

14. It has been acknowledged that the discharge position across the system continues to be a challenge, which, if left unaddressed, could result in de-stabilisation across the system. We have a growing population and as a system, we are witnessing higher levels of acuity which significantly impacts the numbers of patients who require interventions and find themselves in a hospital bed at some point along their journey. Whilst we have several schemes in place to avoid admissions, we acknowledge that some admissions are unavoidable.

15. We must ensure that we are addressing this through the direction of BCF funding available to us. In the spirit of collaboration and recognising that we cannot do this alone, a programme of works has been established via York and Scarborough Teaching Hospitals which forms part of the Urgent Care Improvement Programme. Whilst we have oversight and visibility of the discharge position, this programme of works enables us to view this through an acute lens, understand some of the internal challenges and bottlenecks which will inform how we direct BCF funding to support this core metric.

16. As a system we are committed to reducing the number of patients with no criteria to reside and facilitating timely discharge. These approaches include the expansion of the existing in-reach model aimed at identifying patients who have low level needs and an

admission can be avoided. We have been able to expand this service by increasing the workforce meaning further reach into the hospital facilitating earlier discharge.

17. The Early Discharge Support Service helps support complex patients being discharged and provide a link between acute and community services. We have found that this has reduced readmissions of complex patients back into hospital and the patients respond well to this service.

**Discharge Destination**

18. There is an acknowledgement that higher levels of acuity continue to result in discharges that are not consistent with usual places of residence. Patients who would normally be discharged home are often requiring additional onward/packages of care preventing them from being discharged to their usual place of residence in some cases.

19. Our ambition is to ensure that all patients are discharged to their usual place of residence without the need for additional or onward care which prevents this. The Early Discharge Support Service and in-reach model are good examples of how we intend to achieve this ambition, identifying patients before they are admitted and getting them back home/usual place of residence instead of a potential admission which may then result in additional care needs, preventing the patient from returning home.

**Financial Information**

20. City of York Council and the ICB collectively oversee £25.3m which is focused on a variety of schemes that will contribute to meeting the BCF performance objectives.

21. We have used the BCF funding streams in several ways to ensure we are meeting the objectives and core metrics set out within the BCF policy framework and we will ensure that available funds are directed to schemes that create the biggest outcomes for people, reducing inequalities and the need for acute care. We will continue

to offer versatile services that are responsive reducing delays in discharges as well as supporting people with long term conditions.

22. We have directed the highest volumes of funding towards community-based schemes including community response (expanding care at home), falls services, urgent care practitioners and community equipment. Significant portions of funding have been used on bed based and residential care to enable the timely discharge of patients from hospital who do require onward care as well as home and domiciliary care.

23. There are several lower value schemes which contribute towards a variety of outputs and these, along with our highest value schemes will all form part of a dedicated review of the BCF which is outlined in our next steps.

**Strategic Priorities**

24. Over the next two years our ambitions are to strengthen our BCF schemes that have the biggest impact, as well as redirect resources where necessary, with a focus on health inequalities. During a recent review to support the delivery of the BCF national conditions we agreed schemes that fit into the specific categories, which will help with future decision making and resource allocation.

25. As a system we are committed to reducing the number of unnecessary admissions into hospital, through helping more people to be supported at home with the right service and right support through a person-centred approach. We acknowledge that some schemes are part of existing core services, however through innovative approaches and new ways of commissioning we are looking at ways to redirect resources and funds around the BCF to make the biggest impact.

26. BCF funded services are a key enabler to integration of health and social care in York. Specifically, the plans improve discharge and reduce pressure on urgent and emergency care and social care services.

27. The BCF is recognised by all partners as a strategic mechanism to integrate resources tied up in committed funds – workforce, buildings, equipment – and consider best value for money for the York pound in the case of uncommitted resources.

28. As part of the York Place Health and Care Partnership development plan we will be exploring, in collaboration with City of York colleagues, how we build on the BCF in terms of pooling resources to deliver shared objectives that deliver the best outcomes for the least cost.

29. Partners are working collaboratively to jointly commission key services and we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents.

**Next Steps**

30. Towards the end of last year, we undertook a review of the current BCF schemes as part of an overarching funding review. This provided the opportunity to identify the schemes that sit within the BCF and crucially, determine which were flexible in terms of having the potential to re-direct funding. This was the first phase of a much wider review of the BCF which partners agree is required.

31. The second phase of this review is to conduct a deep dive into each individual scheme, assessing value for money, key performance indicators and contract management and monitoring processes. With this comes the opportunity to identify any areas of duplication and develop a proposal to potentially re-direct funding to make maximum use of the core BCF. Part of this review will identify contractual obligations and durations which will inform any timeline for new commissioning arrangements.

32. In addition to reviewing the schemes within the BCF, we are also taking this opportunity to pause and reflect on what the mechanism

for delivery monitoring should be. This has previously been in the form of a Delivery Group, responsible for oversight of the BCF and engagement with providers. With the shift in direction towards joint commissioning, we feel that this is an ideal opportunity to redefine what we need from a delivery function.

33. More than ever the requirement and desire to co-produce this collaborative and integrated approach has come to the fore. These new ways of working continue to require joined up leadership with the values, behaviours, and attitudes we collectively aspire to, exhibited in a consistent way. To continue the great work that has been witnessed and maintain the momentum to deliver services collaboratively we must ensure we have the platform in place to facilitate this. Whether this is in the form of a delivery forum dedicated solely to BCF or potentially part of a wider forum focusing on overarching joint delivery will form part of our proposals for consideration.

34. The impact of these potential changes must be considered in the broader context of the BCF, considering that our current BCF plan takes us to 2025 with expected new guidance which may inform our future direction of travel.

**Implications**

35. **Financial**: The financial implications are detailed in this report and associated planning submission.

36. **Human Resources (HR)**: There are no HR implications.

37. **Equalities**: There are no equalities implications.

38. **Legal**: There are no legal implications.

39. **Crime and Disorder:** There are no crime and disorder implications.

40. **Information Technology (IT)**: Several schemes are dedicated to assistive technology.

41. Property: There are no property implications.

**Recommendations**

42. The Health and Wellbeing Board are asked to consider the content of this report and support the ongoing oversight of the planning and implementation of the Better Care Fund. Furthermore, we are asking the Board to note the next steps with agreement that the findings and any associated proposal(s) are discussed at a future meeting.

**Contact Details**


| **Author:** | **Chief Officer Responsible for the report:** |
|---|---|
| Zoe Delaney<br>Assistant Director, Community Integration<br>Humber and North Yorkshire ICB (York Place)<br>07762 982 632 | Sara Storey<br>Corporate Director, Adult Social Care, and Integration<br>City of York Council<br>07720 155632 |


| **Report Approved** | √ | **Date** | 10.07.2024 |
|---|---|---|---|

| **Wards affected** | ALL |
|---|---|

**For further information please contact the author of the report**
**Background Papers:**

**Annex A** – Better Care Fund Planning Submission

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Annex A1:

# BCF Planning Template 2024-25

**1. Guidance**

## Overview

**Note on entering information into this template**

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

### 2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

6. Please ensure that all boxes on the checklist are green before submission.

7. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

### 4. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

**4.2 Hospital Discharge**

A new text field has been added this year, asking  for a description of the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation. Please answer this briefly, in a couple of sentences.

The capacity section of this template remains largely the same as in previous years, asking for estimates of available capacity for each month of the year for each pathway. An additional ask has now also been included, for the estimated average time between referral and commencement of service. Further information about this is available in the capacity and demand guidance and q&a documents.

The demand section of this sheet is unchanged from last year, requesting expected discharges per pathway for each month, broken down by referral source.

To the right of the summary table, there is another new requirement for areas to include estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways. Please estimate this as an average across the whole year.

**4.3 Community**

Please enter estimated capacity and demand per month for each service type.

The community sheet also requires areas to enter estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

### 5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2024-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations, DFG allocations and allocations of ASC Discharge Fund grant to local authorities for 2024-25. The iBCF grant in 2024-25 remains at the same value nationally as in 2023-24.

2. The sheet will be largely auto-populated from either 2023-25 plans or confirmed allocations. You will be able to update the value of the following income types locally:

- ICB element of Additional Discharge Funding
- Additional Contributions (LA and ICB)

If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

3. The sheet will pre populate the amount from the ICB allocation of Additional Discharge Funding that was entered in your original BCF plan. Areas will need to confirm and enter the final agreed amount that will be allocated to the HWB's BCF pool in 2024-25. As set out in the Addendum to the Policy Framework and Planning Requirements; the amount of funding allocated locally to HWBs should be agreed between the ICB and councils. These will be checked against a separate ICB return to ensure they reconcile.

4. The additional contributions from ICBs and councils that were entered in original plans will pre-populate. Please confirm the contributions for 2024-25. If there is a change to these figures agreed in the final plan for 2024-25, please select 'Yes' in answer to the Question 'Do you wish to update your Additional (LA/ICB) Contributions for 2024-25?'. You will then be able to enter the revised amount. These new figures will appear as funding sources in sheet 6a when you are reviewing planned expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2023-24 (i.e. underspends from BCF mandatory contributions) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field at the bottom of the sheet to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

**6. Expenditure**

This sheet has been auto-populated with spending plans for 2024-25 from your original 2023-25 BCF plans. You should update any 2024-25 schemes that have changed from the original plan. The default expectation is that plans agreed in the original plan will be taken forward, but where changes to schemes have been made (or where a lower level of discharge fund allocation was assumed in your original plan), the amount of expenditure and expected outputs can be amended. There is also space to add new schemes, where applicable.

If you need to make changes to a scheme, you should select yes from the drop down in column X. When 'yes' is selected in this column, the 'updated outputs for 2024-25' and 'updated spend for 2024-25' cells turn yellow and become editable for this scheme. If you would like to remove a scheme type please select yes in column X and enter zeros in the editable columns. The columns with yellow headings will become editable once yes is selected in column X - if you wish to make further changes to a scheme, please enter zeros into the editable boxes and use the process outlined below to re-enter the scheme.

If you need to add any new schemes, you can click the link at the top of the sheet that reads 'to add new schemes' to travel quickly to this section of the table.

For new schemes, as with 2023-25 plans, the table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet, please enter the following information:

**1. Scheme ID:**

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

**2. Scheme Name:**

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

**3. Brief Description of Scheme**

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

**4. Scheme Type and Sub Type:**

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.

- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn ""yellow"". Please select the Sub Type from the dropdown list that best describes the scheme being planned.

- Please note that the dropdown list has a scroll bar to scroll through the list and all the options may not appear in one view.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

**5. Expected outputs**

- You will need to set out the expected number of outputs you expect to be delivered in 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.

- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

- A change has been made to the standard units for residential placements. The units will now read as 'Beds' only, rather than 'Beds/placements'

**6. Area of Spend:**

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.

**7. Commissioner:**

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.

- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.

- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

**8. Provider:**

- Please select the type of provider commissioned to provide the scheme from the drop-down list.

- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

**9. Source of Funding:**

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority

- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

**10. Expenditure (£)2024-25:**

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

**11. New/Existing Scheme**

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

**12. Percentage of overall spend.**

This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This was a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

## 7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2024-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2024-25.

Some changes have been made to the metrics since 2023-25 planning; further detail about this is available in the Addendum to the BCF Policy Framework and Planning Requirements 2023-25. The avoidable admissions, discharge to usual place of residence and falls metrics remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics.

The effectiveness of reablement metric will no longer be included in the BCF as there is no direct replacement for the previous measure.

The metric for rate of admissions to Areas should set their ambitions for these metrics based on previous SALT data.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:

- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

**1. Unplanned admissions for chronic ambulatory care sensitive conditions:**

- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2024-25. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.

- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2023-24 are pre-populated in the template and will display once the local authority has been selected in the dropdown box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:

https://future.nhs.uk/bettercareexchange/view?objectId=143133861

- Technical definitions for the guidance can be found here:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

**2. Falls**

- This metric for the BCF requires areas to agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter the indicator value as well as the expected count of admissions and population for 2023-24 and 2024-25 plan.
- We have pre-populated the previously entered planned figures for your information and further more recent data will be available on the BCX in the data pack here: https://future.nhs.uk/bettercareexchange/view?objectID=116035109

Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

**3. Discharge to usual place of residence.**

- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. Areas should agree ambitions for a rate for each quarter of the year.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet where available else we will use the previously entered plan data.

**4. Residential Admissions:**

- This section requires inputting the expected and plan numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2023-24. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Although this data collection will be discontinued it is anticipated this will map across to the new CLD extract once this becomes available.

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HM Government

NHS England

# Better Care Fund 2024-25 Update Template

**2. Cover**

**Version 1.3.0**

*Please Note:*

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

| | | Complete: |
|---|---|---|
| **Health and Wellbeing Board:** | York | Yes |
| **Completed by:** | Zoe Delaney | Yes |
| **E-mail:** | zoe.delaney8@nhs.net | Yes |
| **Contact number:** | 07762 982 632 | Yes |
| **Has this report been signed off by (or on behalf of) the HWB at the time of submission?** | Yes | Yes |
| **If no please indicate when the HWB is expected to sign off the plan:** | | Yes |

| | Role: | Professional Title (e.g. Dr, Cllr, Prof) | First-name: | Surname: | E-mail: | |
|---|---|---|---|---|---|---|
| ***Area Assurance Contact Details:** | Health and Wellbeing Board Chair | Cllr | Lucy | Steels-Walshaw | cllr.isteels-walshaw@york.gov.uk | Yes |
| | Integrated Care Board Chief Executive or person to whom they have delegated sign-off | | Sarah | Coltman-Lovell | sarah.coltman-lovell@nhs.net | Yes |
| | Additional ICB(s) contacts if relevant | | Michael | Ash-McMahon | m.ash-mcmahon@nhs.net | Yes |
| | Local Authority Chief Executive | | Ian | Floyd | ian.floyd@gov.gov.uk | Yes |
| | Local Authority Director of Adult Social Services (or equivalent) | | Sara | Storey | sara.storey@york.gov.uk | Yes |
| | Better Care Fund Lead Official | | Zoe | Delaney | zoe.delaney8@nhs.net | Yes |

| | | | | | |
|---|---|---|---|---|---|
| LA Section 151 Officer | | Debbie | Mitchell | debbie.mitchell@york.gov.uk | Yes |
| | | | | | |
| | | | | | |
| | | | | | |

*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

**Please see the Checklist below for further details on incomplete fields**

| | Complete: |
|---|---|
| 2. Cover | Yes |
| 4.2 C&D Hospital Discharge | Yes |
| 4.3 C&D Community | Yes |
| 5. Income | Yes |
| 6a. Expenditure | No |
| 7. Narrative updates | Yes |
| 8. Metrics | Yes |
| 9. Planning Requirements | Yes |

<< Link to the Guidance sheet

^^ Link back to top

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Annex A3:

# Better Care Fund 2024-25 Update Template

**3. Summary**

Selected Health and Wellbeing Board: York

## Income & Expenditure

Income >>

| Funding Sources | Income | Expenditure | Difference |
|---|---|---|---|
| DFG | £1,601,197 | £1,601,197 | £0 |
| Minimum NHS Contribution | £15,725,320 | £15,725,319 | £1 |
| iBCF | £5,368,798 | £5,368,798 | £0 |
| Additional LA Contribution | £0 | £0 | £0 |
| Additional ICB Contribution | £0 | £0 | £0 |
| Local Authority Discharge Funding | £1,254,495 | £1,254,495 | £0 |
| ICB Discharge Funding | £1,431,567 | £1,431,567 | £0 |
| **Total** | **£25,381,376** | **£25,381,376** | **£0** |

Expenditure >>

**NHS Commissioned Out of Hospital spend from the minimum ICB allocation**

| | 2024-25 |
|---|---|
| Minimum required spend | £4,549,751 |
| Planned spend | £8,139,160 |

**Adult Social Care services spend from the minimum ICB allocations**

| | 2024-25 |
|---|---|
| Minimum required spend | £7,450,197 |
| Planned spend | £7,720,545 |

Metrics >>

## Avoidable admissions

| | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan |
|---|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population) | 211.8 | 211.8 | 211.8 | 211.8 |

## Falls

| | | 2023-24 estimated | 2024-25 Plan |
|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Indicator value | 2,121.9 | 2,177.0 |
| | Count | 881 | 904 |
| | Population | 38874 | 38874 |

## Discharge to normal place of residence

| | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan |
|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | 94.3% | 95.5% | 96.0% | 95.3% |

## Residential Admissions

| | | 2022-23 Actual | 2024-25 Plan |
|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 479 | 469 |

Planning Requirements >>

| Theme | Code | Response |
|---|---|---|
| **NC1: Jointly agreed plan** | **PR1** | Yes |
| | **PR2** | 0 |
| | **PR3** | Yes |
| **NC2: Social Care Maintenance** | **PR4** | Yes |
| **NC3: NHS commissioned Out of Hospital Services** | **PR5** | 0 |
| **NC4: Implementing the BCF policy objectives** | **PR6** | Yes |
| **Agreed expenditure plan for all elements of the BCF** | **PR7** | Yes |
| **Metrics** | **PR8** | Yes |

# Annex A4(i):

**Better Care Fund 2024-25 Update Template**

**4. Capacity & Demand**

Selected Health and Wellbeing Board: York

| Hospital Discharge | Capacity surplus. Not including spot purchasing | | | | | | | | | | | | Capacity surplus (including spot puchasing) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Capacity - Demand (positive is Surplus)** | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
| Reablement & Rehabilitation at home (pathway 1) | 46 | 33 | 49 | 48 | 47 | 50 | 51 | 53 | 52 | 53 | 55 | 55 | 60 | 43 | 63 | 62 | 61 | 65 | 66 | 69 | 68 | 69 | 71 | 71 |
| Short term domiciliary care (pathway 1) | -15 | -8 | -14 | -14 | -15 | -15 | -14 | -15 | -16 | -15 | -15 | -15 | -6 | -3 | -6 | -5 | -6 | -6 | -5 | -6 | -6 | -5 | -6 | -5 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | -4 | -5 | -7 | -6 | -4 | -6 | -7 | -7 | -5 | -6 | -8 | -7 | -2 | -2 | -3 | -3 | -2 | -3 | -3 | -3 | -2 | -2 | -3 | -3 |
| Other short term bedded care (pathway 2) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | -3 | -2 | -2 | -2 | -3 | -2 | -3 | -3 | -3 | -3 | -3 | -3 | -2 | -1 | -1 | -1 | -2 | -1 | -2 | -2 | -1 | -2 | -2 | -2 |

**Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.**

The Home from Hospital Scheme provides critical support to pathway 0 patients. We also have the York Integrated Care Team who carry a caseload of 3,000 frail patients and support discharge and admission avoidance. Other schemes that will support this include, the Supported Discharge Service. We have a Hospital at Home Service as well as utilising the YICT to provide antipatory care which will help to keep patients out of hopsital in the first place. Based on May 2024 data (latest data), 73 patients per month are receiving voluntary care sector support to enable Pathway 0 discharges, and we therefore estimate that 876 people will require this type of service per year.

| Capacity - Hospital Discharge | | Refreshed planned capacity (not including spot purchased capacity | | | | | | | | | | | | Capacity that you expect to secure through spot purchasing | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Service Area** | **Metric** | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
| Reablement & Rehabilitation at home (pathway 1) | Monthly capacity. Number of new packages commenced. | 49 | 35 | 51 | 51 | 51 | 53 | 54 | 56 | 56 | 56 | 58 | 58 | 14 | 10 | 14 | 14 | 14 | 15 | 15 | 16 | 16 | 16 | 16 | 16 |
| Reablement & Rehabilitation at home (pathway 1) | Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased) | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | | | | | | | | | | | | |
| Short term domiciliary care (pathway 1) | Monthly capacity. Number of new packages commenced. | 32 | 18 | 30 | 32 | 33 | 34 | 31 | 34 | 35 | 35 | 33 | 35 | 9 | 5 | 8 | 9 | 9 | 9 | 9 | 9 | 10 | 10 | 9 | 10 |
| Short term domiciliary care (pathway 1) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | 24 | | | | | | | | | | | | |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly capacity. Number of new packages commenced. | 7 | 11 | 14 | 13 | 9 | 12 | 16 | 14 | 10 | 14 | 17 | 16 | 2 | 3 | 4 | 3 | 2 | 3 | 4 | 4 | 3 | 4 | 5 | 4 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 | | | | | | | | | | | | |
| Other short term bedded care (pathway 2) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other short term bedded care (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | | | | |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Monthly capacity. Number of new packages commenced. | 6 | 4 | 4 | 4 | 6 | 4 | 4 | 4 | 7 | 4 | 4 | 4 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | | | | | | | | | | | | |

| Demand - Hospital Discharge | | Please enter refreshed expected no. of referrals: | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pathway** | **Trust Referral Source** | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
| **Total Expected Discharges:** | Total Discharges | **70** | **50** | **73** | **74** | **74** | **76** | **78** | **80** | **80** | **80** | **83** | **83** |
| Reablement & Rehabilitation at home (pathway 1) | Total | **3** | **2** | **2** | **3** | **4** | **3** | **3** | **3** | **4** | **3** | **3** | **3** |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST | 3 | 2 | 2 | 3 | 4 | 3 | 3 | 3 | 4 | 3 | 3 | 3 |
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| **Short term domiciliary care (pathway 1)** | Total | **47** | **26** | **44** | **46** | **48** | **49** | **45** | **49** | **51** | **50** | **48** | **50** |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST | 47 | 26 | 44 | 46 | 48 | 49 | 45 | 49 | 51 | 50 | 48 | 50 |
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| **Reablement & Rehabilitation in a bedded setting (pathway 2)** | Total | **11** | **16** | **21** | **19** | **13** | **18** | **23** | **21** | **15** | **20** | **25** | **23** |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST | 11 | 16 | 21 | 19 | 13 | 18 | 23 | 21 | 15 | 20 | 25 | 23 |
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| **Other short term bedded care (pathway 2)** | Total | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
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| **Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)** | Total | **9** | **6** | **6** | **6** | **9** | **6** | **7** | **7** | **10** | **7** | **7** | **7** |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST | 9 | 6 | 6 | 6 | 9 | 6 | 7 | 7 | 10 | 7 | 7 | 7 |
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Annex A4(ii):

**Better Care Fund 2024-25 Update Template**

**4. Capacity & Demand**

Selected Health and Wellbeing Board: York

Community — Refreshed capacity surplus:

| Capacity - Demand (positive is Surplus) | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Urgent Community Response | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation at home | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other short-term social care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Average LoS/Contact Hours

| Full Year | Units |
|---|---|
| 0 | Contact Hours |
| 0 | Contact Hours |
| 43.23 | Contact Hours |
| 41 | Average LoS |
| 0 | Contact Hours |

**Capacity - Community**

Please enter refreshed expected capacity:

| Service Area | Metric | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | Monthly capacity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Urgent Community Response | Monthly capacity. Number of new clients. | 101 | 105 | 101 | 105 | 105 | 101 | 105 | 101 | 105 | 105 | 95 | 105 |
| Reablement & Rehabilitation at home | Monthly capacity. Number of new clients. | 64 | 61 | 63 | 60 | 66 | 65 | 67 | 65 | 71 | 75 | 68 | 65 |
| Reablement & Rehabilitation in a bedded setting | Monthly capacity. Number of new clients. | 8 | 10 | 11 | 13 | 12 | 12 | 13 | 13 | 12 | 10 | 16 | 11 |
| Other short-term social care | Monthly capacity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Demand - Community**

Please enter refreshed expected no. of referrals:

| Service Type | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Urgent Community Response | 101 | 105 | 101 | 105 | 105 | 101 | 105 | 101 | 105 | 105 | 95 | 105 |
| Reablement & Rehabilitation at home | 64 | 61 | 63 | 60 | 66 | 65 | 67 | 65 | 71 | 75 | 68 | 65 |
| Reablement & Rehabilitation in a bedded setting | 8 | 10 | 11 | 13 | 12 | 12 | 13 | 13 | 12 | 10 | 16 | 11 |
| Other short-term social care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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Annex A5:

# Better Care Fund 2024-25 Update Template

**5. Income**

Selected Health and Wellbeing Board: York

| Local Authority Contribution | |
|---|---|
| Disabled Facilities Grant (DFG) | Gross Contribution |
| York | £1,601,197 |
| | |
| DFG breakdown for two-tier areas only (where applicable) | |
| | |
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| | |
| **Total Minimum LA Contribution (exc iBCF)** | **£1,601,197** |

| Local Authority Discharge Funding | Contribution |
|---|---|
| York | £1,254,495 |

| ICB Discharge Funding | Previously entered | Updated | Comments - Please use this box to clarify any specific uses or sources of funding |
|---|---|---|---|
| NHS Humber and North Yorkshire ICB | £1,431,567 | £1,431,567 | |
| | | | |
| | | | |
| **Total ICB Discharge Fund Contribution** | £1,431,567 | £1,431,567 | |

| iBCF Contribution | Contribution |
|---|---|
| York | £5,368,798 |
| | |
| **Total iBCF Contribution** | **£5,368,798** |

| Local Authority Additional Contribution | Previously entered | Updated | Comments - Please use this box to clarify any specific uses or sources of funding |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total Additional Local Authority Contribution** | **£0** | **£0** | |

| NHS Minimum Contribution | Contribution |
|---|---|
| | £15,725,320 |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total NHS Minimum Contribution** | **£15,725,320** |

| Additional ICB Contribution | Previously entered | Updated | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|---|
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| **Total Additional NHS Contribution** | **£0** | **£0** | |
| **Total NHS Contribution** | **£15,725,320** | **£15,725,320** | |

| | 2024-25 |
|---|---|
| **Total BCF Pooled Budget** | **£25,381,376** |

| **Funding Contributions Comments**<br>Optional for any useful detail e.g. Carry over |
|---|
| |

**See next sheet for Scheme Type (and Sub Type) descriptions**

# Better Care Fund 2024-25 Update Template

**6. Expenditure**

To Add New Schemes

Selected Health and Wellbeing Board: York

<< Link to summary sheet

| Running Balances | 2024-25 Income | Expenditure | Balance |
|---|---|---|---|
| DFG | £1,601,197 | £1,601,197 | £0 |
| Minimum NHS Contribution | £15,725,320 | £15,725,319 | £1 |
| iBCF | £5,368,798 | £5,368,798 | £0 |
| Additional LA Contribution | £0 | £0 | £0 |
| Additional NHS Contribution | £0 | £0 | £0 |
| Local Authority Discharge Funding | £1,254,495 | £1,254,495 | £0 |
| ICB Discharge Funding | £1,431,567 | £1,431,567 | £0 |
| **Total** | **£25,381,376** | **£25,381,376** | **£0** |

**Required Spend**

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

| | 2024-25 Minimum Required Spend | Planned Spend | Under Spend |
|---|---|---|---|
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £4,549,751 | £8,139,160 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £7,450,197 | £7,720,545 | £0 |

**Checklist**

Column complete:

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | |

**>> Incomplete fields on row number(s):**

272, 273, 274, 275, 276, 277

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | **Previously entered Outputs for 2024-25** | Updated Outputs for 2024-25 | Units | **Planned Expenditure** Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) | Provider | Source of Funding | New/ Existing Scheme | Previously entered Expenditure for 2024-25 | Updated Expenditure for 2024-25 (£) | % of Overall Spend (Average) | Do you wish to update? | Comments if updated e.g. reason for the changes made |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | DFG and Falls | DFG | DFG Related Schemes | Discretionary use of DFG | | 245 | 245 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG | Existing | £1,467,977 | £1,601,197 | 76% | Yes | differential uplift applied |
| 2 | Packages of Care - Care at Home | Care package pressures due to demographic changes | Home Care or Domiciliary Care | Domiciliary care packages | | 123568 | 123568 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £3,133,481 | £3,344,305 | 11% | Yes | differential uplift applied |
| 3 | Packages of Care - Care at Home | Care package pressures due to demographic changes | Home Care or Domiciliary Care | Domiciliary care packages | | 49578 | 49578 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | iBCF | Existing | £1,189,878 | £1,417,015 | 4% | Yes | 3.5% uplift applied |
| 4 | Packages of Care - Care at Home | Care package contingency re Winter and COVID pressures | Home Care or Domiciliary Care | Domiciliary care packages | | 6542 | 6542 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £165,886 | £157,000 | 1% | Yes | 3.5% uplift applied |
| 5 | Packages of Care - Care at Home | Care package contingency re Winter and COVID pressures | Home Care or Domiciliary Care | Domiciliary care packages | | 6392 | 6392 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | iBCF | Existing | £153,416 | £164,280 | 1% | Yes | 3.5% uplift applied |
| 6 | Contribution to social work staff | Contribution to Social Work post | Care Act Implementation Related Duties | Other | Early intervention and prevention | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £164,200 | £163,174 | 15% | Yes | 5% uplift applied |
| 7 | Carers Support | Carers centre, support worker posts and carers support | Carers Services | Respite services | | 1099 | 1099 | Beneficiaries | Social Care | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £755,787 | £726,701 | 82% | Yes | 3.5% uplift applied |
| 8 | Contribution to social work staff | Implementation of Care Act | Care Act Implementation Related Duties | Other | Early intervention and prevention | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £524,207 | £510,379 | 48% | Yes | 5% uplift applied |
| 9 | Local Area Coordination | Community Facilitator | Prevention / Early Intervention | Other | Early intervention and prevention | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £29,470 | £29,286 | 2% | Yes | 5% uplift applied |
| 10 | Reablement contract | Reablement (Human Support Group) | Home-based intermediate care services | Reablement at home (to support discharge) | | 617 | 617 | Packages | Social Care | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £1,261,663 | £1,429,000 | 75% | Yes | Balance to overall fund value |
| 11 | FNH and other Step-up/Step-down beds | 10 discharge to assess beds plus 1 flat at Marjorie Waite Court | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement accepting step up and step down users | | 572 | 572 | Number of placements | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £285,263 | £283,482 | 26% | Yes | 5% uplift applied |
| 12 | Telecare and Falls | Be Independent | Assistive Technologies and Equipment | Assistive technologies including telecare | | 224 | 224 | Number of beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £221,923 | £224,108 | 9% | Yes | 6.7% uplift applied |
| 13 | Community Equipment | Be Independent | Assistive Technologies and Equipment | Community based equipment | | 1102 | 1102 | Number of beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £207,439 | £209,480 | 8% | Yes | 6.7% uplift applied |
| 14 | Home adaptations | Be Independent | Housing Related Schemes | | | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £86,625 | £87,723 | 7% | Yes | 7% uplift applied |

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| 15 | Packages of Care - Care at Home | Increased Reablement capacity | Home Care or Domiciliary Care | Domiciliary care packages | | 7703 | 7703 | Hours of care (Unless short-term in which | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | Existing | £184,871 | £191,249 | 1% | Yes | 3.5% uplift applied |
| 16 | Self-support champions | Self-support champions | Prevention / Early Intervention | Social Prescribing | | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | Existing | £109,342 | £114,810 | 6% | Yes | differential uplift applied |
| 17 | Ways to Wellbeing | Social Prescribing - Ways to Wellbeing | Prevention / Early Intervention | Social Prescribing | | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | Existing | £167,663 | £0 | 10% | Yes | withdrawn |
| 18 | Ways to Wellbeing | Social Prescribing - Ways to Wellbeing | Prevention / Early Intervention | Social Prescribing | | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £2,113 | £0 | 0% | Yes | withdrawn |
| 19 | Live Well York | Improved curation of Information and advice | Prevention / Early Intervention | Social Prescribing | | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | Existing | £54,649 | £5,000 | 3% | Yes | withdrawn |
| 20 | Alcohol prevention | Alcohol advice | Prevention / Early Intervention | Social Prescribing | | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £54,995 | £35,000 | 3% | Yes | Per Peter Roderick DPH |
| 21 | Contribution to social work staff | 7 day working | High Impact Change Model for Managing Transfer of Care | Other | Chg 5. Seven-Day Services | | 0 | | Social Care | | LA | | | Local Authority | iBCF | Existing | £223,637 | £99,565 | 95% | Yes | Discharge Liaison only |
| 22 | Local Area Coordination | Local Area Coordination | Prevention / Early Intervention | Other | Early intervention and prevention | | 0 | | Social Care | | LA | | | Local Authority | iBCF | Existing | £328,722 | £386,108 | 19% | Yes | differential uplift applied |
| 23 | BCF support role | Performance Support role | Other | | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £0 | | 0% | No | Existing |
| 24 | Venn capacity and demand | Capacity and demand exercise | Other | | | | | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £0 | | 0% | No | Existing |
| 25 | Physiotherapy in step-down beds | Physiotherapy in step-down beds | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | | 104 | 104 | Number of placements | Social Care | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £49,092 | £46,462 | 4% | Yes | No uplift applied |
| 26 | CRT | Community Response Team (Expanding care at home) | Community Based Schemes | Integrated neighbourhood services | | | 0 | | Community Health | | LA | | | NHS Community Provider | iBCF | Existing | £119,817 | £126,000 | 0% | Yes | Existing |
| 27 | Home from Hospital | Home from Hospital | Home Care or Domiciliary Care | Domiciliary care packages | | 2340 | 2340 | Hours of care (Unless short-term in which | Social Care | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £33,684 | £32,045 | 0% | Yes | National uplift applied |
| 28 | Home from Hospital | Home from Hospital | Home Care or Domiciliary Care | Domiciliary care packages | | 1560 | 1560 | Hours of care (Unless short-term in which | Social Care | | NHS | | | Charity / Voluntary Sector | iBCF | Existing | £23,315 | £23,480 | 0% | Yes | differential uplift applied |
| 29 | Packages of Care - Placements | 5 Additional Short term Stepdown/up beds. | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement accepting step up and step down users | | 45 | 45 | Number of placements | Social Care | | LA | | | Private Sector | iBCF | Existing | £40,170 | £41,576 | 4% | Yes | 3.5% uplift applied |
| 30 | Packages of Care - Placements | Res and nursing beds over Winter | Residential Placements | Care home | | 256 | 256 | Number of beds | Social Care | | LA | | | Private Sector | iBCF | Existing | £230,720 | £238,795 | 0% | Yes | 3.5% uplift applied |
| 31 | Packages of Care - Placements | Secure capacity to enable placements to be made to reduce impact on DTOC's. | Residential Placements | Care home | | 402 | 402 | Number of beds | Social Care | | LA | | | Private Sector | iBCF | Existing | £361,530 | £374,184 | 0% | Yes | 3.5% uplift applied |
| 32 | Packages of Care - Placements | Retaining Home Care Packages "open" for 4 weeks | High Impact Change Model for Managing Transfer of Care | Improved discharge to Care Homes | | | 0 | | Social Care | | LA | | | Private Sector | iBCF | Existing | £14,000 | £14,490 | 6% | Yes | 3.5% uplift applied |
| 33 | Packages of Care - Placements | Live in Care | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) | | 3605 | 3605 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | iBCF | Existing | £86,520 | £89,548 | 0% | Yes | 3.5% uplift applied |
| 34 | Packages of Care - Placements | Be Independent falls Support | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 0 | | Social Care | | LA | | | Local Authority | iBCF | Existing | £20,000 | £21,000 | 0% | Yes | 3.5% uplift applied |
| 35 | YICT | York Integrated Care Team | Integrated Care Planning and Navigation | Care navigation and planning | | | 0 | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £1,128,703 | £1,076,787 | 13% | Yes | National uplift applied |
| 36 | Urgent Care Practitioners | Urgent Care Practitioners | Community Based Schemes | Other | Rapid / Crisis response | | 0 | | Community Health | | NHS | | | NHS Acute Provider | Minimum NHS Contribution | Existing | £666,885 | £638,734 | 2% | Yes | National uplift applied |
| 37 | Hospice at Home | Hospice at Home (extended hours and part funded with NYCC) | Home Care or Domiciliary Care | Domiciliary care packages | | 6374 | 6374 | Hours of care (Unless short-term in which | Community Health | | NHS | | | Local Authority | Minimum NHS Contribution | Existing | £182,874 | £174,116 | 1% | Yes | National uplift applied |
| 38 | MH Crisis response | Street Triage | Community Based Schemes | Other | Rapid / Crisis response | | 0 | | Mental Health | | NHS | | | NHS Mental Health Provider | Minimum NHS Contribution | Existing | £181,721 | £173,019 | 1% | Yes | National uplift applied |
| 39 | CCG Out of Hospital commission | Incl. Specialist Nursing, Integrated Community Teams, Community Therapies | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 0 | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £5,513,582 | £5,637,370 | 17% | Yes | National uplift applied |
| 40 | CCG Out of Hospital commission | Incl. Specialist Nursing, Integrated Community Teams, Community Therapies | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 0 | | Community Health | | NHS | | | NHS Community Provider | iBCF | Existing | £1,691,623 | £1,696,357 | 6% | Yes | differential uplift applied |
| 41 | A Bed Ahead | Changing Lives - A Bed Ahead | Housing Related Schemes | | | | 0 | | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £88,625 | £84,381 | 7% | Yes | National uplift applied |
| 42 | FNH and other Step-up/Step-down beds | Fulford Nursing Home | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement (to support discharge) | | 104 | 104 | Number of placements | Community Health | | NHS | | | Private Sector | iBCF | Existing | £205,896 | £224,341 | 20% | Yes | differential uplift applied |

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| 43 | Rapid Assessment and Therapy Service | RATS Extended Hours | Other | | | | 0 | | Acute | | NHS | | | NHS Acute Provider | Minimum NHS Contribution | Existing | £192,280 | £182,435 | 5% | Yes | National uplift applied (net of QEP and convergence) |
| 44 | Rapid Assessment and Therapy Service | RATS Extended Hours - Social Worker | Other | | | | 0 | | Social Care | | NHS | | | Local Authority | Minimum NHS Contribution | Existing | £62,812 | £62,419 | 2% | Yes | 5% uplift applied |
| 45 | Vaccinations | Vaccinations of Homeless | Prevention / Early Intervention | Other | Prevention | | 0 | | Primary Care | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £4,321 | £4,123 | 0% | Yes | 5% uplift applied |
| 46 | FNH and other Step-up/Step-down beds | Nursing short stay beds | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement accepting step up and step down users | | 91 | 74 | Number of placements | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £96,616 | £74,000 | 9% | Yes | 3.5% uplift applied |
| 47 | FNH and other Step-up/Step-down beds | Nursing short stay beds | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement accepting step up and step down users | | 49 | 71 | Number of placements | Social Care | | LA | | | Private Sector | iBCF | Existing | £49,000 | £71,000 | 5% | Yes | 3.5% uplift applied across scheme |
| 48 | Dementia Support | Dementia - support to individuals and carers | Community Based Schemes | Other | Dementia support | | 0 | | Mental Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £35,723 | £33,809 | 0% | Yes | Roundings |
| 49 | NQ project | Northern quarter project manager (grade 9) | Enablers for Integration | Programme management | | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £22,020 | £21,882 | 10% | Yes | 5% uplift applied |
| 50 | CCG VCS contracts | Various CCG VCS contracts | Community Based Schemes | Other | Voluntary Sector | | 0 | | Social Care | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £220,252 | £209,704 | 1% | Yes | National uplift applied |
| 51 | Move Mates | Move the Masses | Prevention / Early Intervention | Other | Voluntary Sector | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £44,647 | £26,250 | 2% | Yes | Within scope of ongoing review |
| 52 | Cultural commissioning | Various VCSE small grants | Prevention / Early Intervention | Other | Voluntary Sector | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | Existing | £31,698 | £20,000 | 2% | Yes | Within scope of ongoing review |
| 53 | Small Tasks at Home | Small grants maintaining people's homes | Prevention / Early Intervention | Other | Voluntary Sector | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | iBCF | Existing | £32,331 | £0 | 2% | Yes | Commissioning review and reduced service requirement |
| 54 | Hospice at Home | End of Life Project | Community Based Schemes | Other | Voluntary Sector | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £35,514 | £0 | 0% | Yes | withdrawn |
| 55 | Health Champions | Health Champions | Prevention / Early Intervention | Social Prescribing | | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £48,447 | £48,145 | 3% | Yes | 5% uplift applied |
| 56 | Packages of Care - Care at Home | Rapid response | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) | | 8237 | 0 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £224,468 | £0 | 1% | Yes | withdrawn |
| 57 | Packages of Care - Care at Home | Rapid response | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) | | 1939 | 1481 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | iBCF | Existing | £50,000 | £50,000 | 0% | Yes | Balance to overall fund value |
| 58 | Residential care beds | 5 additional residential beds | Residential Placements | Short-term residential/nursing care for someone likely to require a | | | 0 | Number of beds | Social Care | | LA | | | Local Authority | Local Authority Discharge | Existing | £518,182 | £402,748 | 0% | Yes | Balance to overall fund value |
| 59 | Nursing care beds | 4 additional nursing beds | Residential Placements | Nursing home | | 335 | 335 | Number of beds | Social Care | | LA | | | Local Authority | Local Authority Discharge | Existing | £329,593 | £370,265 | 0% | Yes | Balance to overall fund value |
| 60 | Home Care | Additional care at home capacity | Home Care or Domiciliary Care | Domiciliary care packages | | 19048 | 19048 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Local Authority Discharge | Existing | £401,702 | £481,482 | 1% | Yes | Balance to overall fund value |
| 61 | Expansion of CRT | Community Response Team (Expanding care at home) | Community Based Schemes | Integrated neighbourhood services | | | 0 | | Community Health | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | £263,980 | £0 | 1% | Yes | withdrawn |
| 62 | Trusted assessor | Trusted assessor provided from local care homes | Integrated Care Planning and Navigation | Assessment teams/joint assessment | | | 0 | | Social Care | | NHS | | | Private Sector | ICB Discharge Funding | New | £41,273 | £0 | 0% | Yes | withdrawn |
| 63 | Additional reablement | Increased Reablement capacity | Home-based intermediate care services | Reablement at home (to support discharge) | | 94 | 0 | Packages | Social Care | | NHS | | | Private Sector | ICB Discharge Funding | Existing | £191,265 | £0 | 8% | Yes | withdrawn |
| 64 | Supported discharge service | Voluntary sector supported discharge service | Community Based Schemes | Low level support for simple hospital discharges (Discharge to Assess pathway | | | 0 | | Community Health | | NHS | | | Charity / Voluntary Sector | ICB Discharge Funding | Existing | £141,544 | £100,000 | 0% | Yes | Commissioning review and reduced service requirement |
| 65 | Additional step down beds | 8 additional beds for 26 weeks | Residential Placements | Short-term residential/nursing care for someone likely to require a | | | 0 | Number of beds | Social Care | | NHS | | | Private Sector | ICB Discharge Funding | Existing | £353,295 | £204,812 | 0% | Yes | Commissioning review and reduced service requirement |
| 66 | Discharge co-ordinator (LA) | Additional social work support | Integrated Care Planning and Navigation | Assessment teams/joint assessment | | | 0 | | Social Care | | NHS | | | Local Authority | ICB Discharge Funding | Existing | £97,666 | £65,733 | 1% | Yes | Commissioning review and reduced service requirement |
| 67 | Discharge co-ordinator (ICB) | Continuation of CHC nursing support | Integrated Care Planning and Navigation | Assessment teams/joint assessment | | | 0 | | Continuing Care | | NHS | | | NHS | ICB Discharge Funding | Existing | £93,041 | £0 | 1% | Yes | withdrawn |
| 68 | Immedicare | Fund Immedicare contract across the City care homes | Assistive Technologies and Equipment | Assistive technologies including telecare | | 1283 | 1283 | Number of beneficiaries | Community Health | | NHS | | | Private Sector | ICB Discharge Funding | Existing | £249,503 | £176,272 | 8% | Yes | Reduced contract value |

Back to top

## Adding New Schemes:

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | | Outputs for 2024-25 | Units (auto-populate) | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) (auto-populate) | Provider | Source of Funding | New/ Existing Scheme | | Expenditure for 2024-25 (£) | % of Overall Spend |
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| 69 | Additional OT to support early discharge | Additional OT to support early discharge | Community Based Schemes | Integrated neighbourhood services | | | | | Continuing Care | | NHS | | | Local Authority | ICB Discharge Funding | New | | £48,000 | 0% |
| 70 | Community Hospitals DLN | Discharge Liaison Nurse | Community Based Schemes | Integrated neighbourhood services | | | | | Continuing Care | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | | £49,145 | 0% |
| 71 | DLN support to wards, Pathway 0 discharges | Discharge Liaison Nurse | Community Based Schemes | Integrated neighbourhood services | | | | | Continuing Care | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | | £49,145 | 0% |
| 72 | Frailty Hub (A&G and HfH - Apr-Jun) | Advice and Guidance and Home from Hospital | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | Private Sector | ICB Discharge Funding | New | | £63,350 | 0% |
| 73 | Frailty Hub | Multi-disciplinary team supporting frailty in the community | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS | ICB Discharge Funding | New | | £254,939 | 1% |
| 74 | CCG Out of Hospital commission | Incl. Specialist Nursing, Integrated Community Teams, Community Therapies | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS | ICB Discharge Funding | New | | £420,171 | 2% |

## Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

### 2023-25 Revised Scheme types

| Number | Scheme type/ services | Sub type | Description |
|---|---|---|---|
| 1 | Assistive Technologies and Equipment | 1. Assistive technologies including telecare<br>2. Digital participation services<br>3. Community based equipment<br>4. Other | Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services). |
| 2 | Care Act Implementation Related Duties | 1. Independent Mental Health Advocacy<br>2. Safeguarding<br>3. Other | Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF. |
| 3 | Carers Services | 1. Respite Services<br>2. Carer advice and support related to Care Act duties<br>3. Other | Supporting people to sustain their role as carers and reduce the likelihood of crisis.<br><br>This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. |
| 4 | Community Based Schemes | 1. Integrated neighbourhood services<br>2. Multidisciplinary teams that are supporting independence, such as anticipatory care<br>3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0)<br>4. Other | Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams)<br><br>Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home' |

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| 5 | DFG Related Schemes | 1. Adaptations, including statutory DFG grants<br>2. Discretionary use of DFG<br>3. Handyperson services<br>4. Other | The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.<br><br>The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate |
| 6 | Enablers for Integration | 1. Data Integration<br>2. System IT Interoperability<br>3. Programme management<br>4. Research and evaluation<br>5. Workforce development<br>6. New governance arrangements<br>7. Voluntary Sector Business Development<br>8. Joint commissioning infrastructure<br>9. Integrated models of provision<br>10. Other | Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes.<br><br>Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others. |
| 7 | High Impact Change Model for Managing Transfer of Care | 1. Early Discharge Planning<br>2. Monitoring and responding to system demand and capacity<br>3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge<br>4. Home First/Discharge to Assess - process support/core costs<br>5. Flexible working patterns (including 7 day working)<br>6. Trusted Assessment<br>7. Engagement and Choice<br>8. Improved discharge to Care Homes<br>9. Housing and related services<br>10. Red Bag scheme<br>11. Other | The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section. |
| 8 | Home Care or Domiciliary Care | 1. Domiciliary care packages<br>2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)<br>3. Short term domiciliary care (without reablement input)<br>4. Domiciliary care workforce development<br>5. Other | A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services. |
| 9 | Housing Related Schemes | | This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units. |

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| 10 | Integrated Care Planning and Navigation | 1. Care navigation and planning<br>2. Assessment teams/joint assessment<br>3. Support for implementation of anticipatory care<br>4. Other | Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals.<br><br>Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams.<br><br>Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside. |
| 11 | Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery) | 1. Bed-based intermediate care with rehabilitation (to support discharge)<br>2. Bed-based intermediate care with reablement (to support discharge)<br>3. Bed-based intermediate care with rehabilitation (to support admission avoidance)<br>4. Bed-based intermediate care with reablement (to support admissions avoidance)<br>5. Bed-based intermediate care with rehabilitation accepting step up and step down users<br>6. Bed-based intermediate care with reablement accepting step up and step down users<br>7. Other | Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. |
| 12 | Home-based intermediate care services | 1. Reablement at home (to support discharge)<br>2. Reablement at home (to prevent admission to hospital or residential care)<br>3. Reablement at home (accepting step up and step down users)<br>4. Rehabilitation at home (to support discharge)<br>5. Rehabilitation at home (to prevent admission to hospital or residential care)<br>6. Rehabilitation at home (accepting step up and step down users)<br>7. Joint reablement and rehabilitation service (to support discharge)<br>8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)<br>9. Joint reablement and rehabilitation service (accepting step up and step down users)<br>10. Other | Provides support in your own home to improve your confidence and ability to live as independently as possible |
| 13 | Urgent Community Response | | Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. |
| 14 | Personalised Budgeting and Commissioning | | Various person centred approaches to commissioning and budgeting, including direct payments. |

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| 15 | Personalised Care at Home | 1. Mental health /wellbeing<br>2. Physical health/wellbeing<br>3. Other | Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type. |
| 16 | Prevention / Early Intervention | 1. Social Prescribing<br>2. Risk Stratification<br>3. Choice Policy<br>4. Other | Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being. |
| 17 | Residential Placements | 1. Supported housing<br>2. Learning disability<br>3. Extra care<br>4. Care home<br>5. Nursing home<br>6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement<br>7. Short term residential care (without rehabilitation or reablement input)<br>8. Other | Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home. |
| 18 | Workforce recruitment and retention | 1. Improve retention of existing workforce<br>2. Local recruitment initiatives<br>3. Increase hours worked by existing workforce<br>4. Additional or redeployed capacity from current care workers<br>5. Other | These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work. |
| 19 | Other | | Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column. |

| Scheme type | Units |
|---|---|
| Assistive Technologies and Equipment | Number of beneficiaries |
| Home Care or Domiciliary Care | Hours of care (Unless short-term in which case it is packages) |
| Bed based intermediate Care Services | Number of placements |
| Home-based intermediate care services | Packages |
| Residential Placements | Number of beds |
| DFG Related Schemes | Number of adaptations funded/people supported |
| Workforce Recruitment and Retention | WTE's gained |
| Carers Services | Beneficiaries |

## Better Care Fund 2024-25 Update Template

**7. Narrative updates**

Selected Health and Wellbeing Board: York

**Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.**

### 2024-25 capacity and demand plan

**Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.**

The BCF Delivery Group regularly reviews the effectiveness of all schemes in supporting the BCF national metrics as well as ensuring we continue to reduce inequalities across the city. Our integrated data sets enable us to specifically target high risk areas with enhanced support offers. We have used our Adult Social Care Management Systems as sources of data to forecast capacity and demand within the community, based on our historical trends. To understand the capacity and demand in the hospitals, we used the NHS Operational Plan estimates along with the internal database to understand the levels of activity we aim to achieve. We work closely as a system to meet the demand on our hospital services by creating the capacity within the community (and equally for our hospitals). A breakdown of the expected numbers monthly can be found on the planning template.

Our current Social Care Data shows an increase in referrals into our front door services, building up a waiting list for people awaiting assessment. We have also seen an increase in referrals for our LAC service where demand has almost doubled in the past 5 months. Data received from Age UK and the CVS also shows significant increases of over 60% into low level early intervention services across York.

We acknowledge that there are some areas where we currently do not capture, as a service, the levle of data in the requested format. We are looking to set up a mechanism in year to reflect this including the development of a BCF performance card this will also involve a re-evaluation of the metrics in the scorecards to determine what outcomes and key performance measures can be attached to each scheme, in addition to the core BCF metrics. A report on the outcome of the appraisal of each of the schemes in the Better Care Fund will be presented to the Board when the work has been completed.

**Checklist Complete:** Yes

**Linked KLOEs (For information)**

Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?

**Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?**

Partnership Working Groups support each programme area, ensuring we reduce duplication, align eligibility criteria, and explore joint training for our multi-disciplinary workforce. These groups also support implementation of our Integrated UEC and Community Offers (York Health and Care Partnership priorities), through work such as the development of the Frailty Hubs and Urgent and Emergency Care redesign.

Partners work collaboratively to jointly commission key services and we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents. Through the further development of the frailty hub we have developed a proactive place-based model of delivery, integrating the community health and social care offer. This involves proactive identification of individuals with complex needs, for example frailty and multiple long terms conditions, using data provided by our population health hub. Individuals have a comprehensive assessment, and review carried out by the right professional, development of personalised care and support plans resulting in the delivery of a range of health and social care interventions to support them to remain well and maintain their independence at home. We are looking to further expand the service and integrate more teams to offer a single point of access across Primary Care Networks. By varying capacity throughout the year to ensure capacity is aligned appropriately to take into consideration at times of greater need we are able to flex social care and NHS service to ensure to maximise the BCF. This includes the availability of reablement and social care beds in times over winter and reduce the beds and hours over periods of reduced demand.

Yes

Does the plan describe any changes to commissioned intermediate care to address gaps and issues?

Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?

**What impacts do you anticipate as a result of these changes for:**

**i. Preventing admissions to hospital or long term residential care?**

The BCF is led through partnership working at Place. Our Partnership is inclusive of our vibrant voluntary and community sector and Independent Care Group representing care homes and domiciliary care agencies.

We are committed to early intervention and preventative approaches, supporting early discharge of people who require hospital admission and providing support for people to remain at home for longer. Working together we are further developing strength-based approaches, supporting people and communities to build on their strengths, introducing self-care models of care and support building resilience and independence. Through partnership working we are developing stronger healthier communities by listening to what matters to our citizens and codeveloping services to meet needs.

Schemes that will support admission avoidance - funded via BCF:

1. Home from Hospital - providing critical support for pathway 0 discharges
2. Urgent Care Practioners - avoiding admissions by treating people at the scene as opposed to conveying to ED
3. Changing Lives - A Bed Ahead - Discharge support primarily for homeless people
4. York Integrated Care Team - Anticipatory Care, carry a caseload of 3,000 frail patients, short term support for patients, HCA support step up from RATS in ED, Care co-ordination function for patients on the caseload, running complex cases MDTs to support discharge
5. Rapid Assessment and Therapy Service - ED based team who's focus is to turnaround frail patients.

Admission avoidance - the Frailty Crisis Hub will support admission avoidance and is evidenced by its use by the wider system, with 24 different organisations having used the Frailty A&G line for support since November. The most frequent referring organisations have UCR, YICT, GPs, appropriate self-referrals from patients on the YICT caseload (as determined by YICT triagers), CRT and YAS paramedics. This Winter, ED conveyances across East Riding, Hull and North Yorkshire increased by an average 33%, whereas there was only a 1% increase York

Yes

Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

**ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?**

As a system we are committed to reducing the number of unnecessary admissions into hospital, through helping more people to be supported at home with the right service and right support through a person-centred approach. A key aim of the Better Care Fund, and the Discharge Fund, is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. We acknowledge that some schemes are part of existing core services, however through innovative approaches and commissioning we are looking at ways to move resources and funds around the BCF and several sub contractual arrangements. These approaches include the expansion of an existing in-reach model aimed at identifying patients in ED who have low level needs and an admission can be avoided. With additional funding we have been able to expand the service by increasing the workforce meaning further reach into the hospital (SDEC/wards) to bring patients, facillitating earlier discharge.

The three scheme areas within the BCF are:

- Early Invention and Prevention
- Intermediate Care and Reablement
- Core Contracted Schemes

Yes

Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

**Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.**

We commissioned a review on our intermediate care services across the system. The review highlighted key areas for the system to consider:

- York has sufficient care services in the system; however, these services were not being utilised and allocated in the most effective way
- Our community and voluntary sector is a great asset in reducing admissions and enhancing this would have a greater impact on reducing admissions.
- An integrated approach to reablement and intermediate care would be beneficial and equally some initial quick wins were identified to improve pathways.

Following the review, a number of immediate and long-term recommendations were put forward for the system to consider and action. These were:

- Changes in eligibility criteria for intermediate care and reablement services based on need rather than service delivery
- Amalgamation of current intermediate care services as there are many different pathways and access points making pathways difficult to navigate
- Review of the discharge hub to develop an integrated hub
- Intermediate care and reablement alignment
- Embed home first approaches across the discharge pathways
- Additional investment into Occupational Therapy
- Further partnerships with the VCSE to support early discharge and admission avoidance using the BCF as a lever
- Develop a community single point of access to support care navigation
- Integrate a holistic mental health offer into our community services
- Improve data flows and interpretation of local data to ensure service improvements are data driven and prioritised based on local need.
- Enhance partnerships between health and social care regarding Urgent and Emergency Care.

During 2024-25 of our BCF plan, we aim to implement the recommendations of the system review and further build on the work carried out in 22/23, with a focus on innovation and enhancing digital options.

Yes

Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?

**Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?**

**Yes**

Yes

**Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.**

Demand by pathway was initially based on the NHS operational plan, and was subsequently adjusted based on local intelligence.

We have made significant progress in strengthening our data flows and will continue to build on this progress between 2023-2025. Data clearly shows that we have seen increases in access for all areas across the system through primary care, early intervention, secondary care and social care. We have seen some of the largest demand on our community voluntary sector services, reablement and intermediate care services in recent years.

Yes

Has the area described how shared data has been used to understand demand and capacity for different types of in

## Approach to using Additional Discharge Funding to improve

**Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.**

We will ensure that available funds are directed to schemes that create the biggest outcomes for people, reducing inequalities and the need for acute care. We will continue to offer versatile services that are responsive reducing delays in discharges as well as supporting people with long term conditions through our developing frailty hub.

We understand the need to ensure we have a responsive well skilled workforce and through our joint workforce board we are working towards a multi-agency approach to training using generalist training models for health and care staff. We will further build on our intermediate care offer reflecting the needs of our wider population including people with dementia, mental health issues, learning disabilities and those with autism. Our jointly commissioned BCF services continue to:

- Reduce the need for ongoing support through social care, promoting independence and control
- Continue to enhance our VCSE and utilise resources to promote early intervention and prevention approaches.
- Build on the strength of local communities and provide services that build on peoples own abilities and strengths
- Enhance personalised care and support through commissioning tailored support through personal budgets
- Enhance mental health and wellbeing services building on the mental health hub and the connecting our city programme.
- Reduce waiting times for people contacting social care
- Reduce length of stay within a hospital setting through enhancing rapid response services and in reach integrated teams

Discharge Destination
There is an ackowledgement that higher levels of acuity continue to result in discharges that are not consistent with usual places of residence – patients who would normally be discharged home are often requiring additional onward/packages of care preventing them from being discharged to their usual place of residence in some cases. Our ambition is to ensure that all patients are discharged to their usual place of residence without the need for additional or onward care which prevents this. The Frailty Crisis Hub and the in-reach model are good examples of how we intend to achieve this ambition (identifying patients before they are admitted and getting them back home/ususal place of residence instead of a potential admission which may then result in additional care needs, preventing the patient from returning home.

The focus of our BCF services remain in line with the BCF policy objectives and national priorities. We will continue to build on the schemes that are supporting the delivery of good outcomes. An integrated workshop was held on the 16th June 2023. The workshop further confirmed agreement from partners to reduce the number of short-term pilots and focus building on effective and efficient BCF schemes that result in positive outcomes.

We are currently updating our 'Preparing for adulthood strategy' to support a seamless approach for young people transitioning out of adult services, particularly considering individuals using mental health services and learning disabilities services as well as those with Special Educational Needs. The policy is being co-produced by people using services and their family and carers. This will enable seamless pathways to services, reducing the number of young people falling through the transitional gap between children's and adult services. We will continue to work with partners, in particular mental health services and the acute trust, to build in specialist support for people who require hospital admission.

Yes

Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan?

Is the plan for spending the additional discharge grant in line with grant conditions?

**Please describe any changes to your Additional discharge fund plans, as a result from**

- **Local learning from 23-24**
- **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**

Through the BCF Delivery Group we will continue to monitor the success of these services and redesign and deflect resources as required. All services developed through the additional funding were agreed following reflection and learning from previous years, including the findings of the national evaluation of the 2022/23 funding. We have agreed that building on existing schemes and redesigning collectively new models will further support the delivery of our target, reducing LoS across all discharge pathways. As a system we may want to ask the LGA to undertake an independent appraisal of its BCF Plan and make improvements based on the outcome and recommendation. Additional funding was used to secure additional bed capacity to support flow through hospital over winter months of significant pressure. Key learning from this has been to ensure that mitigations are in place for the removal of the additional beds whilst still demonstrating timely discharge. Some existing challenges that impacted or limited the impact of the additional funding included

Yes

Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

## Ensuring that BCF funding achieves impact

**What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?**

Partnership Working Groups support each programme area, ensuring we reduce duplication, align eligibility criteria, and explore joint training for our multi-disciplinary workforce. These groups also support implementation of our Integrated UEC and Community Offers (York Health and Care Partnership priorities), through work such as the development of the Frailty Hubs and Urgent and Emergency Care Redesign.

Partners work collaboratively to jointly commission key services and we continue to develop our integrated team model, supporting in-reach and early intervention. Through our shared vision, partners have built strong, trusting relationships with improved communication. This is underpinned by robust governance, leading to effective decision making to improve outcomes for York's residents.

Yes

Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

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## Better Care Fund 2024-25 Update Template

### 7. Metrics for 2024-25

Selected Health and Wellbeing Board: York

### 8.1 Avoidable admissions

*Q4 Actual not available at time of publication

| | | 2023-24 Q1 Actual | 2023-24 Q2 Actual | 2023-24 Q3 Plan | 2023-24 Q4 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population<br><br>(See Guidance) | Indicator value | 207.7 | 205.1 | 186.1 | 181.3 | Local Data 2023-24<br>Q1: 444 Q2: 462 Q3: 451 Q4: 469(provisional)<br><br>2024-25 Plan based on 2023_24 admissions plus *2.6% growth (1873)<br><br>Q1: 456: Q2: 474: Q3: 463: Q4: 481<br>NB: Figures include 0 los as York Trust unlikely to introduce SDEC in 24/25.<br><br>* The 2.6% is the unmitigated growth for NEL beds we used in our capacity demand and flow waterfall in the operational planning submission.<br><br>This was made up of a weighted population growth in the ICB of 0.3%, increasing acuity of patients who are presenting at A&E, an average of c: 40 patients queueing for a bed at midnight across our A&E departments in HNY and a number of medical outliers on surgical wards. | Our community and voluntary sector is a great asset and enhancing this would have a greater impact on reducing admissions. We have several BCF-funded services in place that support admission avoidance, including social workers, occupational therapists and the rapid response team within the emergency department. Proactive social prescribing model for patients with respiratory conditions who live in areas of deprivation and are at high risk of admission to support them to stay well. The Frailty Crisis Hub (part funded through BCF) will support admission avoidance and is evidenced by its use by the wider system, with 24 different organisations having used the Frailty A&G line for support since November. The most frequent referring organisations have UCR, YICT, GPs, appropriate self-referrals from patients on the YICT caseload (as determined by YICT triagers), CRT and YAS paramedics. This Winter, ED conveyances across East Riding, Hull and North Yorkshire increased by an average 33%, whereas there was only a 1% increase York. |
| | Number of Admissions | 465 | 459 | - | - | | |
| | Population | 201,672 | 201,672 | - | - | | |
| | | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan | | |
| | Indicator value | 211.8 | 211.8 | 211.8 | 211.8 | | |

>> link to NHS Digital webpage (for more detailed guidance)

### 8.2 Falls

| | | 2023-24 Plan | 2023-24 estimated | 2024-25 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|
| | Indicator value | 1,966.8 | 2,121.9 | 2,177.0 | 2023-24 estimated: 881<br>2024-25 plan based on *2.6% growth<br>NB: Figures include 0 los as York Trust unlikely to introduce SDEC in 24/25. | The York Integrated Care Team provides anticipatory Care for a caseload of 3,000 frail patients. This involves proactive identification of individuals who may be at risk of an admission (inluding falls risks) using data provided by our population health hub. We anticipate that this scheme will support admission avoidance and emergency |

| | | | | | | |
|---|---|---|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Count | 814 | 881 | 904 | * The 2.6% is the unmitigated growth for NEL beds we used in our capacity demand and flow waterfall in the operational planning submission.<br><br>This was made up of a weighted population growth in the ICB of 0.3%, increasing acuity of patients who are presenting at A&E, an average of c: 40 patients queueing for a bed at midnight across our A&E departments in HNY and a number of medical outliers on surgical wards. | admissions due to falls by identifying these patients prior to crisis point. |
| | Population | 38,874 | 38874 | 38874 | | |

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

**8.3 Discharge to usual place of residence**

*Q4 Actual not available at time of publication

| | | 2023-24 Q1 Actual | 2023-24 Q2 Actual | 2023-24 Q3 Actual | 2023-24 Q4 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | Quarter (%) | 94.0% | 95.2% | 94.6% | 94.3% | Plan is based on 23_24 admissions plus *2.6% growth.<br><br>Moderate increase applied to percentages. | There is an ackowledgement that higher levels of acuity continue to result in discharges that are not consistent with usual places of residence – patients who would normally be discharged home are often requiring additional onward/packages of care preventing them from being discharged to their usual place of residence in some cases. Our ambition is to ensure that all patients are discharged to their usual place of residence without the need for additional or onward care which prevents this.<br><br>Improving Performance and meeting ambitions through the year:<br><br>There are a number of BCF schemes that aim to support patients to remain in the normal place of residence inculding Changing Lives, Hopsice at Home, York Integrated Care Team, Community Response Team (expanding care at home). Running parallel to these schemes are a number of other system initiatives that will also support |
| | Numerator | 3,798 | 4,004 | 3,818 | 3,772 | | |
| | Denominator | 4,039 | 4,205 | 4,036 | 4,000 | | |
| | | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan | | |
| | Quarter (%) | 94.3% | 95.5% | 96.0% | 95.3% | | |
| | Numerator | 3,891 | 4,149 | 4,338 | 4,406 | | |
| | Denominator | 4,126 | 4,343 | 4,520 | 4,623 | | |

**8.4 Residential Admissions**

| | | 2022-23 Actual | 2023-24 Plan | 2023-24 estimated | 2024-25 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 479.5 | 440.6 | 501.8 | 468.6 | The figure was derived using the budgets for 2023-24 and 2024-25. The budget for 2024-25 for OP residential and nursing care is lower than in 2023-24, so the number of new admissions we expect during 2024-25 has been lowered accordingly. | We will continue to use "Home First" support to ensure that people have the most opportunity to be provided with domicilary care services rather than residential / nursing care provision. We have a number of BCF schemes which support this approach including the |
| | Numerator | 187 | 180 | 205 | 194 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| nursing care homes, per 100,000 population | Denominator | 39,000 | 40,850 | 40,850 | 41,402 | | York Integrated Care Team who provide anticipatory care, have a current caseload of frail patients who they activley work with to keep |

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

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**Better Care Fund 2024-25 Update Template**

**8. Confirmation of Planning Requirements**

Selected Health and Wellbeing Board: York

| | Code | 2023-25 Planning Requirement | Key considerations for meeting the planning requirement<br>These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates | Confirmed through | Please confirm whether your BCF plan meets the Planning Requirement? | Please note any supporting documents referred to and relevant page numbers to assist the assurers | Where the Planning requirement is not met, please note the actions in place towards meeting the requirement | Where the Planning requirement is not met, please note the anticipated timeframe for meeting it |
|---|---|---|---|---|---|---|---|---|
| NC1: Jointly agreed plan | **PR1** | **A jointly developed and agreed plan that all parties sign up to** | Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11*<br><br>Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25*<br><br>Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11*<br><br>Have all elements of the Planning template been completed? *Paragraph 11* | Cover sheet<br><br>Cover sheet<br><br>Cover sheet<br><br>Cover sheet | Yes | | | |
| | Not covered in plan update - please do not use | **A clear narrative for the integration of health, social care and housing** | Not covered in plan update | | | | | |
| | **PR3** | **A strategic, joined up plan for Disabled Facilities Grant (DFG) spending** | Is there confirmation that use of DFG has been agreed with housing authorities?<br><br>In two tier areas, has:<br>- Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or<br>- The funding been passed in its entirety to district councils? | Cover sheet<br><br>Planning Requirements | Yes | | | |
| NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer | **PR4 & PR6** | **A demonstration of how the services the area commissions will support the BCF policy objectives to:**<br><br>**- Support people to remain independent for longer, and where possible support them to remain in their own home**<br><br>**- Deliver the right care in the right place at the right time?** | Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?<br><br>Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?<br><br>Have gaps and issues in current provision been identified?<br><br>Does the plan describe any changes to commissioned intermediate care to address these gaps and issues?<br><br>Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans?<br><br>Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions? | | Yes | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Additional discharge funding | **PR5** | **A strategic, joined up plan for use of the Additional Discharge Fund** | Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges?<br><br>Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan?<br><br>Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding? | | Yes | | | |
| NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time | **PR6** | **A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time** | PR 4 and PR6 are dealt with together (see above) | | | | | |
| NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services | **PR7** | **A demonstration of how the area will maintain the level of spending on social care services and NHS commissioned out of hospital services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution** | Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution?<br><br>Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution? | | Yes | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Agreed expenditure plan for all elements of the BCF | **PR8** | **Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?** | Do expenditure plans for each element of the BCF pool match the funding inputs?<br><br>Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives?<br><br>Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable)<br><br>Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend?<br><br>Is there confirmation that the use of grant funding is in line with the relevant grant conditions?<br><br>Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area?<br><br>Has funding for the following from the NHS contribution been identified for the area:<br>- Implementation of Care Act duties?<br>- Funding dedicated to carer-specific support?<br>- Reablement? Paragraph 12 | | Yes | | | |
| Metrics | **PR9** | **Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?** | Is there a clear narrative for each metric setting out:<br>- supporting rationales that describes how these ambitions are stretching in the context of current performance?<br>- plans for achieving these ambitions, and<br>- how BCF funded services will support this? | | Yes | | | |

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**Health and Wellbeing Board** **24 July 2024**

Report of the Chair of the York Health and Wellbeing Board

## Chair's report and updates

## Summary

1. This paper is designed to summarise key issues and progress which has happened in between meetings of the Health and Wellbeing Board (HWBB), giving Board members a concise update on a broad range of relevant topics which would otherwise entail separate papers.

## Key Updates for the Board

Partnership

2. **York Health and Care Collaborative**: an update from the collaborative is at **Annex A** to this report.

3. **The Ageing Well Partnership** continues to co-ordinate identified priorities under this arm of the Joint Local Health and Wellbeing Strategy. One of the 10 outcomes under the strategy was to look to reduce the proportion of adults who report feeling lonely from 25% to 20%. We recognise that York does not perform well here even though it is asset rich with a wide range of social offers. We worked alongside York, Hull & Sheffield Universities through the Curiosity Partnership to try to create a better understanding of this "conundrum". This utilises the Partnership's infrastructure and capacity to support universities, local authorities the voluntary and community sectors and local citizens to collaborate and address local priorities, through the research partnership.

4. In March a loneliness showcase was delivered at the Guildhall which combined showcasing a range of asset-based approaches including local area coordination, social prescribing, Homeshare, Musical Connections and York Cares, recognising the Think Local Act Personal rainbow of community centred approaches, that are used in York to help reduce social isolation as well as workshops to try to get a clearer understanding of the challenges in York and the potential ways forward. Presentations were delivered by the Director of Public Health on loneliness data in York, alongside a keynote address from Dr Kalpa Kharicha, Kings College London and research lead at the Campaign to

End Loneliness. Dr. Jon Burchell from the University of Sheffield also presented research findings on a two year study of local area coordination, a summary of the research and blog has been produced by the National Local Area Coordination Network here  a blog recognising local area coordination as a bridge from loneliness to active citizenship, supporting isolated residents to connect well in their communities, develop good relationships and build social networks.

5. Although it is recognised that this is an all-age issue, often triggered by a significant life change, there is a strong impact on older communities which is why this piece of work was led through the Ageing Well Partnership. There was a view that we were not comparing like with like by using regional comparators (York performing 3rd worse across Yorkshire and Humberside). It was therefore agreed that we should compare with equivalent cities like Oxford and Chester to see if this changes how York performs. It was noted that due to York and equivalent cities having a wide range of opportunities, the expectations of social engagement may be higher in York than in other parts of the region. If results show that actually the self-reporting loneliness figures are comparable to equivalent cities, then the actions may be more around how we continue to offer an asset-based approach in a climate of reduced funding to prevent an increase in reporting feeling lonely.

6. A report from the Curiosity Partnership on the Loneliness Showcase and copies of the presentations are available on request.

7. The Age Friendly Communities, World Health Organisation toolkit is the agreed approach to support delivery against the ageing well arm of the strategy. Some examples of some more recent impacts are:

   - Supporting the International Day of Older People for the second year, celebrating older people contribution to society through stories and creativity.
   - Home Instead wins socially responsible business 2023 which includes their work in partnership with Age Friendly York for Take A Seat.
   - Created Age Friendly York Ambassadors providing the opportunity for York citizens to contribute and influence change through topics they are passionate about.
   - Promoted taxi survey to try to improve the offer of residents that use a wheelchair.
   - Co-produced discussion groups on older people prevention commissioning; domestic abuse and environmental impacts on older people.
   - Providing a joined up approach to making an impact for people with dementia and their carers through creating shared action points.

Children and Young People

8. **The School Health and Wellbeing Survey 2023** was commissioned by Public Health and is the second large scale survey on the health and wellbeing of children and young people in the city carried out between 2021 - 2024. The aim of the survey is to inform and support policy and decision making across the local authority, in schools, and among other key stakeholders in the city. The survey covered a range of health-related topics and was available to pupils in years 4 and 6 in primary schools, years 8 and 10 in secondary schools, and year 12 in sixth forms. The questions focused on social context, health outcomes, health behaviours and health harms relevant to young people's health and wellbeing.

9. The survey was open to all schools across York (excluding private and independent settings) and ran between November 2023 through to January 2024. There were a total of 2,956 participants, with 1033 responses from 15 primary schools and 1,923 responses from six secondary/sixth-form schools.

10. This year the University of York assisted with co-production and development of the questionnaires to include validated measures and scales and the Business Intelligence Team carried out the data analysis.

11. Schools received their own data pack, with an individual school level report, as well as a city-wide summary report. All reports have now been shared with the participating schools and an animation has been commissioned to share with young people. Results can be found on: https://www.healthyork.org/

12. Stakeholders have also been briefed on the positive, persisting and emerging trends within the data and work is ongoing to understand what we can do as a city to deliver interventions at a community and population level to improve health and wellbeing outcomes and reduce inequalities. The findings also aim to help schools develop priorities, establish programmes, and advocate for resources for health programmes and policies.

13. **The York Neurodiversity Programme** currently consists of two projects:

    - ADHD Foundation Charity Project (CYC funded)
    - Partnership in Neurodiversity in Schools Project (DfE funded via the ICB)

14. The long-term outcomes include:

- Enable neurodiverse children and young people to meet their educational potential (achieve their targets and expectations).
- Increase participation in classroom and social environments / experiences.
- Build the culture of Joint Partnership to support neurodiverse children and young people.
- Improve preparation for adulthood outcomes for neurodiverse children and young people – ensuring they are aspirational.
- Embed strengths-based approach to neurodiversity.

15. The programme includes a programme of webinars for education professionals and parents/carers which will run until December 2024. Eight schools are engaged with the ADHD Friendly Schools award and 9 schools will receive training and support through the PINS project.

16. **The SEND Health Needs Assessment** has been completed and signed off by the SEND Partnership Board. The Board has asked that the recommendations are turned into an action plan. Delivery of the action plan will be monitored by the SEND Partnership Board. The findings from the Health Needs Assessment will also be used to inform the review of the SEND Strategy and the Joint Commissioning statement which will be taking place in September/October 2024.

Public Health

17. **A new Drug and Alcohol Service launched**: from 1st July, leading health and social care charity Change Grow Live (CGL) are the new provider of York Drug and Alcohol Service. The charity will deliver a £1.8m service to provide community-based treatment and interventions for York residents wishing to access support for substance/alcohol use. Change Grow Live helps tens of thousands of people each day, delivering over 150 services across the UK including supporting individuals, families and communities whose lives are adversely affected by crime, substance use, homelessness, anti-social behaviour, domestic violence, social deprivation and lack of opportunity.

18. Locally, Change Grow Live (CGL) will deliver an integrated alcohol and drug treatment and recovery service to be available to all York residents. Recovery is at its core, as well as recognising the role that trauma exposure can have on our residents, enabling them to be free from drug and/or alcohol dependence and enter recovery. CGL also provide harm reduction and safer use guidance for people who do not want recovery at this moment but want to take substances in a safer way and stay well until they may wish to make further changes in their lives.

19. The service will support everyone, at all ages, providing dedicated support for adults and children and young people. York residents can access treatment and support through contacting the service directly, or through referrals from local health and care professionals. There is a single point of contact telephone number (01904 464 680) and online referral/self-referral form.

20. **Health Protection**: Several health protection issues have been concerning public health teams over the last months. These are listed below:

    - Measles rates have been high, comparable with 2018 which saw a number of large outbreaks, and around a third of cases have required some form of hospital treatment. The majority of cases were not fully vaccinated; rates are now stabilising, and a national drive around vaccination is feeding through into coverage rates. If people are unsure of their vaccination status or that of their children, they are advised to ask their GP
    - Pertussis (whooping cough) rates have also been high, and sadly there have been a number of infant deaths – York has very high coverage for maternal pertussis vaccine and we encourage people who are pregnant to ensure they are vaccinated to reduce the risk of harm to their new born
    - There has been a national rise in rates of Shiga Toxin-producing e.coli (STEC), which has now been linked to a possible food item source, and has involved product recall
    - Data has also been published on STI rates, which are rising in York and nationally (for example gonorrhoea, syphilis, and new Sexually Transmitted Infections) whilst and screening rates for diseases such as chlamydia are falling

21. **City of York Council Health newsletter**: We have recently started a fortnightly newsletter from CYC focussing on all types of health matters, which has signed up 1,395 subscribers in just a couple of months, and with a strong open rate. You can sign up using this link.

22. **CYC Health Trainer Team success**: Our Health Trainer team has released its most recent service data. In the most recent year, the 1152 referrals. The general service saw 492 referrals, 366 people engaged, with 86% achieving 1 or more goals, and 67% achieving all goals. On the stop smoking specific service, there were 660 referrals – 331 set a quit date, 72% successfully quit at 4 weeks. The service accepts self referrals The health trainers can also offer support around smoking and vaping for teenagers, healthy eating and weight management and support and guidance around alcohol use.

| **Author:** | **Responsible for the report:** |
|---|---|
| Compiled by Tracy Wallis<br>Health and Wellbeing Partnerships Co-ordinator | Cllr Lucy Steels-Walshaw<br>Executive Member for Health, Wellbeing and Adult Social Care |

**Report Approved** ✔ **Date** 15.07.2024

**Specialist Implications Officers**
Not applicable

**Wards Affected:** **All** ✔

**For further information please contact the author of the report**

**Annexes**

**Annex A**: Update from the York Health and Care Collaborative

YORK HEALTH & CARE COLLABORATIVE

# Annex A:

**Report of York Health and Care Collaborative; Update July 2024**

## 1. Introduction

This report provides an update on the work of the York Health and Care Collaborative (YHCC). The responsibility for leading health promotion and prevention activities across the city is with City of York Council. YHCC provides a forum to share population health intelligence and receive feedback from a wide range of provider and commissioning partners.

## 2. Progress on Priorities since the last report to HWBB;

Since the last update York Health and Care Collaborative have focussed on several areas including Frailty, Women's Health, Children and Young People and Obesity and the Impact. Development of Integrated Neighbourhood Teams (INT's).

## 3. Outcomes of the meetings included:

- Frailty – encouraging the use of Rockwood scoring by health professionals for assessing Frailty. An overview of the community frailty services in the city and what they are able to offer including the York Integrated Care Team, Frailty assessment clinic, Community Response Team and York Frailty Crisis Hub. An action from this meeting was to share the contact details of the York Integrated Community Team and Community Response Team to colleagues as an option for out of hospital care if it is deemed appropriate.
- Women's Health – Discussions on the National Women's Health Strategy including the 7 key priority areas of the strategy Menstrual Health and Gynaecological issues; Fertility, Pregnancy, Pregnancy Loss and PN support; Menopause; Mental Health and Wellbeing; Cancer; The health impact of Violence against women and girls and Healthy aging and Long Term conditions. IDAS shared information on the rise in Domestic Abuse and what services their service offers and information on the Integrated Care Boards Women's Health profile was shared including how to access and what is on the profile.

- Children and Young People – Data from Primary Care records for diagnosis of Anxiety and Depression in Children and Young People showed a 3% increase per age band in diagnosis of either Anxiety, Depression or Both and the most common areas of diagnosis being in the Heworth, Fulford and Osbaldwick/Murton areas of the city. Following discussions on Mental Health support in Schools an action was for all organisations to raise the importance of involvement of education in diagnosing children with Mental Health conditions. Discussions ensued on the Raise York Family Hubs, what the family hub offer is, how to access Family Hubs, where they are located and future plans.
- Obesity and the Impact – Discussions proceeded on the different tiers of support for weight management in York, What services are on offer for each tier, who runs and how to access the services, Data on Obesity Figures in the York Place footprint from primary care records. It was agreed for whether Obesity should be a priority for the city and the Health Inequality for access to Tier 3 weight management services should be escalated to York Health and Care Partnership.

## 4. Future work for YHCC

The direction for York Health and Care collaborative going forward will focus on the development and creation of Integrated Neighbourhood Teams across the York Place Footprint while also maintaining a focus on prevention areas.

Topics that have been scheduled for future meetings to include, Winter Planning, Drug and Alcohol Challenges, Smoking & Respiratory. York Health and Care Collaborative will go through a transition to report into York Health and Care Partnership.

**Health and Wellbeing Board** 24 July 2024

**Report of the York Health and Care Partnership**

## Summary

1. This report provides an update to the Health and Wellbeing Board (HWBB) regarding the work of the York Health and Care Partnership (YHCP), progress to date and next steps.

2. The report is for information and discussion and does not ask the Health and Wellbeing Board to respond to recommendations or make any decisions.

## Background

3. Partners across York Place continue to work closely together to integrate services for our population. The YHCP shares the vision of the York Joint Local Health and Wellbeing Strategy that in 2032, York will be healthier, and that health will be fairer.

4. The YHCP has an Executive Committee (shadow) which is the forum through which senior Partnership leaders collaborate to oversee the delivery of the Partnership priorities. The Executive Committee meets monthly, and minutes from the last 3 meetings held in April, May and June are included as **Annexes** to this report.

## Update on the work of the YHCP

<u>York Health and Care Partnership Annual Report and Joint Forward Plan</u>

5. The Annual Report and Joint Forward Plan can be found at **Annex A** to this report. The annual report reflects on the work undertaken towards delivering YHCP priorities in 2023/24. The Joint Forward plan section of the report confirms that the priorities set by the YHCP in 2023/24 are long term, transformational ambitions, and therefore remain the same in 2024/25. A workplan outlines the actions to be undertaken in partnership, for each priority in 2024/25. These support

the ambitions and goals contained within York's Joint Local Health and Wellbeing strategy and the Humber and North Yorkshire Health and Care Partnership Strategy.

6. Integrated Care Systems are required to publish an update to their Joint Forward Plans for 2023 – 2028. YHCP's contribution to Humber and North Yorkshire's Plan is represented by this workplan, in the Annex A report. At the same time, Humber and North Yorkshire has undertaken a refresh of its strategy with stakeholders across the Integrated Care Partnership, including local authorities.

April 2024 Executive Committee Meeting (**minutes at Annex B)**

7. The April meeting of the Executive Committee focused on integrated working in local communities. Often called locality or neighbourhood-based working, this refers to how multi-agency or multi-disciplinary teams organise themselves to work jointly around geographic communities. The following reports and presentations were received and discussed:

8. **Locality Model**: a report was received which set out a process to define geographic areas that would ultimately lead to a locality model for health, care and community services. This piece of work aligns with the YHCP priorities to *integrate our community offers* and *embed an integrated prevention and early intervention model*.

9. **Integrated Neighbourhood Teams**: YHCP received a presentation on developing integrated neighbourhood teams, which confirmed that these would be mapped onto the emerging Locality Model.

10. On discussing both items YHCP members expressed support and highlighted a need for all agencies to have a shared vision and values which would require cultural and behavioural change; reducing complexity; user friendly language and producing a 'roadmap' to aid understanding of expectations.

11. **Update to York Health and Care Partnership Place Development in 2024/25**: The YHCP received, discussed and approved the final version of a framework developed by all six health and care partnerships in the area, called 'Humber and North Yorkshire Strategic Framework: A Shared Framework for Excellence, Prevention and Sustainability at Place'. Reference was also made to a local York Plan to respond to this, including:

    - Development of a narrative

- Supporting our teams to act as ‘one team’ at every level of executive, managerial and professional level of leadership across our organisations, to find better ways of delivering services and addressing wider determinants of health.

- Enabling our communities to shape, participate in and take ownership of their services.

- Establishing how, by working differently, we can drive out avoidable costs and shift all our resources to support prevention, better care, and sustainability.

May 2024 Executive Committee Meeting (**minutes at Annex C)**

12. The focus of the May meeting of the Executive Committee was prevention/children and young people. The following reports and presentations were received and discussed:

13. **Future Service Delivery Model and Estates Development**: YHCP received a presentation highlighting themes from workshops bringing professionals together to co-design a new narrative which describes York’s future model for health, care and prevention in the context of integrated locality team-based working, and how buildings and infrastructure could be shaped to realise this. Key points highlighted in the discussion including the political perspectives in the context of a new Mayoral Combined Authority and City of York Council Local Development Plan for the built environment including housing and population growth; key worker and affordable housing; a workforce strategy in the context of culture change and the development of an out of hospital place based model of care; promoting York as a healthy city.

14. **Raise York**: YHCP received a presentation entitled *Raise York: Working Together with Children and Families to Improve Lives*. Raise York is a network of people, places and online support. It supports children, young people and families from pregnancy to adulthood. For the next 3 years its priorities are:

    - Infant feeding
    - Perinatal mental health and parent/carer – infant relationships
    - Healthy weight in under 5s
    - Communication and language skills
    - Children and young people’s mental health
    - Cost of living

Its outcome ambitions are:

- Increasing knowledge
- Increased confidence
- Increased resilience
- Reduction in isolation
- Increase in social networks

15. The presentation also included information on lessons learned from pilot activity, the 'toolbox' to support delivery of the ambitions, the children's workforce induction and the Solihull programme.

16. **Early Talk for York**: YHCP received a presentation about Early Talk for York, a local area approach to improving speech and language communication outcomes for children aged 0 to 5. The presentation highlighted the benefits of joint working and having a consistent approach and narrative. Health and Wellbeing received similar information at their May 2024 meeting.

June 2024 Executive Committee Meeting (**minutes at Annex D)**

17. The focus of the June meeting of the Executive Committee was driving social and economic development. The following reports and presentations were received and discussed:

18. **The future of the population: building our population health management approach across Humber and North Yorkshire**: the focus of this presentation was in the context of the local ambition for everyone to live longer and healthier lives by narrowing the gap in healthy life expectancy between the highest and lowest levels in communities by 2030 and increasing healthy life expectancy by 5 years by 2035. Over the coming years we would expect to see a growth in the older population and more demand on health and social care services. There will be challenges around increasing capacity, improving productivity and efficiency and re-focusing on prevention.

19. **Preventative services in York – scoping assessment**: this paper outlined some results of an initial scoping exercise around prevention services, supporting a range of prevention activities:

    - Behaviour change to reduce smoking, alcohol use, obesity, loneliness

- Health champions in community
- Local area resilience and social inclusion
- Tackling determinants of health through social prescribing – loneliness, isolation, financial hardship
- Prevention of disease/delay progression in general practice
- GP list-based searches, optimising health whilst waiting for elective procedures, cardiovascular health
- Clinical health coaching for patients at risk of high intensity emergency care use

20. The ensuing discussion of the item highlighted the priority of the York Health and Care Partnership to embed an integrated prevention and early intervention model. YHCP agreed to look at ways of working together to maximise outcomes from available resources in the context of the challenges discussed as part of the **population health** item.

21. **Assurance report**: this report set out progress against delivery of the 2024/25 Place priorities and NHS performance objectives. Areas of discussion with regards to NHS performance included:

    - Improvement in A&E waiting times and working towards achieving a minimum standard of 78% of patients waiting no more than four hours by the end of March 2025. However it was noted that long delays were experienced by some patients in May and June and plans were in development to address this to get performance back on track.
    - The Integrated Care Board is working towards ensuring that 85% patients who need an appointment get one within 14 days, by the end of March 2025. York practices are already achieving this for their registered populations. 87.5% of patients were booked and seen within 14 days in April, with a total of 119,917 appointments delivered that month by York GPs.
    - Eradicating very long waiting times (those over 65 weeks) for planned hospital (elective) care by the end of year. The number of patients waiting a year or more is reducing and the total number of patients on the waiting list is also reducing. The planned improvement trajectory has been exceeded for these

measures locally which is good news for local residents but there is still a long way to go to achieve 18 week referral to treatment standards.

- Treating more patients within the 62-day cancer treatment standard (to 70%) and the 28 day faster diagnosis standard (to 77%) by March 2025. Plans are in place to achieve these standards by addressing delays in diagnostic pathways and improvement plans in place for Urology, Skin and Head and Neck, closely monitored by the Humber and North Yorkshire Cancer Alliance.

22. **Social care workforce priorities update**: this update set out workforce priorities including recruitment and retention; care leavers; education and training; workforce data and key worker accommodation. Work continues across York to create new opportunities and to retain the existing social care workforce, but this is not without its challenges.

Work of the York Population Health Hub

23. The York Population Health Hub continues to spearhead initiatives to improve population health outcomes in our city. One of the notable projects includes supporting York Medical Group Primary Care Network (PCN) in developing a practice-based Prevention Team. This team is poised to enhance preventative care within the community, focusing on reducing the incidence of chronic diseases through proactive health measures and patient education.

24. In collaboration with York St John University, the Hub is also looking at facilitating placements for media studies students. This partnership aims to leverage the students' skills in creating impactful health promotional campaign materials. By engaging these creatives, the Hub hopes to produce engaging and effective content that promotes healthy living and disease prevention across various media platforms.

25. Another effort by the Hub involves the development of advanced methods to analyse primary care data. A key focus is on constructing a comprehensive profile of childhood obesity using child growth percentiles, a resource previously unavailable to health professionals in this detailed format. This new tool will enable better identification, monitoring, and intervention for childhood obesity, supporting more tailored and effective health strategies.

26. In June, the Hub successfully hosted a "Lunch & Learn" event, concentrating on Special Educational Needs (SEN). This event featured insightful presentations from colleagues at the City of York Council and local schools, fostering a deeper understanding and collaborative approach to addressing the needs of children with SEN. The event underscored the importance of community and inter-agency cooperation in creating inclusive educational environments.

27. Through these initiatives, the York Population Health Hub continues to make significant strides in population health, driving innovation and collaboration to enhance the well-being of the York community.

York Mental Health Partnership

28. The partnership hosted a spring workshop to recast its vision and aims, originally set out when the city's Connecting Our City programme was initiated. During the workshop, the York model for community mental health transformation was revisited and agreed, reflecting the Connecting Our City work and aspirations. All partners contributed to the work. In May, this work informed our Expression of Interest (EOI) for NHSE funding to set up a 24/7 community mental health centre in York. Prepared by the partnership, the EOI was submitted as part of the ICB's regional submission and was supported by senior system leaders. We were pleased to be shortlisted and hosted an NHSE visit on 20th June, co-hosted between the Hub @ 30 Clarence Street and the York St John Communities Centre. We will be informed of the outcome after the forthcoming UK general election.

29. Key work supported by the partnership included the opening of York's first (post-prototype) Community Mental Health Hub at 30 Clarence Street. The Hub manager and team, supported by the Connecting Our City project team and Joint Delivery Board (set up, by the partnership to support operational, management and leadership matters associated with the Hub), are to be applauded for their work. The Hub is open on a phased basis (including hours of opening and the number of people supported) and the team are both supporting people who had previously accessed community services via 30 Clarence Street, and seeing individuals referred via the NHS Access team. The transition to Hub 1 was enabled and informed through learning from the prototype phase. In addition, the Connecting Our City project team have been supporting partners through contractual and organisational changes, alongside

reinvigorating key programme pathways. The Eating Disorders and Neurodiversity work pathways are developing well, and an Older Peoples workstream is underway, with plans to support older people within and exiting Foss Park hospital. All work is underpinned by co-production and the VCSE are core to all York Mental Health Partnership/Connecting Our City work.

30. Currently, the partnership is developing the work programme for 2025-2028, including the rollout of other mental health hubs and the scoping of a Community Interest (CIC) venture for community-based services in York. Additionally, we are awaiting the outcome of the EOI. Success will significantly influence the direction and pace of positive and constructive change to community mental health provision.

31. Additionally, the co-chairs of the mental health partnership have had an initial meeting with the Corporate Director for Children and Education at City of York Council to talk about children and young people's mental health. There will be a further meeting in July where the co-chairs of the partnership will meet with the Corporate Director and his team to scope how the partnership can inform and support work with children, young people and families.

**Contact Details**

| **Authors:** | **Chief Officer Responsible for the report:** |
|---|---|
| Tracy Wallis, Health and Wellbeing Partnerships Co-ordinator, City of York Council | Sarah Coltman-Lovell, NHS Place Director<br><br>Report Approved Y<br><br>Date: 12 July 2024 |

**Wards Affected** ALL

**For further information please contact the author(s) of the report**

**Annexes**

**Annex A:** Annual Report and Joint Forward Plan
**Annex B:** Minutes from the April 2024 meeting
**Annex C:** Minutes from the May 2024 meeting
**Annex D:** Minutes from the June 2024 meeting

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Humber and North Yorkshire
Health and Care Partnership

# York Health and Care Partnership Annual Report and Joint Forward Plan

May 2024

# Introduction

The Humber and North Yorkshire Health and Care Partnership is the Integrated Care System (ICS) which plans healthcare in our region. Within this partnership, York sits as one of six 'Places'. You can find out more about the Humber and North Yorkshire Partnership here. In York, our Place Partnership is called the York Health and Care Partnership (YHCP). The YHCP brings together partners across health and care to deliver improvements in experience and outcomes for people living in York.

Welcome to the 2023/24 annual report for the YHCP. This report will capture some of the successes and achievements across the different priorities of the Partnership over the year. We are publishing this annual report at an important time for the YHCP as we continue to develop and strengthen integration across partners to reduce health inequalities and improve the health of York's population.

2023/24 has been a busy, challenging, and exciting year for the YHCP. Health and Care organisations in York are working towards developing strong, multi-agency system teams to meet the health and social needs of our residents, and whilst we always strive for continuous improvement, significant progress has been made towards delivering our priorities in 2023/24. This document provides a summary of this progress and outlines the YHCP's plans to continue improving health and care services for York in 2024/25.

## Our purpose

The purpose of the YHCP is to reduce health inequalities and increase healthy years lived for people in York, by working together to address the determinants of health. We want to improve people's lives by providing the right support at the right time, to ensure everyone can have a happy and healthy life in York. We share the ambitions highlighted in the Joint Local Health and Wellbeing Strategy and are working in partnership to deliver the six big ambitions and ten big goals for York.

The YHCP has formed a number of system teams to support delivery of our priorities, which are evidence of the strong partnership culture the YHCP has developed over 2023/24. For example the York Population Health Hub (PHH) works across partners to oversee Population Health Management, Public Health Intelligence, and the Joint Strategic Needs Assessment, and to enable the healthcare system to make better use of data, insight, and population health approaches. By bringing together partners, the PHH enables the YHCP to focus on the wider determinants of health by using multi-agency data that can inform place-led approaches which respond to the specific needs and characteristics of the population of York. For example, in our Proactive Social Prescribing project delivered by York Centre for Voluntary Service (CVS), we are not only focussing on a single long-term condition, but the area that people live in and how their housing conditions may exacerbate their symptoms. This highlights the key role Place can play as a convener of all system partners to drive improvements in holistic, personalised care for people and implement the Joint Local Health and Wellbeing Strategies. As these system teams and 'Hubs' develop, the YHCP will play a key strategic role to ensure there is a consistent, effective, and holistic offer for people living in York where duplication and inefficiencies are minimised.

The YHCP has identified six long-term, transformational priorities to be delivered collaboratively over the next five years, focussed on strengthening integration, reducing health inequalities, and improving population health for people who live in York. The aim of these priorities is to deliver personalised care through integration, enabled by shared approaches to data and digital, workforce and estates, finance and quality, communication, and co-production. The priorities will support delivery of the Joint Health and Wellbeing Strategy for York and the '10 big ambitions' for our population, as well as contributing to the delivery of the Humber and North Yorkshire Health and Care Partnership Strategy. A detailed workplan sits behind each priority which is not included in this report. The YHCP monitors progress towards each priority through monthly meetings and progress is also reported to the Health and Wellbeing Board.

The six key priorities are:

1. Strengthen York's integrated community offer
2. Implement an integrated Urgent and Emergency Care (UEC) offer for York
3. Further develop Primary/Secondary shared-care models
4. Embed an integrated prevention and early intervention model
5. Develop a partnership based, inclusive model for children, young people, and families
6. Drive social and economic development

## Key partnership achievements against these priorities in 2023/24 include:

- Implementation of the York Frailty Hub focusing on prevention and admission avoidance. We are strengthening the relationship with key partners to deliver collaborative, integrated care, making the best use of collective resource.
- York & Scarborough Hospitals Trust successfully led procurement for a new GP Out of Hours service with Nimbuscare due to deliver the service across the York & Scarborough Hospitals Trust footprint (Whitby, Scarborough, Malton, York, and Selby) from April 2024.
- The establishment of the York Place Primary/Secondary Care Interface Group with senior clinical representation from Primary Care and York & Scarborough Hospitals, which is leading practical, clinical pathway transformation projects in partnership with Hospital colleagues.
- We have accelerated our Long-Term Conditions Programme to strengthen secondary prevention care in York, including the launch of three static health kiosks placed in areas of deprivation to improve detection and treatment of hypertension and reduce health inequalities.
- For children and young people, the Early talk for York and More talk for York approach has been developed to identify speech language and communication needs.
- As part of our joint workforce plan, partnership recruitment activities and initiatives across health and care partners have commenced, including care leavers and the volunteer workforce, with a highlight being the joint recruitment fair between health and social care held in November 2023.

## Engagement in 2023/24

The organisations that make up the YHCP all undertake their own engagement and coproduction exercises to ensure that services are developed alongside the people who will be using them, and the partnership continues to benefit from this work as a whole when organisations share their findings and best practice around coproduction. As a key strategic partner of the YHCP, Healthwatch York have continued to lead engagement work across the YHCP, championing the voice of people in York and

ensuring that people's views are reflected in service transformation and delivery. Key highlights from Healthwatch York's work include:

- Publication of the Urgent Care report, engagement work funded by the YHCP to support the ongoing urgent care transformation work in York. This report ensured that the YHCP heard from people who live in York who told us that a disjointed UEC system was difficult to navigate. This helped the YHCP identify the next steps for transformation, reflective of what our residents had told us.
- Publication of the Independent Evaluation of the Pilot Pathway Adult ADHD and Autism report which is being used to inform improvements across ICB pathways across North Yorkshire and York.
- Publication of the Health and the Cost of Living May 2023 report highlighting the impact that the Cost of Living crisis is having on the health and wellbeing of people in York. This qualitative feedback was complimented by the York Population Health Hub's second Cost of Living Data Pack, which brought together multi-agency data to demonstrate the impacts observed in the city. Together, these two reports have been disseminated to inform leaders and practitioners about the health impacts of the financial situation and have formed the basis for a Population Health Hub Lunch and Learn to further educate the workforce about potential impacts and issues to be aware of for residents.
- Work to explore people's experiences of mental health crisis care
- Launch of the Core Connectors scheme working jointly with the ICB. Core Connectors are young people aged 16–25 who help other young people have their voices heard, they listen to people's experiences and capture what is working and where services could be improved to support service transformation. The Core Connectors will be focusing on engaging with people who experience health inequalities.

## YHCP work to address Health Inequalities

Reducing health inequalities is a key role of Place Based Partnerships, and work to reduce health inequalities is a golden thread throughout each of the YHCP's priorities. The YHCP receives health inequalities funding from the Humber and North Yorkshire Integrated Care Board (ICB) to address local need in line with the Core20PLUS5 Framework. Throughout 22/23 and 23/24 the YHCP has been delivering a series of projects to utilise this funding, demonstrating the key partnership work happening in this area. These projects include:

- Bolstering the Ways to Wellbeing grant led by York CVS
- Supporting the York Ending Stigma campaign led by York CVS
- York's first ever Health Mela held in September 2023 with representation from all YHCP partners
- Increasing access to healthcare services for people who work in sex led by the ICB and Nimbuscare
- Placement of static health kiosks in areas of deprivation to support increased prevalence and subsequent treatment of hypertension, led by the ICB and Nimbuscare
- Roll out of the Asthma Friendly Schools Initiative and Speech and Language Training, led by the ICB and York & Scarborough Teaching Hospitals Foundation Trust (Y&SFT)
- Improvements in the school absence pathway led by CYC
- Launch of the Baby Friendly Initiative led by CYC Public Health

- Health and wellbeing support for York's asylum seeker and newly settled refugee communities in partnership with Refugee Action York
- Establishment of the primary and secondary care health inequalities training programme delivered in partnership by the ICB, CYC Public Health, Healthwatch York and York CVS

For more information on health inequalities in York, the York Population Health Hub has produced a Core20PLUS5 profile (expected to be published end of April 2024 – link to be added), outlining the groups who are most likely to experience health inequalities in the city.

## Case Study – Maternal and Child Nutrition Health Inequalities work

**UNICEF Baby Friendly Initiative:** There is strong evidence that adopting the UNICEF Baby Friendly Initiative standards and accreditation programme within a service act as a key intervention in improving infant feeding support for parents through ensuring that practitioners' knowledge and skills are developed and maintained at a high standard and that parents experiences of care are considered. York's Healthy Child Service has committed to implementing the UNICEF Baby Friendly Standards to improve infant feeding support for parents and families within the City and to provide targeted support to reduce inequality.

**Food Insecurity – Infant Formula:** Working in partnership with the Healthy Child Service, maternity and the Welfare and Benefits team, we have created a pathway for families which means that they will be able to access infant feeding support during financial hardship or food crisis (which conforms to the World Health Assembly International Code of Marketing of Breastmilk Substitutes and subsequent resolutions (the Code)) and receive wrap around care, enabling them to access additional support services to meet ongoing needs.

**York Healthy Schools Programme:** The Healthy Schools programme was launched by City of York Council in partnership with North Yorkshire County Council in March 2023. Funded and supported by the Public Health team, it is free for all publicly funded schools in York to join including academies. Since its launch in March last year, a quarter of schools in York have signed up to join the programme. The online programme supports schools to work towards improving the health and wellbeing of pupils and staff through an evidence-based 'whole school approach' across four key themes: personal, social, and health education (PSHE); emotional health and wellbeing; active lifestyles; and food in schools. Schools can work towards Bronze, Silver and Gold Healthy School awards.

**York's Hungry Minds:** In January 2024, City of York Council launched a universal free school meal pilot in Westfield Primary School and a free Breakfast club pilot in Burton Green Primary School, with the aim of reducing food insecurity and increasing nutritional status amongst children. There is some evidence of a beneficial impact of universal free school meal provision on pupil health and educational outcomes such as improved nutrition and academic performance. The pilot is due to be evaluated to demonstrate the impact that this has had on children.

**Health Trainers:** In early 2023, the Health Trainer service launched a useful guide called "Eating healthy on a budget". The guide gave practical support and advice to families around how to have healthy and nutritious meals while keeping costs to a minimum, tips on healthy swaps and a look at the cost of cooking appliances.

**Home-Start Cookery Classes:** Services from Home-Start have been commissioned by Public Health since 2023 and through contract monitoring arrangements it was identified that families needed further practical support around learning how to prepare healthy, budget-friendly meals at home.

Home-Start had an established relationship with a cookery school, who provide valuable resources and support to families in the city, particularly those with young children. This existing arrangement means that the service to reach families who may benefit from this initiative and volunteers are able to identify families in need and extend invitations to those who may benefit most.

Through this initiative families are able to participate in cooking demonstrations led by a skilled chef. Demonstrations not only showcase essential cooking techniques but also empower parents to take an active role in meal preparation. Participants of the course are also given printed menu cards and other 'take-home' resources in order to replicate the recipes and cooking methods learned during the sessions.

**What does the work highlighted in this report mean for people and communities in York?**

Working across partners to deliver our priorities will mean more joined up care, less duplication, and more effective, integrated health and care services for people living in York. We want to support people living in York to start well, live well, age well and end their lives well, and we intend to achieve this by delivering our six priorities which cover all ages, mental and physical health, and the wider determinants of health, to provide holistic and joined up health and care support to our population. The Joint Forward Plan section of this report includes more detail on what each priority will mean for people living in York. We are aligned with the Health and Wellbeing Strategy in our delivery of these priorities and share the ambition that **in 2032 York will be healthier, and that health will be fairer.**

Engagement and coproduction exercises are built into the workplan that sits behind each priority and are led by each organisation that forms the YHCP, to ensure that as a partnership we are continuously reflecting on what the public tell us and building this into service transformation where possible.

### Delivery through the Charter of Behaviours

The work of the YHCP described in this document for 2023/24 and 2024/25 will continue to be delivered through the Charter of Behaviours, as outlined in our Prospectus:

- We are in it together
- We trust in people
- We are permission-giving and empower staff
- We are person-centred
- We commit to freeing the power of the community
- We commit to improving population health
- We connect clinicians and professionals
- Our finances will align

# 1. Delivery against our six priorities

This section of the document provides an update towards the delivery of our six priorities in 2023/24. We have taken a look back at what we said we would deliver in our joint workplan and provided an update against each of these actions.

### Strengthen York's Integrated Community Offer

This priority includes our partnership ambitions to strengthen community integration across health and social care, and physical and mental health. The aim of this work is to improve models of community-based support which are preventative, so people do not need to seek professional help so often and can find mental wellness in connections and communities.

| What we said we would deliver | What we have delivered in 2023/24 |
|---|---|
| Create an integrated frailty community hub. | Implemented a truly integrated frailty model which focuses on prevention, helping people in crisis to remain at home by reducing conveyance and admission to hospital, and supporting frail individuals to be discharged back to home safely and quickly.<br><br>A Frailty Crisis Response Hub was launched in November 2023, part of which was a Frailty Advice and Guidance line ran by a GP with a specialist interest in Frailty. The line provides additional support to clinicians working with vulnerable and frail people, with the hope that with this additional support, these individuals can continue to be cared for at home.<br><br>Paramedics making use of the Advice and Guidance line are actively promoting this service. |
| Health and social care service integration that supports end-to-end pathways (admission avoidance, in hospital, transfer, home) focused on improved outcomes that support the delivery of local and national plans, with personalised care at the centre of our approach. | Discharge Hubs at Scarborough and York have adopted new ways of working with extended multi-disciplinary team (MDT) membership which enables all partners to have oversight of cases. The MDT can escalate issues in real time to senior managers for speedy resolutions that support safe transfers of care for hospital inpatients.<br><br>York introduced a new 'One Team' multi-provider daily call with a focus on collaboration in provision of packages of care, includes health and local authority, working in partnership.<br><br>New processes have been established by City of York Council to facilitate earlier discharge and unblock issues which can lead to delays for patients waiting to leave hospital.<br><br>Established a York and North Yorkshire ICB-led Discharge Quality Improvement Group to undertake system-based<br><br>Quality improvement initiatives to improve the experience and overall quality of the discharge processes.<br><br>Twinning of a Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Older People ward and a York Hospital Older People's ward to share skills and learning to improve pathways and overall experience of care for those patients living with dementia and experiencing physical ill health. |
| Understand where community integrated pathways work well e.g. heart failure and look where similar models of integrated care could be adopted locally. | Focus on Y&SFT Virtual Hospital Programme, linking multiple specialties that have cross cutting pathways such as Heart Failure/Respiratory. |

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| | Benchmarking against local systems who excel in discharge planning and speedy transfers of care. |
| Continue to work in partnership to support implementation and expansion of Mental Health Community Hubs. | Following the prototype hub development and reviewing the lessons learned from the prototype partners are now in the process of implementing our first Mental Health Community Hub as part of the Community Mental Health Transformation.<br><br>Accommodation: 30 Clarence Street has been confirmed as the location for the first hub and a weekly task and finish group is working to ensure that all of the operational requirements are in place for the opening of the hub. Initial discussions have taken place with primary care colleagues about potential locations for future hubs. |

## Case study: York's Integrated Frailty Hub

The York Frailty Hub is an integrated offering from all services commissioned to provide care and support for citizens in York that are Frail. The 3 different arms of the York Frailty Hub include:

- Anticipatory Care
- Crisis Response
- Discharge Support

This is a truly integrated frailty model which focuses on prevention, helping people in crisis to remain at home and avoid an admission whilst respecting their wishes, and supporting people to be discharge home from hospital safely and when they are ready. As part of this offering, a Frailty Crisis Response Hub has been in place since 1st November, which sees the collaboration of four providers working together at Acomb Garth Community Centre.

**The model is comprised of:**

- A GP with a Specialist Interest in Frailty running an Advice & Guidance phoneline Mon-Friday 9am – 8pm, available to Yorkshire Ambulance Service (YAS) and the wider local system – provided by Nimbuscare
- A Social Care Worker running the Duty Social Care Hotline, receiving urgent referrals for people experiencing a social care crisis – provided by City of York Council
- Y&SFT Urgent Community Response (UCR) / Community Response Team (CRT) Triage receiving calls for people requiring an urgent community response and linked to the wider UCR/CRT team based at the hospital – provided by Y&SFT.
- Social prescriber linked to CVS – connecting people with local community activities and services that can help improve their health and wellbeing, provided by York CVS
- People also receive support from a Frailty Nurse linked to York Integrated Care Team/Nimbuscare

The aim is to support and keep people that are vulnerable and frail safe in their homes whenever possible, whilst respecting people's wishes for care at home. Since its inception, the Frailty Advice & Guidance line has received over 800 calls to date and avoided over 320 ED admissions. The Extra Discharge Support Service is also a service that was set up this year and is provided by three voluntary sector organisations which support patients when they are discharged from hospital. The service has supported over 600 patients to be discharged home either more safely or quickly than they otherwise would have been.

## Implement an integrated Urgent and Emergency Care Offer for York

The aim of this priority is to deliver safe, reliable, and resilient services providing the right care, right place, right time.

| What we said we would deliver | What we have delivered in 2023/24 |
|---|---|
| Urgent Care (Urgent Treatment Centre and Out of Hours). The strategic intention is to develop a prime provider 24/7 Integrated Urgent Care (IUC) service model across the York and Scarborough Teaching Hospitals Foundation Trust (Y&SFT) footprint which meets population need by delivering the right care, at the right time, in the right place, first time, in line with Fuller principles. | York place has seen real progress. Nimbuscare worked collaboratively with Totally PLC to operate the overnight GP Out of Hours (OOH) which improved resilience across all Totally PLC delivered urgent care services going into winter 2023/24.<br><br>Y&SFT will be the lead provider of Urgent Care (GP OOH and Urgent Treatment Centres) from 1st April 2024 having already assumed lead provider for Selby UTC from Harrogate Hospitals Trust in 2023.<br><br>Announced in December 2023, Y&SFT successfully led procurement for a new GP Out of Hours service with Nimbuscare due to deliver the service across the Y&SFT (Whitby, Scarborough, Malton, York, and Selby) from 2nd April 2024. |
| Clinical Assessment Service: support Healthcare Professionals through frail, elderly pathways as alternative to ED. | A Frailty Advice & Guidance (A&G) Line was established in 2023, primarily with a view to providing ambulance crews with support for clinical decision-making. While ambulance crew take up has been slower than anticipated, the A&G team provide a valuable service to a wide range of health and care providers and fully integrated within the Frailty Hub, itself increasingly integrated with the community services team. Funded by winter resilience monies, the GP in Yorkshire Ambulance Service Control Room (Nimbuscare) are also feeding into the A&G/Hub. |
| Development of additional direct access pathways to Same Day Emergency Care (SDEC) from community. Implementation of approach through redesign and integration of reablement and intermediate care. Fully embedded multi agency in reach team to support early discharge increasing flow. | Work is ongoing to build capacity to enable direct access to SDEC. |

## Further develop Primary/Secondary shared-care models

The aim of this priority is to develop shared care models between patients, GPs, and specialists, so patients receive a personalised, seamless, and holistic care experience.

| What we said we would deliver | What we have delivered in 2023/24 |
|---|---|
| Move away from referral-to-specialist towards a shared care model between patient, GP, and specialists. | Referral for Expert Input REI (Rapid Expert Input) has continued to develop across the 3 Specialties which are live – Neurology, Dermatology, Rheumatology – with good uptake and support from Primary and Secondary Care colleagues. |
| York has a referral platform in place which provides a platform for pathway standardisation, administrative and clinical review of Hospital referrals, and a support service for offering patients choice and booking them into Hospital clinics. | The Referral Support Service function continues to work across the Y&SFT footprint – providing the Gateway referral management system that improves the quality/completeness of referrals and compliance with commissioning policy to maximise workflow efficiencies across the Interface, and to help manage Hospital demand. |
| The Advice & Guidance platform is being developed between to include more specialties increasing integration between primary and secondary care. | Conversations continue via the Primary/Secondary Interface Group around bringing more specialties on board with our Advice & Guidance Platform, REI, which facilitates shared care between GP's and Hospital Specialists. |
| York and Scarborough areas are further developing forums for GP and Hospital clinicians to explore opportunities for creating shared care models, where care is managed collaboratively to best meet the patients' needs | The York Place Primary/Secondary Care interface Group meets monthly with a focus on pathway transformation and closer working between GP's and Hospital Specialists to support shared care. The group will expand to include Scarborough colleagues. We have started to develop the role that GPs with specialist interests play in these shared care models through a pilot in Gynaecology. |
| The Outpatient Transformation Programme will enable more patients to choose when and how they access Hospital Outpatient Clinics. | The Outpatient Transformation Programme is currently looking at new models of care (Referral for Expert Input and Connected Health Network, Patient Initiated… etc.), Patient Initiated Follow Up, and online/digital access to follow up appointments. We have used the national framework provided by the Getting It Right First Time (GIRFT) Programme to identify and act on opportunities to improve access to outpatient clinics. |
| Collaborative working will enable Primary Care direct booking into Hospital SDEC / speciality hot clinics – and Virtual Ward access for frailty, respiratory patients, bypassing the Emergency Department (ED). | Primary Care and Hospital colleagues have been working on these pathways during 2023/24. Pathways are becoming more connected through Respiratory/Frailty Hubs for example. |

## Embed an integrated prevention and early intervention model

The purpose of this priority is to enable a shift in all areas to prevention and early intervention models across the life course so that York's population can live healthier, longer lives.

| What we said we would deliver | What we have delivered in 2023/24 |
|---|---|
| Tackle multi-morbidity through secondary prevention: strengthen and accelerate our secondary prevention programmes of work for Long Term Conditions (LTCs) and multiple LTCs, and the major conditions strategy. | Accelerated our secondary prevention programmes of work, including Cardio Vascular Disease (CVD) (hypertension treatment to target health inequalities programme and launch of static health kiosks in areas of deprivation), Diabetes (implementation of Locally Enhanced Service and embedding of specialist diabetes nurses), and Respiratory (Population Health Management approach to support Children and Young People (CYP) asthma nurse with spirometry uptake). |
| Improve prevention and early intervention pathways: inform modifications to services and pathways to strengthen secondary prevention services to increase early diagnoses and undertake more secondary prevention work. | As above, we have accelerated our secondary prevention programme working closely with partners to embed secondary prevention approaches and support Practices with COVID recovery.<br><br>Work has begun in year to scope our integrated prevention approach for the city, including contract reviews and reviewing the prevention workforce across the YHCP. This will continue into 2024/25.<br><br>A series of Population Health Management (PHM) projects are also being delivered by the York Place team to test and develop our approach to PHM, including Waiting Well (delivered jointly with Nimbuscare), the Brain Health Café (delivered jointly with Dementia Forward) and the Proactive Social Prescribing project (delivered jointly with York CVS). |
| Improve our PHM infrastructure and capabilities: York PHH will work with partners to develop our PHM infrastructure and capabilities to strengthen Information Governance (IG) and digital and data infrastructure. | Strengthened collaboration between PHH and GP Business Intelligence (BI) leads to embed PHM work in Practices.<br><br>Developed information sharing charter, learning from the Humber, to be embedded across York Place. |
| Improve intelligence: York PHH will provide access to population health data to understand our population better (including the wider determinants of health), further defining York's CORE20Plus5 population. | The PHH has produced multi-agency analysis on the cost-of-living crisis to demonstrate the impact on our citizens and areas of focus for the city.<br><br>The PHH has also updated the Core20PLUS5 profile for adults to provide a comprehensive overview of this population to be used in service planning and delivery. |
| Embed prevention and early intervention models through an integrated offer across the system: influence, secure and ringfence recurrent prevention budgets. Lead conversations for the strategic commissioning of services across sectors which tackle health inequalities. | As above, work has begun on scoping our integrated prevention offer for the city which will influence the delivery of prevention services in the future.<br><br>We have commissioned and delivered a series of health inequalities projects across partners including Refugee Action York, Nimbuscare, York & Scarborough Teaching Hospitals Foundation Trust, Public Health, and York CVS. |

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| | Designed a primary and secondary care health inequalities training programme to be delivered to health inequalities leaders in 2024/25. |

## Case study: Spotlight on proactive case management

York Centre for Voluntary Service, City of York Council Public Health, the ICB and general practice are working together to deliver a proactive social prescribing project, made possible through a bespoke pot of funding from the ICB's personalised care team. The project focusses on improving outcomes for people with respiratory conditions who are likely to be affected by the cost-of-living crisis through proactive case identification and management.

Using specialist clinical and public health advice, this group of individuals were chosen due to the impact that the cost-of-living crisis may have on their conditions, for example, through living in a cold home or not being able to afford a prescription. It was also identified that respiratory conditions can exacerbate over the winter period and often lead to A&E attendances and non-elective admissions when providers are experiencing significant pressures. Therefore it was agreed that the social prescriber would support these people to manage their conditions safely at home throughout the year to avoid exacerbations over the winter period.

People are proactively identified by primary care through a population health management approach using multi-agency data on respiratory conditions, risk of non-elective admission and postcode (to identify individuals living in areas of deprivation who may be impacted by the cost-of-living crisis). These individuals are then offered interventions from a social prescriber, such as support attending Long Term Condition Reviews, referrals to the CYC Health Trainer team, and empowering individuals to attend community groups for peer support.

The project has received positive feedback received from patients highlighting the impact of personalised social prescribing on their overall well-being. By addressing not only the medical aspects of respiratory health but also considering the wider social determinants, the project aims to enhance the holistic care experience for individuals facing respiratory challenges.

## Develop a partnership based, inclusive model for children, young people, and families

The aim of this priority is to ensure that children are at the centre of our city life, and work is done in partnership to raise a healthy generation of children.

| What we said we would deliver | What we have delivered in 2023/24 |
|---|---|
| Embed prevention and early intervention models through an integrated offer across the system for children and young people | Children and Young People (CYP) plan developed by City of York Council (CYC) with health input from CYP quality lead and CYP Mental Health commissioner.<br><br>Family Hubs implementation commenced, and proposal being submitted for health inequalities funding to support a health practitioner role within family hubs.<br><br>System wide communication and input into the ICB wide Healthier Together webpage/resources including locally produced resources.<br><br>Integrated Bowel and Bladder workshops for CYP co-designed and co-delivered by Healthy child service and specialist Bowel and bladder nurses.<br><br>Recommissioned initial health assessments (IHA) for CYP who are looked after to improve timeliness of assessments.<br><br>Commissioned a second school Mental Health Support Team (Well-Being in Mind) delivered by TEWV.<br><br>Jointly recommissioned the School Well-Being Service across all York state schools.<br><br>Baby Friendly Initiative (BFI) funding from York's health inequalities funding led by Public Health – infant feeding lead appointed, and plan being developed to achieve BFI status in city.<br><br>Early talk for York and More talk for York approach to identifying speech language and communication needs in children and young people.<br><br>Developing resources to support 'Waiting Well' approach for CYP who are waiting on Speech and Language Therapy (SaLT) or Occupational Therapy (OT) waiting lists.<br><br>Developed an integrated model of residential and edge of care support for young people who have or at risk of developing complex care and health needs. This 'Together We Can' service is based on a 'no wrong door approach' and benefits from jointly funded and commissioned clinical psychologist and speech and language therapist. |

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| | Special educational needs and disability (SEND) operational plan coproduced and implemented by partners and stakeholders across the city. |
| Tackle health inequalities using the CORE20PLUS5 approach | CYP Health inequalities delivered to primary care protected learning time.<br><br>Childrens Alliance and Transformation work:<br><br>➢ Asthma-Risk stratification undertaken by ICB CYP asthma team with primary care to identify those CYP locally who need review due to number of short acting beta-agonists, useful medications for supporting people with asthma.<br><br>➢ Primary care records and community diagnostics to be used to support diagnosis of CYP with likely asthma but no formal diagnosis yet.<br><br>➢ Asthma friendly schools post funded by York's health inequalities money- post currently out to advert with York & Scarborough Teaching Hospitals Foundation Trust.<br><br>➢ Epilepsy Mental health screening and psychology intervention pilot locally. |
| Work across the partnership on models of care, for example establishing a primary care led model for Children and Young People's Mental Health with Nimbuscare, Tees, Esk and Wear Valley and the York & Scarborough Teaching Hospitals Foundation Trust, and the development of family hubs. | School attendance support worker jointly commissioned by York Place and CYC.<br><br>Family Support Worker jointly commissioned by York Place and CYC to work with children with most complex autism presentations and their families. |

## Drive social and economic development

This priority will ensure that the YHCP works at the heart of our communities to use and grow the assets we have to improve population health and economic prosperity, maximising our collective capability, working in partnership taking a cradle to career approach. This will support the ICS to meet it's 'Fourth Purpose' to 'help the NHS to support broader social and economic development.' We know that effective action to tackle health issues requires not only a change in health and care services, but for health issues to run as a golden thread through local strategy to ensure all partners are aligned in their direction of travel for our population.

| What we said we would deliver | What we have delivered in 2023/24 |
|---|---|
| **Infrastructure, Housing and Healthcare developments**<br><br>Work with Public Health colleagues to input into Local Development Plan to influence built environment and public realm as it impacts people's health, including new housing mapping exercise.<br><br>Work with partners on more joined up, financially sustainable services.<br><br>Look to invest in health provision in areas where economic regeneration will be supported by health access footfall. | Embedded a robust, consistent response process to new housing developments in order to request funding contributions to mitigate the impact of population increases on Primary Care.<br><br>Strengthened close working with CYC colleagues to act as ambassadors for health input into the CYC Local Development Plan.<br><br>Secured Section 106 contributions for a number of development schemes across the city which will be used to support practices either expand, reconfigure, or consolidate existing premises to meet the increased populations. |
| **Workforce, training, and skills**<br><br>Contribute to a city-wide workforce plan, working with our universities and colleges to give us innovative solutions, as well as creating higher-paid research and teaching jobs to boost our economic and wage growth.<br><br>Collaborate with partners to provide flexible offers for health and care training.<br><br>Listen to our communities and find local solutions fill local workforce gaps | Local workforce priority actions have been developed around 5 key themes:<br><br>Recruitment activities and initiatives across health and care partners including care leavers, and the volunteer workforce.<br><br>Employee of the city – rotational programmes, harmonisation of terms and conditions, development of career pathways<br><br>Student Placements – innovative ideas to expand placement capacity, retention, guaranteed offers, apprenticeships, and paid internships<br><br>Understanding the workforce data across health and care partners<br><br>Key Worker accommodation – exploring opportunities for increased key worker/affordable housing and exploring benefits mitigating affordability to work in York.<br><br>Partnership Health and Care recruitment event held in West Offices in November 2023.<br><br>Strengthened relationship with the North Yorkshire and York Workforce Group which has delivered on:<br><br>• A pilot Legacy Mentoring programmes for all nurses and registered manager in social care.<br>• The development of a platform to provide workforce support to Registered Managers and their management teams in social care. |
| **Supporting social development for vulnerable groups** | Continued delivery of health and care provision to support York's asylum seeker population through Refugee Action York and Nimbuscare, including delivery of vaccination programmes with support from Public Health. |

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| Joint partner working on services and support to York Asylum Seekers.<br><br>Continued delivery of the vaccination programmes to maintain protection in the most vulnerable communities.<br><br>Work with the York Health and Care Collaborative to understand how we can work in partnership to strengthen our prevention approach and understand the impact of the wider determinants of health. | Delivery of the winter vaccination programme in line with guidance issued by NHS England.<br><br>The York Health and Care collaborative continue to work across the partnership to identify how collaboration can be strengthened between services across all ages and physical and mental health. |
| **Strengthening links to wider partnership strategy**<br><br>Plan for how Health and Care will contribute to the City's Economic and Climate Change Strategies, building on the work our organisations and HNY ICB are already doing and ensuring health is included in all policies (cleaner air, a cleaner NHS, net carbon zero by 2030, climate resilience, contribution to local skills and employment work) | Established a Health sub-group of the relaunched York Climate Commission<br><br>Furthered involvement in the Greener General Practice Network<br><br>Launched a consultation on Air Quality Management Plan 4<br><br>Gillygate Air Quality Action plan developed<br><br>CYC Carbon Reduction Programme including 7x successful Net Zero projects funded<br><br>'Fuel for thought' campaign explaining health risks of indoor woodburning<br><br>Commencement of several employments and health initiatives (WorkWell, IPS)<br><br>Health and Wellbeing embedded in York and NY Mayoral Combined Authority framework, including pipeline projects for gainshare. |

### Case study: collaborative work to support asylum seekers with health and care needs

York continues to welcome asylum seekers to the city and as a partnership, the YHCP has been working collaboratively to support these people with their health and care needs.

The ICB and Nimbuscare have delivered bespoke primary care services to people arriving in the city to ensure their initial health and care requirements are met. This includes supporting people with complex issues and trauma through tailored, enhanced support to address their needs effectively, which may not be possible through other services. Translation services are also available to enable people to access care and develop and understanding of how to navigate the health and care system in York. Three of our City Practices have also been closely involved in this programme of work and register all new arrivals so that they are able to access wider health services across the system. Nimbuscare have also focused on young children MMR vaccinations, and Vaccination UK has supported with older groups.

Funded by the YHCP health inequalities budget, Refugee Action York are also working closely with asylum seekers to deliver a health and wellbeing support programme. This includes support for individuals to participate in exercise classes, group sessions on topics such as the menopause and mental health and hiring out community venues for group sport activities.

## 2. Conclusion

As this report has highlighted, there has been a significant amount of work undertaken by the YHCP and its system teams through 2023/24 to improve the health of people living in York and address health inequalities. The Partnership is strengthening through the integration of teams, and although great progress has been made, we always strive for continuous improvement and now is not a time to be complacent. There are a number of short-term projects outlined in this project which are testing approaches to new models of care as the YHCP goes through a period of growth and transformation. Over the coming years the YHCP will, where possible, look for longer term, sustainable opportunities for evidence-based care models that are effective following thorough evaluation and reduce duplication through consolidation. 2024/25 will see further advancement towards the achievement of our priorities and a continued dedication to improving the health and wellbeing of York's residents.

You may have noticed that there are quite a lot of references to the word **‘hub’** - 37 to be exact! This has developed organically as people come together from different parts of our system to create change to deliver better, more integrated care.

### Development of 'Hubs' in York Place

Hubs are multi-agency ‘front doors’ which work together and anchor support to groups of our population with similar needs.

People may work from the same set of buildings and may have standard operating procedures.

There are emerging Hubs for families, mental health, and frailty.

Hubs help connect people to each other, and to the system, and build from the natural communities and capabilities.

# 3. Joint Forward Plan 2024/25

In 2023/24, with support from each Place and Collaborative the Humber and North Yorkshire Integrated Care Board published its Joint Forward Plan. The aim of the plan is to set out how the ICB, and its Provider Partners will contribute to and deliver the Humber and North Yorkshire Health and Care Partnership strategy and other local priorities over a five-year period.

The Joint Forward Plan includes detail about York's priorities (as outlined in this document). Each Place and Collaborative in the ICB is required to provide an annual update on their priorities and workplan as part of the Joint Forward Plan refresh. The remainder of this document outlines the YHCP's Joint Forward Plan refresh, including an update on our priorities and workplan for 2024/25.

### The York Health and Care Partnership's Joint Forward Plan Refresh

Leaders across the YHCP have been working closely to identify a series of Place intentions for 2024/25 to realise our integration capabilities as a whole system. These intentions reflect our strategic plans for the YHCP and underpin the workplan included below.

**YHCP strategic intentions for 2024/25:** Signal our intentions to increase responsibility for services organised at Place level, taking a phased approach to deepen collaboration, build from experience, and embed learning.

- Take steps to accelerate delivery of shared objectives through joint planning and formalising integration arrangements that is financially better and leads to better outcomes.
- Enable our front-line teams to work to aligned budgets, plans and outcomes, particularly in services which target broadly the same population groups and outcomes.
- Harness the strength of our strong, independent organisations to pool and direct our collective capabilities to deliver for York and represent York in the wider system.
- Work with the other five Place health and care partnerships and ICB via a Strategic Framework.
- Develop a Service Offer which helps to overcome the unprecedented challenges we face and demonstrate the premium of place.
- Strengthen our governance arrangements to make it happen, building shared responsibility for delivery and accountability for outcomes, to shift decision-making to place.

### York's Growing and Changing Population

Work undertaken by the York Population Health Hub in 2023/24 has revealed that our population is changing. Our Joint Forward Plan and priorities are adapting to meet the needs of our changing population and to mitigate the challenges these changes may bring.

#### Population growth

- The resident population of York is forecast to grow by approximately 35,000 between 2023 and 2033 with the largest percentage increases in the over 65's, an estimated additional 13,800 residents aged 65+ by 2033.
- The GP registered population is forecast to increase from 251,000 (currently) to 255,600 by 2033.

- All health and care services will be put under increasing pressure with an increased and ageing population.

### Population health

- In 2022, life expectancy for males declined from a peak of 80.2 years (2019) to 79.2 (2022), and for females declined from a peak of 84.1 years (2019) to 83.3 (2022). Male life expectancy in York has now crept below the national average for the first time (York is 75$^{th}$ out of 148 LAs).
- The number of individuals living with multiple Long-Term Conditions is increasing in York, indicating increased and more complex health and care requirements for these individuals in future years.
- 1 in 9 children in York are living in poverty, and there was a 68% increase in average food bank voucher uptake per 1000 people between 2020/21 and 2022/23.
- As we welcome Refugee and Asylum seeker communities to York the YHCP is required to deliver and adapt services to meet the complex health and care needs of these individuals.

### Estates challenges

- Rising demand for care from a growing and ageing population is expected to put pressure on the healthcare estate.
- The combined primary/community care space is estimated to already be approximately 2,500m2 short of current needs; forecasts indicate the overall shortfall in estate capacity will double to 5,500m2 by 2033 (approximately the size of a football pitch).

### Engagement

As outlined above, the organisations that make up the YHCP all undertake their own engagement and coproduction exercises to ensure that services are developed alongside the people who will be using them. In 2024/25 the YHCP will work to strengthen the sharing of organisation led coproduction and engagement exercises, and organisations should look to work together where possible to undertake this work in partnership.

Healthwatch York will continue to lead on engagement activities across the YHCP in 2024/25 with a focus on access to Primary Care. The work will focus on what is working and where residents would like to see change. The Core Connectors scheme outlined on page 4 will also be a key area of focus for Healthwatch York.

The ICB will continue to undertake engagement activities in York Place, including a key piece of work on NHS 111 to increase awareness and understanding of NHS 111, and to gather greater insight into the local populations' views and experiences of using NHS 111.

### Health inequalities

Reducing health inequalities will continue to be a key role of Place Based Partnerships, and work to reduce health inequalities remains a golden thread throughout each of the YHCP's priorities for 2024/25. In 2024/25 the YHCP will receive health inequalities funding from the Humber and North Yorkshire ICB to address local need in line with the Core20PLUS5 Framework. Throughout 22/23 and 23/24 the YHCP has

been delivering a series of projects to utilise this funding, demonstrating the key partnership work happening in this area. This work will continue in 2024/25 through the following projects:

- **Maternal and child nutrition** to develop an Infant Feeding Strategy and delivery plan for the improvement of maternal and child health outcomes through better nutrition during preconception, pregnancy, and early childhood to achieve UNICEF Baby Friendly Accreditation for the Healthy Child Service and Primary Care settings across York.
- **Children and Young People's Asthma Friendly Schools project** to reduce health inequalities for CYP with Asthma by ensuring school staff have appropriate training, support, and awareness of CYP Asthma through the employment of a respiratory nurse to provide training across primary and secondary care with a focus on health inequalities.
- **Children and Young People's School Absence Project** supporting Children & Young People with anxiety related school absence, this project aims to reduce absences from school, improve educational outcomes and the social and emotional health and wellbeing of CYP.
- **Brain Health Café** to support individuals on the waiting list for the memory service to embed personalised care approaches for people with cognitive decline and provide support to carers. A population health management approach is planned in 24/25 to ensure those experiencing health inequalities are supported to attend the café.
- **York CVS Ways to Wellbeing Small Grants Programme** providing health inequalities funding into the Programme which funds projects which enhance community connections and improve health and address the causes of health inequalities, particularly in areas of deprivation or for those disadvantaged by inequality in the city.
- **York's second Health and Arts Mela** to support healthcare initiatives at York's second Health and Arts Mela, a multicultural festival bringing York's communities together to celebrate the arts and learn more about the health and care services available in the city.
- **GP outreach for vulnerable women p**roviding preventative health care and support with long term conditions.
- **Raise York Family Hubs health inequalities project,** lacing a paediatric advanced clinical practitioner role in the Family Hubs model that would deliver a range of interventions to build confidence and health literacy in families and help families access support to make best use of community assets.
- **Refugee Action York's** wellbeing and Recreational Activities for Asylum Seekers and newly settled refugees project, providing fortnightly health and wellbeing drop-in sessions, tailored sessions for individual groups, and a wellbeing fund for individuals to apply for to assist with their health and wellbeing.
- **Homelessness provision** providing primary care services to residents at Peasholme and Robinson Court, who are amongst the most deprived population often presenting with complex physical and mental health needs.

These are a series of short-term projects which do not currently have sustainable funding. For 25/26 onwards, the YHCP will explore a more strategic, sustainable approach to reducing health inequalities in York and will ensure this is in line with other policy developments happening in the city.

## 2024/25 priorities

The priorities set by the YHCP in 2023/24 are long term, transformational ambitions, and will therefore remain the same in 2024/25. The workplan has been updated below to outline our actions for each priority in 2024/25.

## Strengthen York's Integrated Community Offer

This priority includes our partnership ambitions to strengthen community integration across health and social care, and physical and mental health.

| What will we deliver? | How will we deliver this in 2024/25? |
|---|---|
| A new Reablement Contract, redesigned specification to ensure we are providing a sustainable, fit for purpose service, achieving best value. | Removing nonvalue added elements of previous contract and strengthening rapid response in reach to support earlier transfers of care for hospital inpatients.<br><br>Working with providers to create a truly integrated model, making best use of collective resource across the system<br><br>Reinvesting monies into other areas of the system to make the biggest impact. |
| Fully integrated Discharge to Assess Model | Work with local authority and YSFT colleagues to design and deliver a discharge to assess model that will redesign the way our community health and 'block booked' care beds operate to support the new model. This will have the biggest impact on reducing delays for hospital inpatients who are medically fit and ready to leave hospital. |
| Integration of Community Services | Co-design of community health 'non bedded' services led by voluntary sector, primary care, community health and York hospital. Providers will work together to design a model that delivers better outcomes for York's older population living with frailty and/or people of working age who are vulnerable or need time-limited extra support. Core functions will include anticipatory care, proactive admission avoidance, and pulling people out of hospital as soon as hospital teams give the green light to transfer. |
| Realign existing resources to facilitate seamless support for people with dementia and their carers in the community. | Work towards delivering a model that includes:<br>• Memory Support Advisers- identification, and early intervention<br>• Support for Carers<br>• Mental health care and treatment<br>• General health care and treatment, including a holistic annual review<br>• Therapeutic interventions, for example cognitive rehabilitation<br>• Dementia friendly environments |

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| St Leonard's Hospice leading work to review end of life care pathways and processes | In 2024/25, YHCP will support St Leonard's hospice to continue to lead the review of pathways and processes and crucially, will ensure that integrated working between the trust and the hospice is central to everything we do. This will ensure that the appropriate people have access to hospice care when they need it on discharge from hospital. This integrated way of working has already commenced with hospice partners having active involvement in the MDT structure aligned to the new discharge improvement process. |
| Continue to work in partnership to support implementation and expansion of Mental Health Community Hubs. | Transfer learning from pilot into a permanent home.<br><br>Recruitment is commencing for clinical, social worker and Voluntary, Community and Social Enterprise sector (VCSE) staff with the aim of the hub being opened in April 2024.<br><br>Evaluating by use of outcome measures as well as service user feedback and continuing to use the model of co production and co design with involvement from the co design group in the evaluation. |

## What will this mean for our population over the next five years?

- Greater access to personalised support and integrated care outside of hospital care for physical and mental health
- Tailored support that helps people live well and independently at home for longer
- Timely support and follow-up from all sectors to reduce the risk of deterioration, embedding a preventative approach
- Increased rapid support to frailty clinicians.
- Greater education of individuals care needs and empowering/giving patients/carers opportunities to be actively involved in their own health management.

## Implement an integrated Urgent and Emergency Care Offer for York

| What will we deliver? | How will we deliver this in 2024/25? |
|---|---|
| With mobilisation of GP OOH and Urgent Treatment Centres at Scarborough, Malton, and York due to start 2nd April and an expectation that new providers will settle in from April – June 2024, all partners expect to realise the ambition, transformation, and benefits of an integrated urgent care service ahead of winter 2024/25. | York & Scarborough Hospitals Trust are now working closely with local GPs in Scarborough, Whitby, York, and Selby, as well as with Nimbuscare to understand how to join up the different contractual responsibilities into a single joined up 24/7 urgent care service.<br><br>UEC Improvement Plan: Multi-Disciplinary work making incremental improvements to capacity, processes, and |

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| | pathways, led by hospital clinical, professional, and operational leads. |
| Expand and enhance the Frailty Crisis Response Hub (part of which is the Frailty Advice & Guidance Line) to deliver a true 'call before convey' service for Yorkshire Ambulance Service and the wider system to support a tangible reduction in unnecessary ED attendances for frail and vulnerable people. | Following the success of the Frailty Crisis Response Hub in 2023/34, in 2024/25 we plan to integrate the service into a co designed community health model which meets future needs and benefits from the combined resources of the general practice, voluntary sector, social care and community health, ambulance, and hospital services. This will enable the Advice & Guidance Line to be included on the Yorkshire Ambulance Service Directory of Services.<br><br>Continuing to enhance the service through the implementation of step-up pathways, improving links between the hub and other community-based services, and better resourcing the clinical visiting capacity of our Urgent Community Response Team, will ensure the hub is able to effectively and safely support frail and vulnerable people to remain at home and avoid unnecessary ED attendances, benefitting the local frail population and increasing confidence in the service and therefore utilisation. |
| Building on the momentum generated at the Urgent and Emergency Care Summit in February 2024, work with system partners to implement the agreed outputs, including a review of the pathways into and out of hospital-based services supporting ED, including the Urgent Treatment Centre, and Speciality-led Same Day Emergency Care services to support effective emergency flow, and build on the success of the GP in Yorkshire Ambulance Service Control Room pilot. | Development of additional direct access pathways to SDEC from primary care and the Frailty Crisis Response Hub to reduce delays for patients and bypass busy ED departments.<br><br>Work with system partners to explore opportunities to enhance clinical assessment in the Yorkshire Ambulance Service Control Room. |

### What will this mean for our population over the next five years?

- A safe, reliable, and resilient service where duplication is reduced, providing remote visits on a 24/7 basis, through a flexible workforce which maximises finite clinical skills and experience whilst also being cost effective.
- Right care, right place, right time: a better experience for patients and reducing pressure on inpatient beds
- Improving ambulance handovers will reduce time spent waiting at ED and support patients to remain, or return home sooner, and safely.

## Further develop Primary/Secondary shared-care models

| What will we deliver? | How will we deliver this in 2024/25? |
|---|---|
| There is an ambition to further develop shared care models between Primary and Secondary Care across the ICB, with a view to providing more integrated care closer to home. | The ICB is evaluating shared care models at Place with a view to scaling up these models where clinically appropriate. |
| Bring more pathways on board with Referral for Expert Input to facilitate shared care pathways. | Continue to explore options with York and Scarborough Hospitals clinicians and GPs to mobilise more pathways on REI. Potential expansion into cardiology, gastroenterology, respiratory, gynaecology, paediatrics, and Ear Nose Throat (ENT). |
| Continue to develop the Primary/Secondary Care Interface Group as a key forum for agreeing principles and culture around joint/collaborative working and sharing pathway development ideas/progress.<br><br>Develop a Pathway Transformation Group to oversee and approve changes in clinical pathways with a focus on clinical governance and safety. | Continue to develop our clinically led Interface Groups with senior leadership from partner organisations, plus engagement with Hospital Specialty leads and GP's. |
| As per the Delivery Plan for Recovering Access to Primary Care - cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients. | Key programme areas:<br>• Onward referrals<br>• Fit notes and discharge letters<br>• Call and recall<br>• Clear points of contact |

## What will this mean for our population over the next five years?

- Shared care models will significantly reduce hand-offs between primary and secondary care, increase agency for the patient/carer, and significantly reduce waiting times for non-admitted treatment.
- The development of more integrated Primary/Secondary Care services and pathways will mean that patients receive a more seamless and holistic care experience – with specialist advice/input where needed – with less need to attend Hospital Outpatient clinics.

## Embed an integrated prevention and early intervention model

| What will we deliver? | How will we deliver this in 2024/25? |
|---|---|
| Delivery of Secondary Prevention Programme | Continued delivery of the LTC programme with a specific focus on strengthening collaboration with primary care providers for streamlined disease management.<br><br>Improve prevention and early intervention pathways: inform modifications to services and pathways to strengthen secondary prevention services to increase early diagnoses and undertake more secondary prevention work. |
| Delivery of Population Health Management Programme | Continue to develop and pilot a series of population health management projects to improve access and outcomes for targeted cohorts of our population, and to inform our future approach to population health management in future commissioning of services. |
| Integrated Prevention Scoping Offer | Scope what an integrated, multi-agency prevention offer should look like for York and make recommendations to the Place Board on future service provision.<br><br>Influence and aim to preserve prevention budgets.<br><br>Lead conversations for the strategic commissioning of services across sectors which focus on prevention and tackle health inequalities. |
| Continue to strengthen the York Population Health Hub<br><br>PHM Infrastructure / Analysis | Support the development of PHM infrastructure and delivery across the partnership, with a specific focus on supporting secondary care and TEWV.<br><br>Enable the system to undertake PHM approaches through lunch and learns and bespoke support to teams.<br><br>Build our data sharing capabilities through finalization of the Information Sharing Charter. |
| Accelerated delivery of the Health Inequalities Programme | Delivery and evaluation of 2022-2024 projects.<br><br>Inform longer term use of health inequalities funding from 25/26 in line with the partnerships' strategic ambitions and based on 2022-2024 project evaluation.<br><br>Delivery of primary and secondary care health inequalities training Programme. |

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| | Support development of Health Inequalities champions network in York with representation from all partners. |
| Strengthen the city-wide Integrated Neighbourhood early intervention and prevention system | A city-wide Integrated Neighbourhood early intervention and prevention system, aligned and joining up primary care, council, community, health, and care, with a single consistent and effective offer that shares culture, behaviours, is an easy-to-navigate/simple pathway from referral through signposting and/or interventions (including through council customer services), with commissioners, including PCNs, delivering within the same model, targeted towards areas of most need. |

### What will this mean for our population over the next five years?

- We are making progress towards becoming a health generating city focussed on prevention, where people can find wellness and connection in their communities.
- We have developed a community of population health and health inequalities champions across the health and care system who are enabled to reduce health inequalities and improve population health both in their organisations and through integrated system working.
- Health inequalities are narrowing through the delivery of a series of projects that are improving health access and outcomes for individuals who experience health inequalities.

### Develop a partnership based, inclusive model for children, young people, and families

| What will we deliver? | How will we deliver this in 2024/25? |
|---|---|
| Support for our schools to support CYP with Asthma to fully participate in school life and manage symptoms to ensure CYP can achieve optimal outcomes | Commissioned Asthma Friendly School (AFS) project nurse to work in partnership with CYC LA and Multi Academy Trusts to become accredited as AFS. |
| Continue to develop the integrated offer for support to children who experience difficulties with bowel and bladder function | Develop additional workshops and targeted support for CYP with additional needs or who are neurodiverse and need more bespoke advice and support.<br><br>Continue to work with colleagues in primary care and healthy child service to ensure they have the right knowledge and support to deliver the Tier 1 level of advice and support in the community. |

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| Review of commissioning arrangements for Speech and Language Therapy services (SaLT) and consideration of joint commissioning possibilities to ensure Speech, language and communication needs (SLCN) of CYP are supported throughout childhood and assessment and intervention is undertaken using the iThrive approach – ensuring all workforce and community can support children with their SLCN<br><br>Early Talk for York approach to reducing SLCN disadvantage that is experienced by children living in areas of deprivation. This could be upscaled and its reach extended if additional funding agreed by system partners. | Review current arrangements for SaLT commissioning which is majority NHS commissioned including service specification for NHS SaLT and consider potential for joint commissioning between education/settings and NHS.<br><br>Work with partners to agree a model for joint commissioning of SaLT services that will meet local needs.<br><br>Health inequalities funding being utilised to develop universal resources for speech and language support.<br><br>NHS SaLT service transformation to continue including the introduction of a SaLT early help and support telephone line for parents/carers and education. |
| Reduce barriers that CYP who are neurodiverse experience in relation to school attendance | Roll out the Partnership for Inclusion of Neurodiversity (PINS) in selected York Schools alongside CYC commissioned Neurodiversity in Schools' support.<br><br>Complete the transformation of Making Sense Together service (Occupational Therapy dept Y&SFT) which includes developing resources to support CYP with sensory processing difficulties.<br><br>Health inequalities funding towards the joint commissioning of family and school link worker when CYP are experiencing school attendance issues (1 year proof of concept to be evaluated and jointly determined, if possible, to expand and continue joint commissioning). |
| Consider an improved integrated approach to SEND (special educational needs and disabilities) using a Family Hub approach and coproducing services with children and families<br><br>Increase support for children and young people with autism with the most complex needs | Senior leaders across York Health and Care Partnership will work collaboratively to review current arrangements and consider joint commissioning possibilities to support CYP who have SEND using Childrens and Families Act and SEND Code of Practice to inform decisions.<br><br>Autism Service Development Funding to pilot a family support worker based at the Beehive to work alongside the psychology- led FIRST: Family Intensive Rapid Intervention Service with the aim of improving participation at school and in community settings. |
| An ICS approach to ensuring CYP have the best start in life and enable everyone to be safe, grow and learn as outlined in the HNY ICB Strategy. | Continue to build on the newly established ICB CYP Integrated Start Well Board, developing an operation model which clearly defines strategies across the ICB footprint with |

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| | those which are best delivered at Place. A clear governance and meeting structure will be developed. |

## What will this mean for our population over the next five years?

- We are making progress towards becoming a health generating city focussed on prevention where children, young people and their families are supported, care is seamless and early intervention is prioritised.
- Children and young people are at the heart of our city life, where good health and wellbeing is priorities from birth.
- CYC Schools will be AFS accredited and CYP in York with diagnosis of asthma will have a Personalised Asthma Action Plan
- CYP will be supported throughout their developmental stages to develop SLC skills with a workforce that is skilled and trained in early intervention and assessment thus reducing need for individual specialist intervention.
- Parents/carers/education staff have timely access to specialist SaLT advice.
- CYP who are neurodiverse feel supported in education settings to thrive and achieve their desired outcomes and parents report that they are confident in schools/settings managing their child's needs.
- Increase in school attendance for CYP who are neurodiverse or experience anxiety in attending school.
- Education staff and parents/carers have training and resources to use to support CYP to improve school attendance.

## Driving social and economic development

| What will we deliver? | How will we deliver this in 2024/25? |
|---|---|
| **Infrastructure, Housing and Healthcare developments** | Partners to describe the City's future service delivery model for health, care, and prevention, and how estate/infrastructure might be shaped to enable this, to inform a tactical estates plan and delivery group.<br><br>Ensuring responses to housing developments are timely, robust, and consistent in their approach.<br><br>We will work with Public Health colleagues, CYC planning officers and local councillors to continue to identify housing development sites and ensure objections are raised. |

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| | We will work more closely with local councillors to ensure good lines of communication, and clear expectations, are set at an early stage in matters that could affect Primary Care estates (e.g. branch closures or other changes to service).<br><br>Through strong, ongoing communication and transparency with wider stakeholders, and further development of the relationship building, and closer ties forged within the York Health and Care Partnership in 2023. |
| **Workforce, training, and skills** | Progress the work on the workforce 5 priority actions (recruitment activities, Employee of the city, student placements, understanding workforce data and key worker accommodation) through the North Yorkshire and York Workforce Group:<br><br>Launch of the Registered Managers workspace which will provide support to the sector across a range of workforce issues.<br><br>Continue to engage with social care providers to understand and seek solutions to their workforce challenges.<br><br>Support health and care organisations adopt the principles of the Care Leaver Covenant and/or the Care Leaver Friendly Employer Charter.<br><br>Increase support to social care providers in the York Place area to recruit necessary workforce, working in partnership with Job Centre Plus.<br><br>Actively participate in the ICB's Workforce Breakthrough programme for 2024/25.<br><br>Build student provision into all commissioned services as part of workforce development. |
| **Supporting social development for vulnerable groups** | Continue to deliver health and social support to York's asylum seeker communities.<br><br>Continue to deliver a series of health inequalities projects aimed at support social development for vulnerable groups, for example supporting the York CVS Ways to Wellbeing Grant Programme. |
| **Strengthening links to wider partnership strategy** | Develop approach to tackling issues with keyworker housing in the city, including developing a number of projects jointly between CYC and health partners to unlock accommodation / bridge affordability gaps for healthcare sector workers.<br><br>Continue to work through the York Economic Strategy on inclusive economic growth, including promoting the Good Business Charter within health and care sectors. |

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| | Contribute to the development of the Y+NY MCA economic framework, including shaping plans for investment of combined authority resource in a way which shapes community health.<br><br>Take bold action to support the Council Plan on climate change, for example explore how joint solutions can be found to reduce the number of HGVs in the city centre to reduce emissions and therefore improve air quality.<br><br>Successfully commence key work and health schemes, e.g. IPS in drugs/alcohol and mental health, and the WorkWell initiative.<br><br>Participate in the University of York's study focussed on system Integration through Network Governance in NHS Place Committees. This research will illuminate our collaboration practices, successes, and challenges at these deeper levels, and strengthen awareness for Managers and Professionals leading system change to strengthen our future position as a Place and ultimately achieve better outcomes for our population. |

## What will this mean for our population over the next five years?

- We are working towards better, joined up services for health and care with sustainable future provision of health and care.
- The holistic needs of patients are being considered through our understanding the wider determinants of health.
- Working towards improved population health through the YHCP using and growing its health assets and collective resources.

Annex B:

# York Health and Care Partnership

**Thursday 25 April 2024, 10:00 - 12:30**
**Severus Meeting Room; First Floor, West Offices**
**Chair: Ian Floyd**

| **Present** | | |
|---|---|---|
| Ian Floyd (Chair) (IF) | Chief Operating Officer | City of York Council (CYC) |
| Sian Balsom (SB) | Manager | Healthwatch, York |
| Mark Bradley (MB) | Place Finance Director, North Yorkshire and York | York Place, Humber and North Yorkshire Integrated Care Board (H&NY ICB) |
| Professor Karen Bryan (KB) | Vice Chancellor | York St John University (representing higher education) |
| Zoe Campbell (ZC) – on Teams | Managing Director North Yorkshire and York Care Group | Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) |
| Cllr Jo Coles (JC) | Executive Member for Health, Wellbeing and Adult Social Care | CYC |
| Sarah Coltman- Lovell (SCL) | York Place Director | York Place, H&NY ICB |
| Cllr Claire Douglas (CD) | Leader of City of York Council | CYC |
| Dr Helena Ebbs (HE) - part | Clinical Place Director, North Yorkshire and York | H&NY ICB |
| Dr Rebecca Field (BF) | Joint Chair of York Health and Care Collaborative | York Medical Group |
| Emma Johnson (EJ) | Chief Executive | St. Leonards Hospice |
| Martin Kelly (MK) | Corporate Director of Children and Young People | CYC |
| Melanie Liley (ML) (on behalf of Simon Morritt) | Chief Allied Health Professional | York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) |
| Peter Roderick (PR) - part | Director of Public Health | CYC |
| Alison Semmence (AS) | Chief Executive | York Centre for Voluntary Services (CVS) |
| Sara Storey (SS) | Director Adult Social Care and Integration | CYC |
| **In Attendance** | | |
| Sara Felix (SF) - part | | York Place, H&NY ICB (secondment) |
| Claire Foale (CF) - part | Assistant Director Policy and Strategy | CYC |
| Dr Lauren Roberts (LR) | Clinical Lead for CVD Prevention, North Yorkshire and York | H&NY ICB |
| Michele Saidman (MS) | Business Executive Support Officer | York Place, H&NY ICB |

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| Sasha Sencier (SS) – on Teams | ICB Head of Governance and Development | H&NY ICB |
| Tracy Wallis (TW) | Health and Wellbeing Partnerships Co-ordinator | CYC |
| **Apologies** | | |
| Gail Brown (GB) | CEO | York Schools & Academies Board |
| Michelle Carrington (MC) | Place Director for Quality and Nursing, North Yorkshire and York | H&NY ICB |
| Brian Cranna | Director of Operations and Transformation, NYY&S | TEWV |
| Professor Mike Holmes (MH) | Chair | Nimbuscare |
| Debbie Mitchell (DM) | Chief Finance Officer | CYC |
| Simon Morritt (SM) | Chief Executive | YSTHFT |

**Minutes**

**1. Welcome and apologies for absence**

The Chair welcomed everyone to the meeting. Apologies were as noted above.

The minutes of the meeting held on 21 March 2024 were approved subject to amendment under item 3, paragraph 5, first bullet point to read:

'Discussion ensued on:

- Agreeing use of the terms 'co- designed' and 'co-produced' with description of the specific groups involved on each occasion.'

***Matters arising***

*Place in 2024/25 Joint Commissioning Arrangements*: JC had discussed Place from the political perspective with SCL noting models such as Brighton and Hove.

*Health Inequalities funding 2024/25*: PR confirmed that the funding information in Annex A of the report was correct but he was still seeking clarification on the 10% overhead reserve money. MB added that this related in part to the cost of managing the resource and distributing it to Place.

There were no declarations of interest in the business of the meeting.

**2. Neighbourhood Locality Model**

CF presented the report which set out the process to agree steps to develop a business case that would ultimately lead to a neighbourhood locality model for council early intervention and prevention services that integrate with health, care and community and align with an Integrated Neighbourhood Framework, co-designed with health and the community. The preferred neighbourhood locality model would be presented to York Health and Care Partnership (YHCP) in the summer as part of the consultation process towards presenting the business case in September 2024. CF highlighted the context of the YHCP Place Priority 3: Embed an integrated prevention, and early intervention offer: *A shift in all areas to prevention and early intervention models across the life course enables people to live a healthier, longer life* noting

that, following a scoping exercise, recommendations would be brought back to the May YHCP meeting around reprioritising of resource to strengthen the prevention offer in the city in line with Place Priorities.

In conclusion CF referred to Green Street Cities as an example of community involvement commending planting of a considerable number of trees in an area where the community had been given the tools and assets.

**3. Integrated Neighbourhood Teams**

In introducing her presentation HE highlighted the context of both agreeing permissions to develop integrated neighbourhood teams and at the same time designing them within the current complex and challenging environment, but also noting that solutions could be reached through working together.

HE's presentation comprised: identifying the problem to be solved; potential solutions based on evidence; the meaning of the term Integrated Neighbourhood Team; how to agree what an integrated neighbourhood team does; frequently asked questions; and next steps.

*Items 2 and 3 were discussed jointly noting the former described the Local Authority process to gain council approval for the local redesign of community services and the latter described the system perspective.*

While support was expressed for the approach described in both reports, detailed discussion on the two papers and their associated requirements and recommendations, included:

- Emphasis on the need for all agencies to have a shared vision and values which would require cultural and behavioural change.
- Concern about accessibility and navigation of the system. Services should be seen as working together in a person focused approach with multi disciplinary working wrapped around the individual but with recognition that not all provision may be in the community. The aim was to reduce complexity for both the population and workforce and to "hide the wiring".
- The need for user friendly language and consistency including consideration of whether an alternative to the term integrated neighbourhood team may be preferred; this may vary in different areas.
- Recognition of the complexity of York boundaries, e.g. Primary Care Networks not being geographically matched in York and the fact that City of York Council also has some commissioning responsibility in rural areas. It was noted that there may be "blurring" of boundaries where appropriate.
- The perspective of building on work that has already taken place alongside developing new ways of working.
- The need to manage expectations of both the population and the workforce in management of complex individuals in a complex system.
- Emphasis on engagement with primary care.
- Account being taken of community mental health transformation when siting services/hubs.
- Ensuring wide representation at the locality mapping workshops including primary, secondary and community care and schools.
- Emphasis on the role of, and engagement with, the voluntary sector but with recognition of its capacity issues.
- Recognition of the political perspective of the challenging financial positions of organisations working to deliver transformation in an environment of diminishing resources.

- A "roadmap" for the expectations at six months, 12 months and 24 months.
- Noting of the potential for a diverse approach to progress delivery of early intervention and prevention.
- Learn from experiences both locally and more widely, including linking workstreams to avoid duplication, with the aim of systematising and streamlining.
- The need for clarity of what an integrated care model will deliver within the challenging financial environment.
- Each agency must recognise the need for change with a collective agreement for the next steps.

IF summarised the discussion as being supportive of continuation of the work but with a number of concerns and caveats to be resolved. The concept of a roadmap to understand progress with the complexities of the system was welcomed to aid understanding. IF requested examples of Integrated Neighbourhood Teams be provided for the next meeting.

**York Place Committee:**

Endorsed the approach to develop the business case for redesigning early intervention and prevention services by establishing Integrated Neighbourhood teams.

Action:
Examples of Integrated Neighbourhood Teams to be provided for the May YHCP meeting.

*SF, CF, PR left the meeting*

**4. Update to York Health and Care Partnership Place Development in 2024/25**

SCL referred to discussion at the March 2024 meeting when the YHCP Place Intentions and Joint Commissioning Arrangements had been presented for discussion and feedback. The discussion had been set in the context of the developing Humber and North Yorkshire Strategic Framework reflecting work undertaken by all six Places. The documents had been updated to reflect both local and Humber and North Yorkshire discussions and also included the approved Humber and North Yorkshire Strategic Framework '*A Shared Framework for Excellence, Prevention and Sustainability at Place'*. Final approval was now being sought for the Place development plans.

SCL described how the Strategic Framework would support transformation to address inequalities and facilitate sharing of resources, planning and staff at Place, also noting YHCP already increasingly operating as a single leadership team. She highlighted the York Plan to deliver the YHCP Strategic Intentions including building and formalising structures, governance arrangements and establishment of a joint commissioning forum as discussed at the previous meeting in preparation for establishing a Joint Committee.

*HE left the meeting*

In terms of next steps SCL explained that progress would be assessed and due diligence undertaken. A further report would be presented at the September YHCP meeting.

Detailed discussion ensued, including:

- The need for both quality and equality assessments.
- Support for the ambition must be with recognition of the financial challenges faced by all organisations.

- The context of financial risk assessment and noting that Local Authorities, primary care and the hospice cannot hold deficits. MB explained that financial principles would be developed from the Local Authority and NHS perspectives to manage risk. Due diligence, engagement, trust and transparency would be required by all partners in the move towards coming together of budgets and accountability.
- Learning from other areas but with awareness of variation in funding.
- Integration being driven by the aim of using resources to maximise benefit and deliver services accordingly.
- Local determination on how neighbourhood teams operate.
- Consideration of mental health, learning disabilities and autism services in the collaborative decision making.
- Emphasis on the perspective of developments being truly transformational in comparison with previous work, also with recognition of the challenge to change culture.

IF highlighted the intention to develop the work gradually maximising opportunities. Each organisation would make their own decision about the Joint Committee and noting the need for a "vehicle" to progress the work.

**York Place Committee:**

i) Noted the final version of the Humber and North Yorkshire Strategic Framework for Places.
ii) Approved the intention to fully explore the option of forming a joint committee from April 2025.
iii) Agreed to engage with respective organisations/networks to influence and drive the intentions and plans of York Health and Care Partnership.

*JC left the meeting*

**5. Update to York Health and Care Partnership Annual Report and Joint Forward Plan**

Due to time constraints this item was not discussed in detail. However, SCL advised that the Annual Report and Joint Forward Plan had been updated to reflect discussion at, and feedback, after the March meeting; final approval was now being sought.

As SB had noted a number of minor amendments required, she agreed to amend the document accordingly prior to its publication.

**York Place Committee:**

i) Approved the changes to the Annual Report and Joint Forward Plan and agreed the document as final, subject to the minor amendments referred to above.
ii) Approved the strategic intentions as final.
iii) Agreed that the document should be made public via the July meeting of the Health and Wellbeing Board and publication on the ICB website.

**6. Any Other Business**

*York Poverty Truth Commission:* CD explained that the Commission worked to bring dignity and respect to people facing poverty. She requested members sign up to the Commission. It was agreed that the information be more widely publicised via inclusion on the July Health and Wellbeing Board agenda. Information at www.yorkcvs.org.uk/york-poverty-truth-commission.

Action:
CD to liaise with TW regarding York Poverty Truth Commission inclusion on the Health and Wellbeing Board agenda.

*Humber and North Yorkshire ICB York Place Team:* SCL noted that her team, which undertakes the co-ordination work of YHCP, currently has two key members on maternity leave. She sought and received support to potentially address the capacity gaps through seeking expressions of interest from staff in the partner organisations.

Action:
SCL to provide information to members for them to pass on to staff for potential expressions of interest in working for the ICB on a maternity leave cover arrangement.

**Information Item: Partnership Award Winners**

SCL referred to the information on HSJ Partnership Awards in the pack and asked members to let her know if they would like to make a nomination.

Annex C:

# York Health and Care Partnership

**Thursday 16 May 2024, 10:00 - 12:30**
**Severus Meeting Room; First Floor, West Offices**
**Chair: Ian Floyd**

| **Present** | | |
|---|---|---|
| Ian Floyd (Chair) (IF) | Chief Operating Officer | City of York Council (CYC) |
| Sian Balsom (SB) | Manager | Healthwatch, York |
| Mark Bradley (MB) | Place Finance Director, North Yorkshire and York | York Place, Humber and North Yorkshire Integrated Care Board (H&NY ICB) |
| Professor Karen Bryan (KB) | Vice Chancellor | York St John University (representing higher education) |
| Michelle Carrington (MC) – on Teams | Place Director for Quality and Nursing, North Yorkshire and York | H&NY ICB |
| Cllr Jo Coles (JC) | Executive Member for Health, Wellbeing and Adult Social Care | CYC |
| Sarah Coltman- Lovell (SCL) | York Place Director | York Place, H&NY ICB |
| Cllr Claire Douglas (CD) | Leader of City of York Council | CYC |
| Dr Helena Ebbs (HE) – on Teams | Clinical Place Director, North Yorkshire and York | H&NY ICB |
| Dr Rebecca Field (BF) – on Teams | Joint Chair of York Health and Care Collaborative | York Medical Group |
| Professor Mike Holmes (MH) | Chair | Nimbuscare |
| Martin Kelly (MK) - part | Corporate Director of Children and Young People | CYC |
| Simon Morritt (SM) - part | Chief Executive | York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) |
| Peter Roderick (PR) | Director of Public Health | CYC |
| Alison Semmence (AS) | Chief Executive | York Centre for Voluntary Services (CVS) |
| Sara Storey (SS) - part | Director Adult Social Care and Integration | CYC |
| **In Attendance** | | |
| Sara Felix (SF) – Item 5 | | York Place, H&NY ICB (secondment) |
| Neil Ferris – Item 5 | Corporate Director of Place | CYC |
| Niall McVicar – Item 3 | Head of Innovation and Children's Champion | CYC |
| Rob Newton (RN) – Item 4 | Effectiveness and Achievement \| Social Mobility Project Manager | CYC |

| | | |
|---|---|---|
| Jenna Tucker (JT) – Item 4 | Allied Health Professionals Senior Manager (Children's Therapies), Family Health Care Group | YSTHFT |
| Michele Saidman (MS) | Executive Business Support Officer | York Place, H&NY ICB |
| Tracy Wallis (TW) | Health and Wellbeing Partnerships Co-ordinator | CYC |
| **Apologies** | | |
| Zoe Campbell (ZC) | Managing Director North Yorkshire and York Care Group | Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) |
| Brian Cranna (BC) | Director of Operations and Transformation, North Yorkshire, York and Selby | TEWV |
| Emma Johnson (EJ) | Chief Executive | St. Leonards Hospice |
| Debbie Mitchell (DM) | Chief Finance Officer | CYC |
| Gary Young | Place Deputy Director Provider Development | H&NY ICB |

The agenda was discussed in the following order.

**Minutes**

**1. Welcome and apologies for absence**

The Chair welcomed everyone to the meeting. Apologies were as noted above.

The minutes of the meeting held on 23 April 2024 were approved subject to clarification of the amendment to the minutes of the 21 March meeting regarding the terms 'co- designed' and 'co-produced' under item 3, paragraph 5, first bullet point. Following discussion, it was now agreed that use of these terms be accompanied by clarification of the specific groups involved on each occasion. The March minutes would be amended accordingly to read:

'Discussion ensued on:

- Agreeing use of the terms 'co- designed' and 'co-produced' with description of the specific groups involved on each occasion.'

***Matters arising***

*Integrated Neighbourhood Teams:* SCL referred to the case studies included in the meeting pack and the email information circulated the previous day with a number of blogs which she commended as helpful examples.

*York Health and Care Partnership Annual Report and Joint Forward Plan:* SCL thanked SB for her proof reading of the document which was currently being finalised. Members would receive a copy in advance of its publication via the July meeting of the Health and Wellbeing Board.

*Formation of a Joint Committee:* IF and SCL had had initial dialogue and a meeting had been arranged for 5 June with officers from CYC and the ICB. SCL additionally noted that the Joint Commissioning Forum had begun work on a project plan, including a timeline; a full report would be brought to the September York Health and Care Partnership meeting.

There were no declarations of interest in the business of the meeting though KB declared during discussion at item 4 that she is a Speech and Language Therapist by profession.

**2. Update on Integrated Prevention Scoping Work**

This item was deferred to the June meeting.

**5. Future Service Delivery Model and Estates Development**

SF gave a presentation *York's future service delivery model for health, care and prevention and How our estate/infrastructure might be shaped to realise this* describing a project overview, areas of consensus for a future model, key features of a proposed future model, requirements to achieve the model, next steps and "telling a story" to attract buy in from stakeholders. A full report would be provided in due course.

SF applauded the commitment of colleagues she had interviewed and noted that the development would be "live" in order to respond to change as appropriate, also highlighting that this was a 10 year vision.

Members commended the presentation and associated work.

Detailed discussion included:

- The local and national political perspectives in relation to the context of development into the Local Plan including private sector investment in assets, housing developments and potential opportunities emanating from the election of the North Yorkshire and York Mayor; for the latter the forthcoming General Election and need for the plan to be future proof.
- Emphasis on demonstrating partnership working and integration of services with economies of scale.
- Adoption of a proactive approach as York Place in the context of access to any potential additional resources.
- The need for key worker and affordable housing as part of the wider infrastructure for integration.
- The challenge of ensuring comprehensive engagement with residents and noting the role of the voluntary sector but with recognition of its limited capacity.
- Aspects of the current estate across the system, associated funding arrangements and challenges, recognition of the financial implications to achieve changes to service delivery with emphasis on investment alongside savings requirements, the context of a collective, creative approach to attracting investment and assurance regarding associated expertise in relation to potential public and private sector funding.
- A workforce strategy as key in the context of the need for culture change in developing an out of hospital Place based model of care, recognition of current workload pressures and recruitment challenges in some areas and the opportunity to establish community based placements for students.
- The context of promoting York as "a healthy city".
- Learning from experience, such as development of the Mental Health Hub and the Community Stadium.
- The need for clarity regarding reference to public sector agencies. There are many private sector/independent sector agencies also providing services that we would want to be included, for example home care providers.

Next steps would be SF's production of a report for members to sign up to as a Place building development approach.

<u>Action</u>
CD to liaise with the new combined authority with regard to potential staff resource opportunities.

*NF left the meeting.*

**3. Raise York**

NM gave a presentation *Raise York: Working together with children and families to improve lives* noting its alignment with the previous discussion and highlighting the context of "it takes a village to raise a child". He described the Raise York outcome ambitions, priorities, lessons learned from pilot activity, the 'Toolbox' to support delivery of the ambitions, the Children's Workforce Induction, the Solihull Programme, the paediatric primary care practitioner within Raise York, the developing SEND Centre of Excellence, a one page summary about each priority area and the "asks" of the York Place Committee.

NM explained that every family in York with children aged 0 to 19 could access the Solihull Programme permanently through a one time passcode 'Raise' and requested this support be promoted to families alongside other contacts.

MK described the aim of bringing specialist services back into the community based in one building noting the potential for this design to be replicated and the need for a partnership approach to funding. This community based approach facilitated recognition of gaps such as autism services.

NM highlighted two of the Raise York's priorities: perinatal mental health and parent/carer-infant relationships and children and young people's mental health. Work was taking place with a view to understanding perceptions of available support and how to access it. The context of normalising access to parental support was emphasised.

*SM left the meeting during this item.*

Members commended the presentation and associated work.

Discussion ensued relating to:

- A communication approach to complement the regular means of communicating with families, namely via General Practice and schools, to ensure awareness about available more in depth support as appropriate. PR additionally agreed to arrange for information to be incorporated in the SMS messaging service in York.
- Support from Child and Adolescent Mental Health Services (CAMHS) regarding the offer to families with mental health concerns.
- Potential consideration of developing a single overall York 'brand' as an umbrella for such as Raise York, Live Well York and the hub developments.
- The context of the former Sure Start centres.

Action
PR to arrange for family support information to be incorporated in the York SMS messaging service.

*CD, SF and MK left the meeting; RN and JT joined.*

**4. Early Talk for York**

In introducing the presentation *Early Talk for York: A local area approach to improving speech and language communication outcomes 0-5* RN highlighted the benefits of joint working and consistent narrative, also noting recognition by Ofsted and the Care Quality Commission for this work. He described impact of Early Talk for York in terms of improvement in practice,

greater early identification of levels of need, system improvements and children's outcomes, all of which lead to wider improvements but also noting areas of challenge. Speech and language support pathways for children aged 0 to 5 were being mapped across York and progress was being made regarding the Healthy Child Service being integrated with Health Visitors.

JT described the collaborative working, including a specialist clinician, which was key to the Early Talk for York model. This enabled a responsive and effective approach for children with special needs. In terms of the transformation work, including addressing the challenge of speech and language therapy waiting times, a Request for Helpline model had been introduced. This enabled access to signposting to support for any concerned parent and had been recognised by the North Yorkshire SEND inspection as 'good' for the waiting well. Additionally, a unique universal and targeted specialist clinician role had been created for the speech aspect also providing a rolling training programme which had good attendances at its 'virtual' offer. The language perspective required further work. Overall demand currently outweighed workforce capacity.

Members commended the Early Talk for York work noting that qualitative evidence would emerge and welcoming the culture shift in terms of families acknowledging a need for support.

*SS left the meeting during this item.*

Discussion ensued during which KB declared her profession of speech and language therapist.

- Aspects of the 'why early language?' message in the presentation would be adapted according to the audience but emphasis remained consistent on the importance of early language development.
- Welcoming the universal targeted service but highlighting the need for children to receive services more quickly and the context of a reactive response for children to be able to access services when their need is identified.
- Evidence of the impact of COVID-19 on speech and language development and associated impact on schools, noting that six children in every primary and secondary classroom were affected; additionally, the perspective of detriment to the 'COVID-19 generation' at a later stage, such as with reading development.
- Raising awareness with parents and communicating with different audiences through appropriate narrative and examples.

In conclusion RN explained that currently the Early Talk for York model was operating in around half of the city and the capacity ceiling of the resource envelope had almost been reached; despite this the ambition was to continue the improvement trend lines. Work had been started on further development of the Early Talk for York model with a small group of primary schools and a few secondary schools.

**Any Other Business**

There was no other business.

**Next Meeting:** Thursday 20 June 2024

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Annex D:

# York Health and Care Partnership

**Thursday 20 June 2024, 10:00 - 12:30**
**Severus Meeting Room; First Floor, West Offices**
**Chair: Ian Floyd**

| **Present** | | |
|---|---|---|
| Ian Floyd (Chair) (IF) | Chief Operating Officer | City of York Council (CYC) |
| Sian Balsom (SB) | Manager | Healthwatch, York |
| Gail Brown | Chief Executive | Ebor Academy Trust |
| Sarah Coltman- Lovell (SCL) | York Place Director | Humber and North Yorkshire Integrated Care Board (H&NY ICB) |
| Dr Helena Ebbs (HE) on Teams - part | Clinical Place Director, North Yorkshire and York | H&NY ICB |
| Dr Rebecca Field (BF) - part | Joint Chair of York Health and Care Collaborative | York Medical Group |
| Professor Mike Holmes (MH) | Chair | Nimbuscare |
| Melanie Liley (ML) | Chief Allied Health Professional | York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) |
| Peter Roderick (PR) | Director of Public Health | CYC |
| Alison Semmence (AS) – on Teams | Chief Executive | York Centre for Voluntary Services (CVS) |
| Cllr Lucy Steels-Walshaw (LSW) | Executive Member for Health, Wellbeing and Adult Social Care | CYC |
| Sara Storey (SS) | Director Adult Social Care and Integration | CYC |
| **In Attendance** | | |
| Jake Abbas (JA) – items 1 to 3 | Deputy Director of Population Health Intelligence | H&NY ICB |
| Professor Federica Angeli (FA) | Chair in Public Management and Strategy, Deputy Dean of School (Strategy and People), School for Business and Society | University of York (secondment to York Place, H&NY ICB from 1 July 2024) |
| Natalie Caphane (NC) | Assistant Director of System Planning and Improvement | York Place, H&NY ICB |
| Nichola Greenwood (NG) – item 5 | Social Care Workforce Lead, York and North Yorkshire | YSTHFT |
| Caroline Johnson (CJ) – on Teams | Place Deputy Nurse Director | York Place, H&NY ICB |
| Michele Saidman (MS) | Executive Business Support Officer | York Place, H&NY ICB |
| Phil Truby (PT) – items 1 to 3 | Public Health Specialist | CYC |
| Tracy Wallis (TW) | Health and Wellbeing Partnerships Co-ordinator | CYC |

| Apologies | | |
|---|---|---|
| Mark Bradley (MB) | Place Finance Director, North Yorkshire and York | H&NY ICB |
| Michelle Carrington (MC) | Place Director for Quality and Nursing, North Yorkshire and York | H&NY ICB |
| Emma Johnson (EJ) | Chief Executive | St. Leonards Hospice |
| Gary Young | Place Deputy Director Provider Development | H&NY ICB |

**1. Welcome, apologies for absence and minutes**

The Chair welcomed everyone to the meeting. Apologies were as noted above.

There were no declarations of interest in the business of the meeting.

The minutes of the meeting held on 16 May 2024 were approved.

***Matters arising***

*Formation of a Joint Committee:* SCL explained that a list of areas was being worked through via the Joint Commissioning Forum on where pooled budgets would be appropriate. She advised that the ICB had been supportive of the ambitious but pragmatic approach presented to them at the update on the joint committee.

*Future Service Delivery Model and Estates Development:* SCL noted that the report had been received and would be socialised by GY with colleagues who had input to the workshops and interviews for their and any final amendments before its presentation to the York Health and Care Partnership meeting.

*Raise York:* PR confirmed that he had arranged for family support information to be incorporated in the York SMS messaging service.

**2. The future health of the population – building our population health management approach across Humber and North Yorkshire**

JA's presentation on population health was in the context of the ambition for everyone to live longer and healthier lives by narrowing the gap in healthy life expectancy between the highest and lowest levels in communities by 2030 and increasing healthy life expectancy by five years by 2035. The key messages related to growth in the elderly population; healthcare demand; and the deprivation mix across the system and places.

JA highlighted:

- On average people in Humber and North Yorkshire are living in poorer health from their early 60s, and much earlier than this in some of our Places, with the healthy life expectancy gap between the most and least deprived areas at Local Authority level being around 13.5 years for males and 11.5 years for females.
- The need to consider the challenges on the basis of four components: increase capacity, improve productivity/efficiency, right place right time (rebalance of health and care sectors) and a focus on prevention; the latter was highlighted with noting that around 42% of the burden of poor health and early death in England is attributable to modifiable risk factors such as smoking and alcohol.

- The need to recognise the wider determinants of health.
- The context of Population Health Management with the NHS leading on secondary prevention as part of an overall system strategy and a focus on the interventions that are known to work and are likely to have the greatest impact, notably for cardiovascular disease, diabetes and respiratory disease.
- Availability of robust evidence based preventative interventions, including at www.england.nhs.uk/ourwork/prevention/secondary-prevention

Detailed discussion included:

- The context of identifying what 'good' looks like for York and investment required across the ICB to enable the best possible outcomes.
- The need for a collective determination to focus on, and not deviate from, the prevention agenda with recognition that outcomes may not be immediate.
- Despite the current financial challenges across all partner organisations, the need for pump priming preventative work for impact to be achieved.
- Emphasis on prevention as an efficiency and the need for a delivery model, noting included Integrated Neighbourhood Teams as part of this.
- The key role of the voluntary and community sectors but emphasis on the requirement for investment to enable this.
- Opportunities to learn from other systems where people live healthier lives for longer.
- Public health financial constraints including impact on capacity to address child poverty.
- The context of prevention not being introduced early enough.

It was agreed that a business case focusing on prevention be developed via the Joint Commissioning Forum in the context of working together to maximise outcomes from available resources presenting recommendations, i.e. specific proposals, to the York Health and Care Partnership. Colleagues from wider than the Joint Commissioning Forum would be invited to assist with this approach.

Action

PR to lead on development of an improvement programme for York's preventative services for presentation at a future meeting.

**3. Preventative Services in York – Scoping Assessment**

In introducing this item PR referred to the paper presented at the October 2023 meeting which outlined the prevention system in York Place and proposed a prevention system scoping exercise to determine how the prevention offer might be optimised. The current paper outlined the results of the initial scoping exercise with proposals for next steps for this in York.

PT referred to the two-stage approach adopted for the scoping exercise: Workforce and service mapping via discussions with service managers/commissioners in the context of development of a landscape map of services and the results now presented to York Health and Care Partnership for discussion and suggested next steps. He highlighted key themes detailed in the report noting all services were willing to be flexible to support prevention, identification of funding as a major issue and highlighting such opportunities as an integrated referral hub with a single point of access and a multi disciplinary team approach.

Detailed discussion ensued including:

- The key role of the voluntary sector in underpinning the prevention agenda but emphasis on risk due to the financial challenge and need for investment.
- The context of maximising social capital given freely.
- The need for consideration of "harder to reach" communities.
- Maximising available services with an approach of "hide the wiring" utilising one point of contact and one referral point.
- Adopting a holistic approach addressing overlapping skills where appropriate and making every contact count.
- The need for a focus on early intervention and prevention in such as childhood obesity.
- Opportunities to maximise aspects of technology.
- The perspective of integration and collaboration opportunities via schools.
- Opportunities relating to career roles, transfer of skills and learning from each other.
- The role of the Population Health Hub as part of the integrated prevention offer.
- The context of a professional personalised approach without creating dependency and with least possible cost to the system; highest quality at lowest cost.
- Development of data sharing, subject to legal requirements, to target communities and improve connection to services.
- Opportunities to learn from the Born in Bradford programme; noting BaBi (Born and Bred in York) in this context.
- Communication with services to highlight the individual contributions to the wider objectives.

In concluding this item and seeking and receiving support for the recommendations, IF emphasised the context of the York Health and Care Partnership's priority to embed an integrated prevention and early intervention model highlighting the importance of items 2 and 3 in this regard. He proposed arranging dedicated time for focused discussion, either a full day or two half days, with invites to wider attendees.

Action
IF. PR and SCL to consider progressing the proposal for dedicated time.

*JA, GB, HE, BF and PT left the meeting and NG joined.*

**4. Assurance Report**

NC presented the report which comprised two sections: progress against delivery of the 2024/25 Place priorities and an update on performance, delivery and efficiency. With regard to the latter she highlighted the context of the system being in recovery from the challenges of 2023/24 but noted:

- Some areas of improvement, e.g. elective care and primary care.
- Mental health remained a concern across most trajectories with dementia diagnosis highlighted in particular, York being an outlier across the ICB. Work was continuing to review the dementia diagnosis pathway and explore options for community-based diagnosis where appropriate, increasing diagnosis and improving primary care recording. Also noted were the local historical context of low rates of dementia diagnosis, new emerging therapies and the Health and Wellbeing Strategy.
- Urgent and emergency care performance had deteriorated since the period covered by the report and work was taking place to understand the increased pressure through May and June. An Urgent and Emergency Care Summit had been held in May.

With regard to progress against Place priorities NC highlighted in the context of earlier discussion the static health kiosks in areas of deprivation launched to increase hypertension

detection and subsequent treatment (funded from the Health Inequalities monies as agreed at the March York Health and Care Partnership meeting), a scoping exercise for an integrated prevention model and a health inequalities training programme for primary and secondary care.

SCL referred to the sustained pressure on urgent and emergency care which had inevitably impacted on patient safety and reported that regular discussions were taking place with partners to support response to these challenges. She also highlighted that the system was working together, aiming to optimise pathways in the community, to manage patient safety and risk in the community.

Members noted the key issues and progress updates relating to Quarter 1 Place priorities including actions undertaken and those in development to further improve performance at Place.

**5. Social Care Workforce Priorities Update**

NG presented the report which provided an update on:

- Workforce priorities in relation to recruitment and retention; care leavers; education and training; workforce data; and key worker accommodation.
- Humber and North Yorkshire Transformation Programme in terms of a review of the 2023/24 Workforce Transformation Plan and identification of work needed for the 2024/25 Programme.
- The context of considerable work taking place across the York area to create future opportunities and retain the social care workforce but recognition of the challenges, in particular the disparity between the social care and health care sector in relation to reward and recognition, a workstream area identified by the Humber and North Yorkshire Health and Care Partnership in their 2024/25 workforce transformation programme.

*AS left the meeting during this item*

Detailed discussion ensued including:

- The context of the increasing ageing population and associated impact on the need for care in the community.
- Noting a degree of local autonomy to address the challenges, e.g. supporting nurses who feel de-skilled and upskilling care workers to create opportunities.
- Impact on providers as a result of changes to international recruitment.
- Impact on staff as a result of suspension/revocation of a number of licenses.
- The context of social care being promoted as a profession with associated career opportunities.
- The wider context of the effect of housing costs on employment in York.
- Recognition of the challenge for staff to be released for education and training without backfill being available, particularly for the smaller providers.

Members:

- Noted the progress on the social care workforce priorities.
- Affirmed their partner organisation’s commitment to supporting care leavers.
- Noted the workforce data available through Capacity Tracker

- Noted the Humber and North Yorkshire Health and Care Partnership workforce transformation programme for 2024/5.

**6. System Integration through Network Governance**

In introducing FA's role SCL explained FA was taking up a six month secondment working two days a week for York Place to undertake a research study titled 'System Integration through Network Governance in NHS Place Committees' (SYNC) noting participants had been nominated as previously agreed. FA would take a professional lead in promoting integration across health, care and prevention.

FA described her experience in studying collaborative and complex health care systems explaining that the project aimed to understand the development of collaboration and integration from both managerial and operational perspectives utilising interviews and questionnaires. She noted learning opportunities - regionally, nationally and internationally – from structures that had transitioned to integrated care systems advising that York was the focus of a case study which could be scaled up. The context of aligning the different stakeholder perceptions of network governance at both partnership level and system level was highlighted.

**7. Any Other Business**

There was no other business.

**Next Meeting:** Thursday 11 July 2024

**Health and Wellbeing Board** 24 July 2024
Report of the Manager, Healthwatch York

# Healthwatch York Annual Report

## Summary

1. This report is for information, sharing details about the activities of Healthwatch York in 2023/24 with the Health and Wellbeing Board.

## Background

2. Healthwatch York has a legal duty to produce an Annual Report by 30 June each year, and to share it with local and national stakeholders[i]. The report, Annex A, contains information about how Healthwatch York have fulfilled their statutory function over the past year.

3. In addition, we are also including a report at Annex B that provides updated responses to the recommendations made in our reports for 2023/24, to support the Board in monitoring progress.

4. We also include a link to our Summary Workplan for 2024/25 as Annex C.

5. Finally, at Annex D we share our Independent Evaluation, which explores how key stakeholders in the city view our work and considers potential developments for the future.

## Main/Key Issues to be considered

6. Healthwatch York are a small team, with a wide remit. The Annual Report provides a summary of work completed through the year 2023/24. The responses to recommendations report aims to bring together action taken by the system in response to this.

## Consultation

7. There has been no specific consultation involved in producing the Annual report, but it is informed by specific and general consultation and engagement activities that Healthwatch York undertake. The Independent Evaluation has been completed in consultation with key stakeholders, relevant to the specific activities of Healthwatch York during 2023/24.

## Options

8. Health and Wellbeing Board are asked to note Healthwatch York's Annual Report 2023/24.

## Strategic/Operational Plans

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

## Implications

10. There are no specialist implications from this report.

- **Financial**

There are no financial implications in this report.

- **Human Resources (HR)**

There are no HR implications in this report.

- **Equalities**

There are no equalities implications in this report.

- **Legal**

There are no legal implications in this report.

- **Crime and Disorder**

There are no crime and disorder implications in this report.

- **Information Technology (IT)**

There are no IT implications in this report.

- **Property**

There are no property implications in this report.

- **Other**

There are no other implications in this report.

**Risk Management**

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

**Recommendations**

12. The Health and Wellbeing Board are asked to:

i. Receive Healthwatch York's Annual Report

ii. Review the responses to recommendations and confirm whether they are satisfied with these.

Reason: To keep up to date with the work of Healthwatch York and monitor progress regarding recommendations.

**Contact Details**

| **Author:** | **Chief Officer Responsible for the report:** |
|---|---|
| Siân Balsom<br>Manager<br>Healthwatch York<br>01904 621133 | |

**Report Approved** √ **Date** 12.07.2024

☐

**Wards Affected:** All **All** ✓

**For further information please contact the author of the report**

**Background Papers:**

**Annexes**

Annex A - Healthwatch York Annual Report 2023/24
Annex B - Briefing – Responses to Recommendations
Annex C - Summary Workplan 2024/25
Annex D - Independent Evaluation 2023/24

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

Annex A:

# The value of listening

Healthwatch York
**Annual Report 2023-2024**

healthwatch York

# Contents



"Thank you to everyone who shared their experiences with us this year. We know sometimes the most important thing we do is just listen. But we also want to do more. So in this report we share how in the past 12 months we have used your words to try and make York better for us all."

The Healthwatch York team

Cover images by Priscilla du Preez and Jamie Wheeler via unsplash

# Message from our Chair

## Health and social care have continued to make headline news both nationally and locally. For Healthwatch York this has inevitably meant our team has been busier than ever. This increase in contact, alongside our reports and surveys, has enabled us to highlight areas of local concern and best practice in health and social care.

York is a beautiful city with its green spaces and historic buildings. At times though, I am reminded of Dickens' 'A Tale of Two Cities'. Inequality is stark within some areas of the city, reported on the national index as areas of significant deprivation. The difference between areas in York with the lowest and highest life expectancy is startling. York has been named among the most expensive areas for people to buy their own home. This excludes many of our lowest paid citizens from owning their own home in their own city. Our cost of living surveys in December and March confirmed that the impact on many York residents is similar to the national picture with people skipping meals, not putting the heating on and feeling increasingly isolated due to reduced social opportunities.

We do have commitments from health and social care partners to make York a city where everyone can share the benefits of living here. Our work is based on the principle that the best people to help shape health and social care services are those people with experience of using them. Our dedicated team and brilliant volunteers look forward to a year of partnership working. This doesn't mean that we always agree, but it does mean that we listen to each other, understand each other's position and work together to be the best that we can be.

I hope you enjoy this Annual Report, in which you will read about the team and the range of work that has been undertaken. I remain proud of being the Chair of Healthwatch York and to continue to support our committed and professional team to represent the views of the people of York

"York is a beautiful city with its green spaces and historic buildings. At times though, I am reminded of 'A Tale of Two Cities' by Charles Dickens. Inequality is stark within some areas of the city, reported on the national index as areas of significant deprivation."

Janet Wright, Chair of Healthwatch York

# About Us

**Healthwatch York is your local health and social care champion.**

We make sure the people who buy and provide local health and care services and support hear your voice. We work with them to use your feedback to improve care. We also help you and your family find up-to-date information and advice that you can rely on.

## Our vision

Together, we can make York better.

## Our mission

Healthwatch York puts people at the heart of health and social care services, enabling you to be heard. We believe that together we can help make York better for everyone.

## Our values are:

Accessible • Empowering • Informative • Participative • Valuing Diversity • Responsive • Inclusive • Supporting Choice • Accountable • Flexible

"I really want to pay tribute to the work that Healthwatch does for residents across the city.... It does an amazing job for residents."

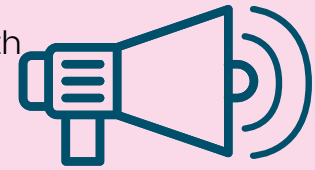
Councillor Jo Coles, Executive Member for Health, Wellbeing and Adult Social Care 2023-24, City of York Council

# Our Year in Review

## Reaching out:

**1,236 people**

shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care.



**606 people**

came to us for clear advice and information about topics such as mental health and the cost-of-living crisis.

## Making a difference to care:

We published

**8 reports**

about the improvements people would like to see in health and social care services.

Our most popular report was

**Breaking Point: A recent history of mental health crisis care**

which highlighted the struggles people face accessing mental health crisis care.

## Health and social care that works for you:

We're lucky to have

**33** outstanding volunteers who gifted us around 30 days of help to make care better for our community.

We're funded by our local authority.
In 2023 - 24 our core contract was for

**£115,610**

which is slightly less than the previous year.

We currently employ

**4 staff** who help us carry out our work.

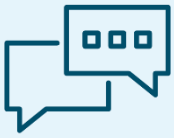
# How we've made a difference this year

## Spring

We updated the York Mental Health & Wellbeing Guide, helping people to navigate local services.

We continued our work monitoring the impact of the rising cost of living on the health of York residents with a new survey and report.

## Summer



Our York volCeS Network continued to meet, enabling the public to speak directly with service providers. Our June meeting looked at LGBTQ+ healthcare.

We published a major report 'Breaking Point: A recent history of mental health crisis care ' which looked at experiences of mental health crisis care in York.

## Autumn

We began an independent evaluation of the new autism and assessment online triage tool and published a report on the experiences of people in York.

Through our Autumn Magazine and engagement events, we kept the public informed of mental health support services available in York.

## Winter

With Healthwatch North Yorkshire, we reported people's experiences at Urgent Treatment Centres across York and North Yorkshire. We found people were grateful for the service, even with long waits.

We met local information and signposting needs by publishing a guide to essential services open over the Christmas period.

# Your voice heard at a wider level

## We collaborate with other Healthwatch to make sure the experiences of people in York influence decisions made about services at Humber and North Yorkshire Integrated Care System (ICS) level.

This year we've worked together as follows:

**Achievement one:** Local Healthwatch representatives have been recruiting Core Connector volunteers, between the ages of 16 and 25, to explore the experiences of health and social care services of other young people within local areas. Under the CORE20PLUS5 initiative, we have been focussing on experiences relating to asthma, diabetes, epilepsy, oral health and mental health.

**Achievement two:** Representatives from Healthwatch attended a workshop to contribute to the Equality Delivery System 2 (EDS2) for Humber and North Yorkshire ICS. The main purpose of the EDS2 is to help NHS organisations to review and improve their performance for people with protected characteristics. The role of Healthwatch was to discuss, challenge, assess and score the evidence presented to us. This was an opportunity to formally influence the ICS's approach to commissioning services which are equitable.

**Achievement three:** Local Healthwatch across the ICS now attend meetings representing all Healthwatch in the area and report back and share information. This collaborative efficiently enables Healthwatch to have a much stronger voice across numerous meetings in the region.

"Healthwatch York makes a vital contribution to the strategic and development work in York and across the wider Humber and North Yorkshire Integrated Care Partnership"

Stephen Eames CBE, CEO Humber and North Yorkshire Integrated Care Partnership

# Listening to your experiences

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

## Improving urgent care services

Last year, we published a report on urgent care across York, Scarborough, Selby and Malton. Commissioned by the Humber and North Yorkshire Health and Care Partnership. Between May and July 2023, Healthwatch York and Healthwatch North Yorkshire ran a survey and staff and 10 volunteers spoke to 305 people in urgent treatment centres to understand their experiences.

We wanted to understand which bits of urgent care (same day GP appointments, pharmacy advice, NHS 111, urgent treatment centres) was working well and where people felt improvements could be made.

**67%**
of people we spoke to in the Urgent Treatment Centres had tried another option before going there.

## What did you tell us about urgent care?

A number of themes emerged from conversations and survey responses. Many went to the urgent treatment centre because of the difficulty of getting a GP appointment. Some people were sent there by their GP or NHS 111. People felt there should be better coordination between services, particularly NHS 111 and urgent treatment centres and the four urgent treatment centres.

There was generally positive feedback about the staff at all levels with most people being delighted with the support when they got it.

It was clear people accepted, even expected, long waiting times but would like clearer information about how long their wait might be and where they are in the queue.

### What difference did this make?

"The Healthwatch Urgent Care Report made sure we heard people's voice in the best way we could, with impartiality. The report told us what we suspected, that patients experienced a disjointed system that was difficult to navigate. When read with the York GP snapshot report, this helped identify that a fully integrated urgent care service was of real value to patients.

We are now working towards a single blended model, with our local hospital and local GPs working together to develop a seamless service for people across York, Scarborough, Malton, Whitby, Selby and Bridlington."

Gary Young, Deputy Director of Provider Transformation, York Health and Care Partnership

## Improving access to mental health crisis care

Last year, we published a report titled 'Breaking Point: A recent history of mental health crisis care in York'. We shared people's experiences of accessing mental health crisis support in the city, alongside the views of staff working to support people experiencing mental ill-health and family members and carers whose loved ones have struggled to access the help they need. We focused on qualitative information hearing from more than 65 people most of whom experienced crisis mental health care in the past five years. The report included feedback from in-depth interviews, workshops and from frontline mental health workers.

**40%**
of calls to the crisis line were not answered at the time of our report

## What did you tell us about crisis care?

The report found that services were struggling to support people, some of whom felt they have been failed at all levels. Although there were stories of excellent care, and staff going above and beyond to help individuals, many people shared experiences of feeling dismissed and stigmatised when they were in crisis wherever they turned for help. Some told Healthwatch York they felt crisis support and after-care was either inaccessible or of such poor quality it was ineffective.

By forming an understanding of the services in York for adults experiencing mental health crises from different perspectives, we aimed to identify ways to improve local services and support.

"Not getting through to the crisis line is a disaster. It is hard for the person making the call... if you've got to that point in life where you think 'this is it' and have had the courage to pick the phone up in absolute desperation and not get through; the knock-on effects of that are disastrous."

Participant in the Breaking Point interviews

"There's a lot of people who have just lost faith in the process and the services. They've been through them so many times waiting for an assessment and jumping through hoops that they just won't go near them even though they're really unwell. I think that is really problematic."

Participant in the Breaking Point interviews

## Improving access to mental health crisis care

Mental health services are under severe pressure throughout England and have been for a long time. This report contributes to the growing awareness of the extent of the problems, and adds to the calls for urgent action to improve support.

Some of the challenges stem from chronic under-funding, but others appear to be cultural, including poor communication, poor training and poor attitudes.

> **It feels like such systems are full of wonderful human beings. But as soon as you look at it from a system level it becomes problematic.**
>
> **It's almost like you want to say to people, please don't take this personally, this is the system's problem not you. You are, presumably, awesome.**

### What difference did this make?

- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) is working in partnership with two voluntary organisations to improve crisis response services, as well as preventative care in York. These services will work alongside the new NHS 111 option 2 service for people needing mental health support.
- TEWV has started an urgent emergency care pathway review, setting up a programme board that looks at urgent and emergency care services including the crisis line, face to face crisis support and inpatient services.
- There has been significant partnership work to support the further development of a mental health hub for York, with plans to create more hubs over time.

> The Trust has now established a co-creation board which includes people who use services and staff. The co-creation board works with service user groups across Trust services to make sure that the Trust continues to develop and sustain how we work in partnership with people who use services, carers and local communities in all our work. The board also works alongside the Care Group Board in ensuring that co-creation is evidenced in the development of new services or service changes.
>
> Brian Cranna, Care Group Director of Operations and Transformation, TEWV

## Raising the voices of York adults seeking diagnoses of ADHD and autism

In March 2023, York Health and Care Partnership (YHCP) introduced a new pilot pathway for adults seeking a diagnosis of autism and/or ADHD.

We began to hear concerns that the new process stopped people from accessing a diagnosis. We took these concerns to YHCP and agreed to conduct an independent evaluation of people's experiences using this new pathway.

We worked alongside York Disability Rights Forum to get a better understanding of what the pathway meant in practice. We developed a survey and held focus groups to hear from people about the challenges they were experiencing.

We published a report in August 2023. We took this report to the Health and Wellbeing Board's September meeting.

In it, we identified the key concerns. These included:

- Digital exclusion and other access concerns.
- Concerns about the appropriateness of the digital tool.
- Concerns about its effectiveness.
- Concerns about whether the pilot complied with relevant legislation and guidance.
- A lack of clarity about how the pilot and the profiler worked, and what would happen next for those who completed it.
- Significant concerns about increased risks to those seeking diagnosis.
- Negative impact on public trust in the health system.
- Questions about the right to choose.

> I have been in tears for the last four hours. My GP sent me the link to the Do It Profiler which I completed today which shows I have many traits of autism. However, I now understand that's it. I can't have a full assessment so can't get a diagnosis under your new system as you only select certain people for further assessment.
>
> Respondent to Healthwatch York survey

## Raising the voices of York adults seeking diagnoses of ADHD and autism

### What difference did this make?

- Substantial changes are now being made to the pathway. Initial triage will return to clinicians. The online profiler will no longer be used for that purpose, although it may be offered as an additional resource for those looking to understand whether they may have autism and/or ADHD.
- YHCP committed to make changes to the pilot in line with public feedback. They ran public engagement events and funded local organisations to run focus groups, making sure people's experiences helped shape the future pathway for assessment and diagnosis..
- GPs will now be able to do medication reviews for ADHD, which will free up significant amounts of time for assessments, increasing capacity from one assessment per day to three.
- Through the Connecting our City neurodiversity workstream YHCP is supporting partnership working to look at how we can grow peer support and help people find useful resources.

The ADHD and autism report held up a mirror to us regarding our initial approach - the neurodivergent community is now the main partner in our conversations. The pathways and our approach around engagement have improved as a result.

We've had a good experience of working with Healthwatch, which adds significant value to the health system in York as a critical friend. As a result we're actively thinking about how else we can work together to improve health outcomes.

It's sometimes hard to achieve a balance with reports, as people often only report on negative experiences. Healthwatch works hard to hear and highlight what does and what doesn't work well for people.

Shaun Macey, Assistant Director of Primary Care Transformation & Pathways
York Health & Care Partnership

For more about Connecting our City contact Kate Helme kate.helme@york.gov.uk or Savanna Thompson savanna.Thompson@York.gov.uk at City of York Council +

# Three ways we have made a difference in the community

## Throughout our work we gather information about health inequalities by speaking to people whose experiences aren't often heard.

### Readability

**It's important that information is clear and gets the right messages across in the right way.**

Healthwatch York's readability volunteers provide feedback on health and care related leaflets, posters and more. They check to see if the information makes sense, is clear and accessible for all. In 2023 – 2024 our readability panel reviewed 86 leaflets and posters. To read more about their work, see page 19.

### Cost of Living

**Healthwatch York undertook further work to deepen our understanding of the impact of the cost of living crisis in York.**

We found that people's physical and mental health were both negatively affected by the crisis. People told us they were using food banks more, struggling to afford good food, and could not afford to heat their homes. Existing health conditions were made worse by the realities of surviving without enough money to pay for essentials.

### Getting out and about

**It is important that we hear from as many people as possible, from all backgrounds across York.**

Healthwatch York holds monthly stalls at venues across the city. But we know that doesn't reach everyone. We work with local charities and groups to make sure we reach as many people as possible. We've been to activities with the local traveller community, attended the local Deaf Café (with a British Sign Language interpreter), joined phone ins with MySight York, talked to refugees at the asylum hotel and at social events and linked up with York Ageing Without Children.

There's a summary of other outcomes we've achieved this year in the Statutory Statements section at the end of this report.


# Here for everyone
# Hearing from all

**Over the past year, we have worked hard to make sure we hear from everyone across York. We consider it important to reach out to the communities we hear from less frequently to gather their feedback and make sure their voice is heard, and services meet their needs.**

This year we have reached different communities by:

- Holding regular engagement stalls across at the city at various community centres, libraries and within the hospital.
- Attending community events organised by partners, such as the Our City Festival, the York Health Mela and the York 50+ Festival.
- Hosting regular themed York volCeS meetings, inviting all community voices to be central to the key decision making of the ICS.

## Seeking many voices from across the community for our research into mental health crisis care

Our report 'Breaking Point: A recent history of mental health crisis care in York' sought to reach out to a wide range of people with different experiences of mental health crisis care in York, from both personal and professional perspectives.

For this report we wanted to hear from a wide range of people with different types of experience of mental health crisis care. We talked to people with lived experience of mental health crisis care, carers and professionals both from within the NHS and from the voluntary and community sector. We sought a full 360° examination of what was happening within mental health crisis care in York.

We talked to:

- People with lived experience of using mental health crisis care services in York.
- Carers of people with experience of mental health crisis care.
- The Mental Health Crisis Team.
- Staff at York Hospital.
- York Mind.

We also held drop-in style workshops and a York volCeS public meeting.

## Hearing from the refugee community in York

We attended a number of social events and conversation cafes for refugees newly arrived in the UK. We talked to people about their experience accessing healthcare in York and provided information and signposting to local services.

We attended events organised by local refugee support group Refugee Action York (RAY)

As a result of conversations at these events, we:

- Provided information about services available in York.
- Were able to show how information about local services was available in over 90 different languages through our website. One Ukrainian woman was moved to tears to finally find some information in her own language to help her navigate NHS services.
- Were able to identify and reach out to vulnerable people seeking healthcare in an unfamiliar environment.
- Included their feedback in our work looking at access to primary care.

# Advice and Information

**If you feel lost and don't know where to turn, Healthwatch York is here for you. In times of worry or stress, we provide confidential support and free information. We'll help you understand your options and get the help you need. Whether it's finding an NHS dentist, making a complaint or choosing a good care home for a loved one – you can count on us.**

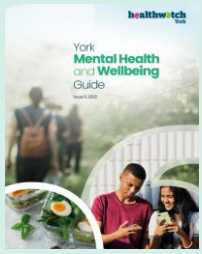
**This year we've helped people by:**

- Providing up-to-date information people can trust about support over the Christmas period.
- Helping people access the services they need.
- Helping people access NHS dentistry.
- Supporting people to look after their health during the cost of living crisis.

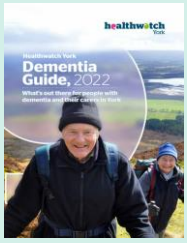
## Advice and information guides

### York Mental Health and Wellbeing Guide Issue 5, 2023

Our Mental Health & Wellbeing Guide was published in April with a print run of 3,000 copies to deal with local demand. It is an essential resource for individuals and advice workers across the city and much in demand.




**"I love these guides. I'm hoping to carry a few with me when I meet up with friends or when people ask me who they should turn to when they need extra support or advice."** - Resident




### The Dementia Guide: What's out there for people with dementia, their families and carers

Our Dementia Guide provides a wealth of information and resources for people living with dementia and their families.

**"No one says it's easy, but you can live well with dementia, take a little more care but you can cope!" -** Contributor to Guide

### Support services over the festive season

Our guide to services open in York over the festive season was circulated widely across the city. The guide included information about warm spaces, pharmacy opening times, foodbanks and community food hubs. We worked with York CVS wellbeing team to make sure the residents they work with received this list directly.

### Healthwatch York website

The Healthwatch York website is a great starting point for news, information and resources.

New pages include:

- New to the area – advice for anyone new to the area, including finding a GP and accessing urgent and emergency care. Available in over 92 different languages.
- PDF versions of all reports, guides, magazines and bulletins.

## Improving urgent treatment centres

It is vital that people's experiences shape new services and that is what happened.

Thanks to our urgent care project, which we led in partnership with Healthwatch North Yorkshire, people's feedback has helped redesign urgent care services in York, Scarborough, Malton and Selby.

We talked to more than 300 people across these four urgent treatment centres. A major theme was the lack of coordination between the centres. People who had already been to one centre found when sent on to a larger centre with more specialist staff they had to start the process all over again. This was because the GP out of hours services were provided by different organisations with no coordination: "I went to Selby UTC where I had an x-ray within an hour. I then had to wait for nearly four hours for them to tell me I had to come to York as I needed more specialist help." This person was starting another long wait at York when they spoke to us.

The feedback from our project reiterated the need for these services to be streamlined. A tender process followed our report and has led to a new contract for York and Scarborough NHS Foundation Trust as the lead provider for urgent care, with Nimbuscare subcontracted to them to deliver GP out of hours services across the four sites from April 2024.

## Improving the quality of leaflets and health information

**Healthwatch York's readability panel has commented on 86 leaflets and posters sent by the local hospital trust and the new GP out of hours service.**

Healthwatch York's readability panel is so highly regarded that our local hospital trust's patient information guidelines state that leaflets cannot be published unless the panel has seen them.

Our 14 volunteers have been commenting on information since 2016, making sure the information makes sense and is understandable and accessible for everyone.

This year, the volunteers commented on 24 leaflets targeted at parents and children and linked to the start of the new GP out of hours contract at local urgent treatment centres. They had six weeks to do this, including one 40+ page booklet on bladder and bowel health. Other topics included swallowing pills, ear infections and advice from Captain Unicorn and Wee Rex!

Dr Rebecca Brown, Child Health and Urgent Care Clinical Lead for Humber and North Yorkshire Health and Care Partnership requested the feedback. She said: "Thank you so much for all the time that has been spent going through these so comprehensively. It is important that we get this information right for families in a way they can understand."

Colm Gough, the local hospital's Macmillan Personalised Cancer Lead said: "Please pass my thanks on to the reviewers who took the time to give such detailed feedback. We'll make the changes before passing it over to our PILS (patient information leaflets) team for final review and sign-off."


# Volunteering

**We're supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we're able to understand what is working and what needs improving.**

**This year our volunteers:**

- Visited communities to promote their local Healthwatch and what we have to offer.
- Collected experiences and supported their communities to share their views.
- Carried out enter and view visits to local services to help them improve.

"I very much enjoy being part of the group of volunteers who are Healthwatch York's readability team. This is an activity which I can do from home in my own time when convenient.

"It is interesting to gain new information about matters that affect the lives of individuals living in York, and to assist in making such information more clear and simple so that everyone can understand.

"Also, I feel that it is important to recognise that not everybody is computer/internet savvy - so easily understood written information is still very important."

Tom –
Healthwatch York

"Last year, I volunteered on a project examining urgent care experiences in York. I talked to people about their experiences while they awaited treatment at York Hospital. This environment was challenging, as many people were in physical pain.

"Approaching these conversations required sensitivity and adaptability. I learned to tailor my communication to each person's situation. Maintaining a positive attitude and demonstrating empathy were crucial.

"Overall, it was immensely rewarding. It highlighted the significant role Healthwatch York plays in amplifying people's voices to improve healthcare services. I am grateful for the opportunity to contribute and for the personal growth I achieved through the experience."

Ciara–
Healthwatch York

**Do you feel inspired?**

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

**www.healthwatchyork.co.uk**

**01904 621133**

**healthwatch@yorkcvs.org.uk**

# Finance and future priorities

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

## Our income and expenditure

| Income | | Expenditure | |
|---|---|---|---|
| City of York Council (CYC) Contract | £115,610 | Salaries and other staff costs | £101,342 |
| Additional CYC income | £5,000 | Overheads and sundries | £22,122 |
| York Health & Care Partnership | £15,524 | Legal and professional | £5,516 |
| Healthwatch England | £3,600 | Computer and website costs | £3,289 |
| Other small pots | £482 | Events | £2,874 |
| | | Publications | £2,719 |
| **Total income** | **£140,216** | **Total expenditure** | **£137,860** |

## ICS funding

Healthwatch across Humber and North Yorkshire also receives funding from our Integrated Care System (ICS) to support new areas of collaborative work at this level. At this time, this funding is limited to our Core Connectors programme only.

| Purpose of ICS funding | Amount to Healthwatch York |
|---|---|
| Core Connectors programme (volunteers aged 16-25) | £13,333 |

## Next steps

Over the next year, our plans are to keep exploring health and care issues that matter most to people in York.

Our top three priorities for the next year are:

1. A year long programme looking at access to GP services.
2. Working with City of York Council to make sure as many people as possible help shape York's neurodiversity strategy.
3. Working with the University of York to help local people get involved in research about health and care issues.

There is no one else who articulates better the voice of people than Healthwatch York. I have worked with them for over a decade and they have been consistent in that.

Tim Madgwick, former Independent Chair of York Safeguarding Adults Board

Healthwatch York acts as a critical friend to the health and care system in York - they are also a champion for co-production and remind us how important it is to involve people.

Tracy Wallis, Health and Wellbeing Partnerships Co-ordinator, City of York Council


# The legal bit – the contract for Healthwatch in York

**Healthwatch York is proud to be part of York CVS. As such, our registered office is York CVS, 15 Priory Street, York, YO1 6ET. The Chair of Healthwatch York sits on the York CVS Board of Trustees, and the Chair of York CVS Board of Trustees sits on the Healthwatch York steering group.**

**Healthwatch York uses the Healthwatch Trademark when undertaking its statutory activities as covered by our licence agreement with Healthwatch England.**

# The way we work

## How we involve others in our governance and decision-making

Our Healthwatch Steering Group consists of nine members. They work on a voluntary basis alongside our staff team to provide direction, oversight and scrutiny of our activities. Our Steering Group ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community. Two members stepped down in April 2024, and we are actively looking to recruit replacements.

Throughout 2023/24, the Steering Group met four times and provided advice and constructive challenge. This has informed our approach to our mental health crisis care work, our engagement on ADHD and autism support, and our initial scoping for the GP access work which is a key priority for 2024/25.

## Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to make sure that as many people as possible were able to share their insight and experience of using services. During 2023/24, we have been available by phone, and email, provided a web form on our website and through social media, as well as attending meetings of community groups and forums and hosting York volCeS.

We make sure that all our publications are available to as many members of the public and partner organisations as possible. We publish them on our website, email them to those on our mailing list, and print and post copies to anyone who asks for them. We share our Annual Report with York's Health and Wellbeing Board, and include the highlights in our Summer magazine. We also provide libraries across the city with copies of our publications – pop in and have a read at your convenience!

## Taking people's experiences to decision-makers

We make sure that people who can make decisions about services hear about your insights and experiences.

In York we take information to sector representatives, like York CVS, Community Pharmacy North Yorkshire, service providers, commissioners, council leaders, councillors, MPs, Humber and North Yorkshire Integrated Care Board and Integrated Care System. We also work with other local Healthwatch, Healthwatch England and the Care Quality Commission to address shared health concerns.

We take insight and experiences to strategic meetings in the city including York Health and Wellbeing Board, York Health and Care Partnership Executive Committee, York Health and Care Collaborative, York Mental Health Partnership, York Safeguarding Adults Board, and Raise York Partnership meetings. We share our data with Healthwatch England to help address health and care issues at a national level.

## Enter and view

We did not conduct any Enter and View visits this year and so no recommendations or actions were put forward through this route. However, we are working to re-establish our work with care homes in 2024.

## Healthwatch representatives

Healthwatch York is represented on the York Health and Wellbeing Board by Siân Balsom, Healthwatch York Manager. During 2023/24 Siân has effectively carried out this role by attending the meetings, sharing Healthwatch York reports, compiling updates at the Board's request, and taking an active role in all Board discussions.

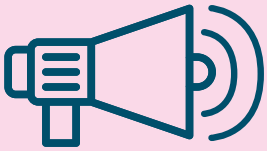
Healthwatch York is represented on Humber and North Yorkshire Health and Care Partnership by Ashley Green, Chief Executive at Healthwatch North Yorkshire and Humber and North Yorkshire Integrated Care Board by Helen Grimwood, Chief Executive at Hull CVS. Siân sits on the System Quality Group which aims to address quality concerns across Humber and North Yorkshire.

## 2023 – 2024 Outcomes summary

| Project/activity | Outcomes achieved |
|---|---|
| Independent evaluation of the pilot pathway for adult ADHD and Autism assessment. | Significant changes to the pathway. Commitment to ongoing co-production and developing support services. |
| Breaking Point report on mental health crisis care. | Improved crisis offer with VCSE partner answering and triaging calls. Commitment to co-production of services. |
| Cost of living work. | Public Health and Housing targeting housing insulation to people living with health conditions impacted by the cold. |
| Urgent care work in partnership with Healthwatch North Yorkshire. | Changes to the provider model, providing handovers instead of hand-offs as people move between urgent care services. |
| Pharmacy survey. | Set a baseline for satisfaction levels. Showed people relatively happy with pharmacy services locally. |
| Mental Health and Wellbeing Guide. | Continued to provide people with up to date information about services able to support mental wellbeing in York |
| Winter services list. | Made sure people in York had vital information over the holiday period. |

# Our call to action

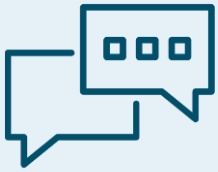
We hope you have enjoyed reading this report. But more than that, we hope it inspires you to share your experiences of health and care with us.



**You are Healthwatch York. Your voice matters.**

We are simply your mouthpiece.

There are lots of ways to share your views:



- Call **01904 621133** and choose option 3
- Email **healthwatch@yorkcvs.org.uk**
- Leave a WhatsApp message on **07512 342379**
- Visit our website and use our trip-advisor style feedback centre: **www.healthwatchyork.co.uk**

To hear more from us, sign up to our monthly bulletins and quarterly magazines.

For information about the health and care system, contact us as above and let us know what you need. We are here to help.

healthwatch York

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# Responses to recommendations

**Partner responses from reports published 2023-24**
**July 2024**

# Contents

# Introduction

Part of the role of a local Healthwatch is to make recommendations to health and care partners – both providers and commissioners (the people who buy the services.)

This briefing includes the recommendations Healthwatch York has made in chronological order, with responses from partners. Initially this report planned to cover our reports from April 2023 to March 2024. We have been asked to include two reports from the previous year, April 2022 to March 2023.

The partner responses detail the actions taken as a result of the recommendations. Most of these updates were provided in April 2024. We have also included previous responses where updates have already been requested.

# Accessible information – June 2022

**Full report can be seen here:** https://bit.ly/AccessibleJun22

| | Report recommendations |
|---|---|
| A1 | Ask what helps and do something about it. Put the user first. |
| A2 | Make accessible information an organisational priority from the top down and make sure everyone knows why it is important. Have understanding, committed staff championing this at all levels. |
| A3 | Make sure that you ask people about their preferred format. Record this and use it to provide information in that format as standard. |
| A4 | Once identified, share people's information needs within organisations. Information about people's needs should only need to be recorded once for people across the organisation to get it right. |
| A5 | Involve people with lived experience to help find pragmatic answers. |
| A6 | Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone. |
| A7 | Each organisation should have one contact / team who work across that organisation to find solutions to accessible information needs quickly and effectively. |
| A8 | Seek and share good practice. Providing information in accessible formats isn't always easy but lots of organisations are trying. Share progress and challenges so that things are constantly improving. |
| A9 | Review what you are doing to make sure it is working and learn from what is and isn't going well. |

Update report published November 2022 here:
https://bit.ly/AccessUpdateMar23

## Responses within the Update report March 2023

## North Yorkshire Police Response

North Yorkshire Police (NYP) do not have a policy on accessible information and, in the main, do not currently comply with the recommendations in the report. However, this is something that we recognise. We have already taken steps to review the report and assess our current position.

I have arranged to meet with the Chair of our Diversity, Equality and Inclusion Board, ACC Elliott Foskett, to consider the recommendations and determine a way forward for NYP.

To support NYP develop and provide improved Accessible Information to our communities, we will review the best practices of HMICFRS, the College of Policing and other Police Forces.

Please find below information relating to each of the nine recommendations.

1. Ensure there is a policy of asking every person if they have a communication need as part of a wider accessible information policy or strategy and action plan: We do not currently have a policy in place to do this. Where a reporting person raises, or NYP identify, a communication need during public interaction, this will be recorded and met where possible.

2. Promote the accessible information policy and ensure that it has champions at every level and a regular agenda item for appropriate meetings: We do not have a specific Accessible Information Policy, our website holds information about the various formats available and complies with the Web Content Accessibility Guidelines (v2.1). Where possible, any gaps are clearly highlighted. NYP will give consideration regarding champions and an appropriate meeting structure to govern the accessibility of information.

3. Ensure a person's information needs are clearly recorded on a person's record and that all staff are aware of this and know where to find the information: NYP does not currently have a consistent way of recording this information within a person's record.

4. Ensure information is shared across the organisation, either through a central IT system or another means so that a person only needs to tell you their information needs once: This is not currently undertaken on our systems.

5. Ensure your accessible information policy and action plan includes ways to find solutions if these do not already exist. Ensure the organisation will not condone an answer of 'that is not possible' without exploring a range of alternatives: NYP do not have a current Action Plan to address the needs of accessible information.

6. Make sure you offer and can deliver a range of alternatives, and this is clear to service users and staff and staff know how to access the formats: NYP offer a range of solutions to provide information in different formats based on individual needs such as hearing and sight impairments. Further detail can be supplied if required.

7. Identify someone to take the role of central contact for accessible information and ensure they have all the support, training and information they need to deliver this. Ensure the rest of the organisation knows about the role and works with them: NYP currently do not have a role in the organisation that would meet this requirement.

8. Identify and learn from good practice and what is not working. Share information across organisations and between organisations: This is not an activity that is routinely undertaken, however when national initiatives are launched that support NYP, this would be communicated to our staff. We have recently adopted some services to assist the public in communicating with NYP.

9. Regularly review your policy and action plan to ensure things are improving. Update your policy and action plan to reflect changes and

improvements: This is not currently undertaken; however, our website statement is updated as required.

## York Hospital Response

“Thank you very much for sharing the Accessible Information Report and the opportunity to attend the launch event and meet your contributors. We recognise the value of focussing on peoples' lived experiences in the report as well as the principles and recommendations you have identified, for us to consider.

We welcome this report and we recognise that there is much to do in this area. We can see this from the information in your report and from feedback from patients and families who use our service, where we have seen an increase in concerns about accessible information during the pandemic period.

We have processes in place to support staff in meeting patient requirements including a transcription service which can put information into a variety of formats and video tablets to support BSL interpreting. We recognise these systems are not fully embedded across all parts of our organisation.

The trust is committed to ensuring that we communicate with patients in their chosen format and accessible information continues to be a key priority in our equality objectives 2020-24.

**Equality objectives**

The trust has three key equality objectives for 2020-2024, one of which is implementing the Accessible Information Standard. However, our response to your report will support us in achieving each of our objectives. Work also continues in relation to our built environment access plan, including items which support accessible communication e.g. hearing loops and signage.

Our annual patient Equality, Diversity and Inclusion report (due to be published this autumn) sets out our progress against our equality objectives since 2020, including progress towards implementing the

Accessible Information objective to date. It will also indicate those actions where review and restart are needed.

Trust Equality Objectives 2020-2024;
Objective 1
To engage with patients, carers, governors, and local stakeholders and organisations, including Humber and North Yorkshire Integrated Care Board and Healthwatch, to listen and understand the needs of our patients.
Objective 2
To engage internally with services to discuss the needs of patients to ensure the reduction in health inequalities, that discrimination is eliminated, and patients and staff are supported with appropriate tools.
Objective 3
To achieve compliance with the Accessible Information Standard 2016.

**Our response to your report**
As a starting point, we have taken steps to engage services across the organisation to share the key messages from the report. We were very pleased to have Healthwatch support us in presenting the key messages at the trust Fairness Forum (chaired by our Chief Executive) and Patient Experience Steering Group (chaired by our deputy Chief Nurse) in July. This allowed colleagues from across the organisation to hear some powerful examples of lived experience and the barriers and negative impact faced by people who require information in different formats. These discussions also highlighted a number of practical steps service areas can take now to help us improve - for example, ensuring staff are aware of the existing processes for getting letters and leaflets transcribed into different formats; the importance of providing an email as well as a telephone contact on letters; encouraging staff to share good practice, take part in e-learning, consider accessibility when making improvements and changes and to log problems.

We have also been considering information from patient complaints, concerns and other patient feedback which can help us understand where we need to do better. We have seen an increase in complaints and

concerns about accessible communication during the pandemic. We recognise that many disabled people who have made a complaint or concern, are likely to have experienced repeated problems with accessing information in their preferred format from a variety of health and care providers. We also know we need to get better at asking people about their accessible communication needs and in using the information we already hold.

As you will know from your involvement in our Fairness Forum and Patient Experience Steering Group, we have a range of challenges, projects and areas for development as well as key opportunities over the next 12-18 months to build improvements on accessible information into our work. This includes making changes as part of our transformation programmes – building better care.

We are also strengthening how we involve patients in our work more widely. We would like to develop better links with people with specific accessible communication needs. We are learning from the examples in your report and we would like to explore ways to involve people with accessibility needs in the work below, as part of our patient and public engagement and involvement strategy.

We will continue to engage colleagues from across the organisation in these issues.

**Next steps**

We anticipate our key opportunity to deliver more accessible communication in 2022-2023 will be through our outpatients transformation work, which will impact on accessible communication across the organisation;

- Accessible outpatient letters

  As part of our outpatients transformation programme, we will implement a new system for generating hospital letters. Over the next 18 months, we expect this to improve the number and type of patient letters we can automatically generate in the appropriate format e.g. large print. This work is beginning with the Ophthalmology

department in Autumn 2022 and will be extended to all services who use our central patient record system. We have discussed some of the examples in your report and we would like to engage people with a visual impairment to help inform and test our approach.

There are a number of other areas for improvement, which will be developed through other parts of the transformation programme. For example, we know we need to get better at asking people about their accessible communication needs and in flagging and using the information we already hold. We need to consider how to improve reminders, two-way communication and patient information leaflets. We must also consider those services who generate patient letters which do not use our central patient record system (e.g. radiology and diagnostics).
In coming months, we will continue work towards our access plan, including items which support accessible communication e.g. hearing loops and signage. We will also be reviewing our arrangements for interpreting (including for British Sign Language); looking at how we can support staff with tools and skills to support accessible communication, including when working with patients and families in response to incidents and concerns. We would welcome your support in engaging people with access needs in this work.

Over the next two years to 2024, we anticipate the actions set against our equality objectives will evolve as the needs of our communities change, as services are developed and technology changes following the pandemic. We intend to build consideration of accessible information and communication into our future ways of working. We can use Equality Impact Assessment work aligned to our transformation programme as a key tool to stimulate change and hope to work with our system partners, to achieve our equality objectives.

We will continue to monitor progress against our equality objectives, via the Fairness Forum and our trust Board and via our transformation programmes.

We will keep you updated on our progress and as our next actions develop.

We welcome your continued support as we develop our work in this area together with feedback and suggestions on how Healthwatch may be able to support us as we move forward."

## City of York Council Response

1. A Joint Report from Healthwatch North Yorkshire & Healthwatch York: Accessible Information was presented to Health & Wellbeing Board (HWBB) on 20th July 2022, highlighting some of the barriers people experience when accessing health and care services. The report contained nine recommendations to make information more accessible. The Board welcomed the report and organisations represented at the HWBB agreed to respond to Healthwatch. The Board asked the manager of Healthwatch York to bring back a further report that detailed the responses they had received. The Council's Management Team (CMT) have considered this report and requested a council response to be drafted.
2. CMT was then asked to consider and have approved the responses to the nine recommendations as outlined below. This is within the context that the council welcomes the report and its recommendations, however being a multi service complex organisation not single service presents a unique set of challenges for the council in responding in a coherent way. This necessarily means that the council is 'working towards' in a number of areas outlined below.
3. Agreed Responses to Recommendations

- Ask what helps and do something about it. Put the user first.

**What do we do now?**

There are a variety of methods by which users can contact the council in respect of all age information about our adults and childrens services (phone/email/letter/visit to request any specific requirements they may

need). When setting up meeting we ask if there is accessibility requirements to ensure it is suitable, when asking if someone wants to be on a mailing list (eg Age Friendly York) we provide the opportunity to receive this by post not just email. If someone wants a printed version of information from Live Well York they can request this in printed format and there is a large print option.

From a corporate perspective users can access the wider customer service in the same methods described above (with the exception of letters as these tend to be handled directly by service areas or business support). Currently, we do not ask if they would like information in a different way.

There is not a cross council approach to issuing letters which invites the user to contact us if they require the communication in a different format (for example, council tax letters or parking) and so the Customer Service passes such requests of this nature directly to the service area such as Parking.

**What more can we do?**
As part of the council's style guide standard include standard accessibility wording for all proactive written communication in relation to how to contact the council to request information in a different format. Target date: December 2022

**Recommendation:** Make Accessible Information an organisational priority from the top down and make sure everyone knows why it is important. Have understanding, committed staff championing this at all levels.

**What do we do now?**
In those key services such Family Information Service, Live Well York, Customer Services (including Web Services) and Communications accessibility is considered as a priority. Our corporate style guide covers the standards we follow and the accessibility section is shown below:

The Style Guide should be used as the basis for all communications and design work. This includes guidance on making PDFs accessible online using the correct colour contrast between text and background and using the appropriate Font Size.

The Style guide also gives examples of use for both digital such as social media, webcasting and website, and print documents such as letters, posters, flyers and adverts.

For consultations printed copies are made available for those not online so people are not digitally excluded. We use a mix of communications methods including media, printed publications, e-newsletters and social media to get information to as wide a group as possible.

One way we communicate with our residents is via ward communications. There are several different ways to do this, ward twitter accounts, ward meetings and ward newsletters and ward posters for noticeboards or sharing on social media. Templates are available from the Communications Team.

Web Services are responsible for all web services offered by CYC. All sites (unless exempt) must comply with the 2018 UK Public Bodies Accessibility Regulations. We have provided a range of options to support people access our services digitally such as;

1. ReachDeck. ReachDeck can help with reading support or if someone prefers to listen to information instead of reading. ReachDeck can also translate our web pages into 78 languages. Translated text can also be spoken out loud, if a 'matching' voice is available (there are currently 35 voices for languages).
2. The publication of an accessibility statement and, a process whereby the individual can request information in an accessible format.
3. A BSL interpreting service

4. People can also adjust their settings when visiting the website such as font, letter spacing, colour and size.

There are dedicated pages on the main CoYC website to inform users about accessibility:

https://www.york.gov.uk/accessibility
https://www.york.gov.uk/translation
https://www.york.gov.uk/AccessibilityStatement#accessibleformat
Also on additional Council led websites:
Live Well York Accessibility Statement
Yor-OK (Family Information Service) Accessibility Statement

We have also faced significant challenges with suppliers who do not always meet the statutory regulations and do not need to if they are not identified as a public body. CYC should be procuring web services via suppliers who are committed to meeting the regulations. Our procurement process includes questions about this.

Customers calling our customer service team can access telephone interpreters to have their call translated to the language of their choice via language line. We also offer BSL video interpretation services for people who access our services face to face.

Live Well York as a partnership community website has been designed as compliant with the international standard Web Content Accessibility Guidelines 2.1 (WCAG) – Level AA.

We have a tool used across the Council run websites (Silktide) which checks the accessibility of pages to enable continual improvement.

**What more can we do?**
Review and strengthen style guide standards in line with accessibility standards including use of colour across both web and print, standardising our writing style and consistency when using 'easy read'
Target date: March 2023

Find alternatives to PDF or having accessibility as a default of using them needs to be embedded across the organisation better. Target date: March 2023

Incorporate accessibility standards and our design guide into equalities training modules. Target date: May 2023

Promote Accessibility Training across the council that covers both print and web accessibility. As a first step bring in a specialist trainer in to train the Communications team for a day. We could offer this up to partner communications teams too to get best practice across the city Target date: March 2023

Develop a 'CYC Accessibility Guide' to refer back to post-training - something that's separate from the style guide - a simplified version would be useful for easy access. Target date: September 2023

**Recommendation:** Make sure that you ask people about their preferred format. Record this and use it to provide information in that format as standard.

**What do we do now?**
As described above people are invited via the website to request services in an accessible format. If made via Customer Services requests will be sent directly to service areas. When people contact customer service by other means such as phone, email or in person we do not capture their preferred format and this may challenging given the range of service the council undertakes in terms of keeping a central record.

**What more can we do?**
See information sharing section below.

**Recommendation:** Once identified, share people's information needs within organisations. Information about people's needs should only need to be recorded once for people across the organisation to get it right.

**What do we do now?**
Generally we do the internal sharing well as CYC has developed 'MDM' for external customers and internal tools for staff like 'Singleview'.

Any new external customer/resident records system that come online are considered, as part of their project plan, for joining MDM, and this is overseen at the council's ICT Board.

For MDM and Singleview the council has the necessary Data Protection in place, working with the Corporate Governance Team, and annually reviewed.

In respect of systems used for example via the Customer Centre – these would need to be considered carefully as our privacy notices and any required data sharing arrangements, state what we are going to use personal information for. At present we share peoples' details across the council where we have a lawful basis to do so for example a safeguarding risk identified, or this had been requested by the person concerned.

**What more can we do?**
We don't have "information needs" as a field within Singleview. Whilst technically possible this may not be recorded or recorded well in individual systems.

We will review all of our case management systems as appropriate to see how information needs are captured in order to action the technical change to make appear on Singleview. Target date: various as opportunities emerge.

As a multi service organisation it may never be possible to achieve "needs should only need to be recorded once" as;

- We have many entry points for customer information, held by variety of systems, that we are always likely to recapture this information.
- We do not routinely update any personal details, let alone information needs, from system to system, for example being we do not move personal information from Mosaic to My Account.

We will work towards 'needs should only recorded once' generally through various data quality practices (examples being updating systems with NHS numbers, dates of death etc.) Target date: various as opportunities arise

We will work towards "review how held action" and then embedding practices for example asking staff to check customer record via Singleview. Target date: various as opportunities arise then introduce into accessibility training

We will ensure that data protection, privacy and information security risk assessments are undertaken in a timely way and any additional data protection, privacy and information security requirements will be put in place where required. Target date: various as opportunities arise.

**Recommendation:** Involve people with lived experience to help find pragmatic answers.

**What do we do now?**
The council is always looking for improved ways to engage, which includes how we provide information. A recent example – we are exploring the opportunity through Age Friendly York to work together with Age UK York, Living4Moments, Wilberforce Trust and Be Independent to provide a workshop on using technology to provide solutions for people who are hard of hearing.

The CYC website development included engagement with a range of users including people representing the blind and partially sighted, older

persons, BAME. The procurement of our BSL included representation from the deaf community.

**What more can we do?**
Communications Team to review, implement and share learnings from recent Our City survey to build into the style and accessibility guides). Target date: March 2023

Work with the council's new Access Officer once appointed to develop standards for engagement as part of Equality Impact Assessments. Target Date: September 2023

**Recommendation:** Provide choice. Don't assume that everyone with a particular issue needs information in the same format or that everything is accessible. Digital is not the solution for everyone.

**What do we do now?**
We recognise that not everyone uses or has access to technology which can digitally exclude people, we are therefore looking to provide access to the same quality of information from Live Well York to community centres with electronic notice boards. We also provide printable personalised booklets. Our approach through the Communities Team is that it is all about relationships so our Local Area Coordinators and Health Champions are out there in the community having conversations rather than expecting everyone to read information. Our commissioned social prescribers are also having conversations as their first approach to engaging and providing information.

We fund and work alongside YOPA to provide information fairs out in different communities in York. We commission Access Able to provide information on the accessibility of community venues and public spaces to ensure people going out to obtain information can visit knowing what the physical environment is. We have had and are developing the next

community information strategy to ensure the way we provide information remains a priority.

Whilst Customer Services promote the use of digital services we know this is not for everyone. Customers can contact us by phone or email. We will also see people face to face if this meets their needs. For any web service we develop internally we encourage all services to develop an approach to non digital customers.

**What more can we do?**
Continue to support of York's digital inclusion partnership 100% Digital York including initiatives to develop greater opportunities to access technology, connectivity, develop skills and/or support within communities. Target date: Ongoing

**Recommendation:** Each organisation should have one contact / team who work across that organisation to find solutions to accessible information needs quickly and effectively.

**What do we do now?**
The single point of contact for many services is through the Customer Centre but they can also go direct to a specific business area if they require a more bespoke solution. Our style guide is provided through our Communications Team.

**What more can we do?**
As seen a range of services within corporate and community services are currently involved at CYC. Access and Inclusion resource within communities will be brought together and led directly by the AD Customers & Communities to provide some overall leadership and support. Target date: September 2023

**Recommendation:** Seek and share good practice. Providing information in accessible formats isn't always easy but lots of organisations are trying. Share progress and challenges so that things are constantly improving.

**What do we do now?**
We have regional meetings to share good practice relating to advice and information provision with other local authorities. Web Services keep up to date with good practice surrounding accessible web services

**What more can we do?**
Share good practice internally from user feedback and regular reviews. Target date: September 2023

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

**What do we do now?**
We review Live Well York periodically which includes accessibility but also provide the opportunity for feedback on any page of the website at any time. We use the Healthwatch York volunteer readability group to feedback on the information pages and whether they are Plain English. We provide Easy Read pages on Live Well York based on feedback from people with learning difficulties.

Web Services use a number of methods to review how we are doing. This includes Silktide (technology which identities areas on the website which do not comply with the 2018 UK Public Bodies Accessibility Regulations) and direct feedback from users.

**What more can we do?**
Review Equality Impact Assessments for learning opportunities when the Access and Inclusion Team is established – Target Date: September 2023"

## York CVS Response

York CVS has considered the recommendations made in the Healthwatch York and Healthwatch North Yorkshire Accessible Information Standards

report, both at Senior Management Team and through the Equality Diversity and Inclusion working group.
The EDI group has recommended that York CVS takes forward the recommendations through some key actions. Namely:

- Developing an Accessible Information Action Plan for the whole organisation
- Identifying staff and volunteer champions for accessible information
- Recording communication needs, initially through member / supporter records, longer term through a CRM system
- Offering a range of alternative formats
- Holding staff training sessions on the use of the Recite Me accessibility toolbar installed on all 3 websites (York CVS, Priory Street Centre, Healthwatch York

## City of York Council update shared April 2024

Healthwatch Accessible Communications – CMT actions

Quarterly meetings to maintain progress up to December 2024, and then implementation plan.

| Action | Progress | Done? |
|---|---|---|
| As part of the council's style guide standard include standard accessibility wording for all proactive written communication in relation to how to contact the council to request information in a different format. | "bookplate" is used across designed graphic design communications and an additional version used in consultation, set out by the social model of disability.<br><br>Templates for customer communications need to be provided (DS) to teams via HR Guidance and Ian's Update | Y<br><br>By Sep 2024 |

| | | |
|---|---|---|
| | modelled on social model of disability.<br><br>DS to inform comms and web services of any language changes | |
| Review and strengthen style guide standards in line with accessibility standards including use of colour across both web and print, standardising our writing style and consistency when using 'easy read'. | Wealth of information already in place on intranet, making amendments to keep approach up to date, in line with web accessibility standard guidance, including writing guidance.<br><br>Gradual integration of accessible content across channels based on Public Accessibility Guidance. Access/web meeting every two weeks to work through all aspects, with comments from web to design by end of March 2024. Meeting to include comms when ready for implementation, for example for video. Recommendations covers social media, writing, video, audio for Director of Customer/Communities to approve by request, and proportionate response.<br><br>Style guide to be completed. Budget code required for externally produced accessible formats to collate and monitor cost of provision. | Y<br><br>Dec 2024<br><br>Dec 2024 |

| | | |
|---|---|---|
| Find alternatives to PDF or having accessibility as a default of using them needs to be embedded across the organisation better. | Noted on website that word version (from service) with enlarged font will be sent on request.<br><br>PDF forms are being converted to online forms, with offline option. Posters being converted to web content. Large “glossy” pdfs being converted to web content iteratively.<br><br>Web to provide print style sheet for printing from web with. | Done<br><br>Ongoing<br><br>Mar 2025 |
| Incorporate accessibility standards and our design guide into equalities training modules. | Awaiting recruitment of Head of Equalities appointment. | To confirm |
| Promote Accessibility Training across the council that covers both print and web accessibility. As a first step bring in a specialist trainer in to train the Communications team for a day. We could offer this up to partner communications teams too to get best practice across the city. | Comms training taken place. Leading Together and DMTs awareness training taken place.<br><br>Mini-module on web accessibility awareness on MyLO (200 + completed). | Done<br><br>Ongoing |

| | | |
|---|---|---|
| Develop a 'CYC Accessibility Guide' to refer back to post-<br>training - something that's separate from the style guide -<br>a simplified version would be useful for easy access. | See above, will be incorporated into style guide. Guidance available on the intranet in the interim | Dec 2024 |
| Communications Team to review, implement and share learnings from recent Our City survey to build into the style and accessibility guides. | Comms to update DS/PW | Sep 2024 |

# Children's Mental Health –Nov 2022

**Full report can be seen here:** https://bit.ly/SnapshotCMHNov22

**Update report published March 2023 here:**
https://bit.ly/CMHUpdateMar23

## Responses within the report provided for the Health and Wellbeing Board in March 2023

**Update from March 2023**
Since the report to the Health and Well-Being Board, Healthwatch York have had discussion with CYC, ICB and TEWV to consider the recommendations made.

The following are key points from those discussions, which indicate progress to date and where further progress will be made:

**Helping deliver the iThrive model**
We acknowledge that there is work to do on helping make sure children's mental health is everybody's business. Although there is a lot of support already available in schools, the whole schools workforce may not be fully aware of the most appropriate support for each child. The SENDIASS (Special Educational Needs and Disability Information and Advice Support Service) role can play an important part in providing impartial, confidential advice to children, young people and their families. There is a need to improve awareness of the potential role SENDIASS can play in providing support to schools to understand their legal responsibilities towards children and young people with special education needs and/or disabilities.

**Waiting times** at CAMHS: we acknowledge there is still work to do to improve this further but waiting times are heading in the right direction:

- Significant improvement in autism assessment waiting times over 2019: average wait is now 150 days, down from 315 days
- Improvement in waiting times for initial assessment across all referrals, currently average 25 days, down from 90 days.
- Positive feedback about all Children's Mental Health services – CAMHS, School Wellbeing Service, Wellbeing in Mind – has been received, through the friends and family test, and service feedback forms.  couple of examples

**New activity now in place**

Well-Being in Mind Team: we have approval for a second team in York, which include a focus on children electively home educated or struggling to get into school.

Yorminds website: a co-produced offer for children and young people aged 12 and above, with advice, signposting and articles.

Broadened York Mind counselling offer for children and young people, now from age 12.

Autism social prescriber in post, working with children and families awaiting assessment or in receipt of a positive diagnosis.

Autism mythbusting
FAQs which show what the facts are for children and families in York
https://www.yor-ok.org.uk/families/Local%20Offer/autism-mythbusting.htm

Improved CAMHS assessment waiting paperwork and signposting – please see the appendices for details

The ICB Children and Young People Mental Health Plan sets out the actions across the ICB: in York we are setting up a multi-agency delivery group to

prioritise and move the plan. Some of the actions in the plan are reflected below.

**Things planned**

There is no lack of ambition for the emotional and mental well-being of children and young people in York. The inception of the ICB is now bringing the commissioning resources closer together in the Place Board, and the York Place Prospectus emphasises children's health and well-being, and the challenges facing the 'Covid Generation'. It focuses on preventative and early support.

The overall system ambition is to move to an integrated approach, with a single route into support across primary care, schools, and the wider community offer. There are a number of models for this approach which can reduce cross referrals, waiting times and ensure children and young people have more rapid access to advice and support. We have some of the building blocks in place, and some of the ideas set out below will further support this. Not all are approved and scoped, and not all are funded.

- Primary Care First Contact Worker to support children in primary care before a referral on to CAMHS and improve CAMHS/primary care liaison
- Family Hubs will roll out from June 2023 and offer advice and signposting alongside the development of access to early advice, particularly for parents of babies and young children Improve joint working and commissioning: this is necessary, both for the health and well-being of our children and young people, and also for the best use of scare resources we have available.
    - Operational delivery group for York Place, we aim to have 1 plan and see it through to completion with joint commitment and planning. There are limited quick wins, mainly in how we communicate across all our partners.

- Opportunity to explore options / preferences for potential peer support and initial information and advice. This is an excellent opportunity to work more closely and directly with HWY support in engaging young people / parents in this.
- Explore enhanced offer for children whilst they are waiting for support: this is across all levels of need not just the specialist CAMHS service.
- Better explanation of pathways to help children, young people, families and professionals understand what support is available and that emotional and mental well-being is not just a matter for the NHS: also, to set expectations; for example, what happens if you pay for a private assessment but then wish to return to the NHS pathway

**Challenges**

There remain significant challenges:

- Resources: time to devote to analysis, planning and strategy; funding is frequently time limited, and there are multiple demands and priorities; people as staffing in frontline services may be below establishment levels and are stretched.
- Redistribution of funds where pump priming not an option: there is limited or no scope to twin track funding whilst new approaches are trialled and embedded
- Nature of transformational change; it takes time, patience and can be a rocky road

**Final thoughts**

We are all agreed that children, young people, families and professionals are right to be concerned when they feel that there is insufficient support available or that they are waiting people.

We are also committed to finding approaches across the whole of the system in York, not just health where a lot of children are automatically referred, but also into school and social activities.

We are also looking to focus more on preventative and early intervention work, this takes time because funding has historically been directed at specialist services.
This will translate into work that can enable us to communicate better, provide more information on how to look after emotional and mental well-being and what is the support available when things are not right, whilst we do further work on more challenging, systemic and long-lasting changes

## Tees Esk and Wear Valleys NHS Foundation Trust

Direct responses to the recommendations made

**Recommendation 1:** It was disappointing to see this recommendation as the support requested is already available. It is easier for schools who are working alongside a WiMT team as they have access to them but there is also the Wellbeing in Schools Teams. Both do a significant amount of training in schools supporting teachers. They offer direct work, signpost to other services and support, and assist with referrals. An example would be the consultation clinics WiMT offer. At the clinics a teacher can come to discuss a child in confidence (so no names) and check if it would be an appropriate referral to WiMT or if it needs to go elsewhere in the system. These also provide an opportunity for learning generally and to pick up useful strategies and information.

**Recommendation 2:** We currently have an on-going piece of work with our SPA team.  This includes looking at how we process referrals, communication with referrers and signposting options if the referral is not right for TEWV CAMHS. This also links to the work on educating the system as we receive a lot of referrals that we would not offer a service to and should have been referred to other providers.  This includes looking at our service leaflets that covers the point below as to who we are and what we

provide. This is all part of a larger piece of work that is due to be completed by the end of August 2023.
**Recommendation 4:** This is also part of the SPA work referenced above. We can also say that all staff must complete as part of their mandatory training Information Governance training. Compliance is monitored by managers.

**Recommendation 5:** Staffing is a National problem in the NHS so not sure how reasonable this is as an action to increase staffing numbers. In York we have seen an improvement in our vacancy rates more recently and are successfully appointing to previous long-standing vacancies but this will remain an on-going concern as we are also seeing an increase in referrals and acuity, especially ADHD/ASD and demand is outstripping capacity. In relation to support there is a need for pre and post ASD diagnostic support for parents in York that is not something TEWV is commissioned to provide.

**Recommendation 6:** This is also part of the SPA work referenced above but also something for all agencies to be part of. Important to consider collectively whether this is just about better signposting or also identifying gaps in service.

## Humber and North Yorkshire Specialised Mental Health, Learning Disability and Autism Provider Collaborative (HNYPC) response to York HWBB Report relating to Children's' Mental Health

The HNY PC are working closely with the Integrated Care Board (ICB), and local place partners to ensure that when a child or young person (CYP) requires admission to a mental health unit that this is embedded as part of a whole pathway.

Building on the iThrive approach, work is focusing on improving the pathways in and out of inpatient care, with a particular focus on reducing

length of stay (as it is known that lengthy inpatient admissions are not always helpful) and keeping young people as close to home as possible so that they can maintain relationships with community CAMHS and social care professionals.

## Current programs of work to meet the increasing pressures following COVID:

1. **Eating disorder.**

There has been an increase in the number of CYP needing inpatient admission for eating disorders, including naso-gastric tube feeding. HNYPC have worked hard to ensure CYP who require admission receive this and as such a higher number of out of area admissions have been necessary to ensure needs are met and best outcomes are achieved for CYP. HNYPC has allocated significant additional funding and is working with providers to develop the following:

- Flexible alternatives to admission to hospital including intensive home treatment for eating disorder
- A whole pathway approach to eating disorders with earlier robust prevention of naso-gastric tube feeding requirement
- Prevention of admission to hospital
- Support for early discharge and reduction in length of stay by working with community teams to level up service provision
- Developing protocols and improving communication with paediatric/medical units in managing eating disorders in CYP.

2. **Develop an integrated referral hub for CYPMHS inpatient referrals**

Currently the two inpatient teams in HNY PC (Mill Lodge and Inspire) assess referrals for their respective place based providers. The access assessment process involves ensuring all necessary information is gathered prior to making a decision regarding whether admission is the appropriate next step and if further assessment is warranted (e.g., CETR information, copies of detention papers etc.) and this is done from existing

capacity and can cause delays and frustration for young people, their families and referrers. All referrals are currently discussed in a weekly meeting with both units and decisions made regarding the most appropriate environment for each young person based on the young person's needs, distance to home and capacity of the units. Work is planned to develop an integrated referral hub:

- To provide a central point for all referrals for inpatient admission to be managed and responded to in a timely manner.
- Improve consistency of response and develop a clear understanding of thresholds for admission and appropriate referrals with community partners.
- Reduce the number of inappropriate referrals/admissions.
- Ensure that referred young person's needs are met in the most appropriate environment as close to home as possible.
- Provide ongoing support/guidance to community referrers whilst a young person is awaiting admission.
- Provide discharge planning support and input to the inpatient and community teams to ensure there is a clear and timely discharge plan with appropriate support available post discharge.

**NHS England Regional Information Provided on any relevant policy and approaches**

- The Healthwatch York Report on Children's Mental Health highlights the significant challenges experienced by many children and young people in trying to access Child and Adolescent Mental Health Services (CAMHS) in York. The strong presence of children and young people's voices throughout the report and the emphasis on lived experience is extremely important and very welcome.
- This report is useful in further reiterating these challenges and the difficulties faced by children and young people. Increasing timely access to high quality, evidence-based mental health services for children and young people continues to be of the utmost priority regionally and nationally.

- Information has been provided on the national picture below and additional context but it is recognised that many challenges exist and the difficulties faced by children and young people and their parents and carers remain.

**National Policy Picture**

A number of Long Term Plan Ambitions and recent NHS England communications relate to the themes highlighted within the report. Key elements are shared below with NHS England's continued commitment to increasing access to mental health services for children and young people.

- Key ambitions and policy areas specifically relating to improving access to CYPMH services include:
    - Increasing access to children and young people's mental health services: By 2023/24 at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams.
    - This builds upon the Five Year Forward View for Mental Health commitment that at least 70,000 additional children and young people each year will receive evidence-based treatment – equating to 35% of those with diagnosable mental health conditions using 2004 prevalence data.
    - Mental Health Support Teams in Schools (MHSTs) offer evidence-based interventions and contribute to the attainment of the national 345,000 ambition for access.
- As highlighted in the recent 2023/24 Operational Planning Guidance, NHS England is continuing in its commitment to deliver the Long Term Plan including core commitments to improve children and young people's mental health services supported with funding.
    - NHS England's Quality Improvement Taskforce has launched a resource pack that aims to improve understanding of the current care and treatment offer for children and young people with mental health needs, learning disabilities and/or who are autistic,

with a specific focus on pathways of care into hospital beds, as well as the experience of inpatient care. The resource pack aims to support professionals to develop their local case for change around pathways of care to increase and improve community provision and reducing unnecessary inpatient admissions and can be found on the FutureNHS Platform.

- As part of the increasing access ambition, the importance of expanding the CYPMH workforce remains. NHS England were pleased to recently announce the publication of the Children and Young People's Mental Health (CYPMH) Workforce Census 2022, which highlights a 5% increase nationally in whole time equivalent (WTE) staff across CYPMH services between 31 March 2021 and 31 March 2022.

**Additional Context**

We would also suggest that the refreshed Humber and North Yorkshire CYPMH Strategic Plan would be a useful resource to view in order to further understand the ICB's commitments and priorities within this area. Mental Health - Humber and North Yorkshire Health and Care Partnership

## TEWV update shared April 2024

| | Recommendation | Response |
|---|---|---|
| C1 | Provide teachers with support when completing referral information on behalf of a child. Giving an understanding of what information is needed, why, and how this relates to special educational needs or impairments, and education health and care plan. | Teachers / CAMHS Clinicians /Social Worker are provided training through locality SEND boards around this area of training. There are also regular local partnership meetings for SEND children in locality / Speciality. |
| C2 | Hold a conversation at the first point of contact with CAMHS outlining service options and the expected journey following referral. | TEWV has a single point of access team in the locality/specialty that triages referrals and signposts to appropriate 'needs' led services within the young person's ICB footprint. When we meet with a young person for assessment we complete an Access to Service form with young person or family to identify needs and any risks, and identify with them the most appropriate clinical pathway. |
| C3 | Provide information on 'who, what, why, when' as part of their journey to receiving support. E.g. who will you see, for what, and why that decision has been made. | When a young person is offered a TEWV CAMHS assessment or treatment pathway, a clinician will spend time with the young person and family describing next steps including 'who, what, why, when' as part of their journey to receiving further treatment. Where a waiting list is identified in our neurodevelopmental pathway we |

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| | | have keeping in touch process to support young people and families in the process. |
| C4 | Improve administration processes in accordance with GDPR. | TEWV are currently developing the administration of our service as we recognise there are opportunities to improve and work co-creatively with young people, families and carers. |
| C5 | Address staff capacity in order to support staff with answering parents', childs', and professionals' questions through the referral pathway. | TEWV strives to have a skilled flexible workforce and we are undergoing a number of service developments to improve. We appointed a project manager in our neurodevelopment service in York, based on feedback and co creation work. |
| C6 | Better signposting support. On first contact with CAMHS, direct individuals to relevant training and information workshops available. | In North Yorkshire, TEWV has been commissioned to provide a Think Together Team, commissioned to support with better signposting support on first contact with CAMHS, including relevant training and information workshops. In York the project manager is supporting with better signposting support on first contact with CAMHS, including relevant training and information. |

# Listening to people with dementia – March 2023

**Full report can be seen here:** https://bit.ly/ListeningMar23

**There are no recommendations within this report. York Health and Wellbeing Board were asked to note the key aspirations outlined in the report, to help inform the Dementia Strategy and subsequent action plans.**

These aspirations are:

1. A key person with knowledge of support available and connections to the person's GP practice
2. A hub, with a wide range of activities, and able to provide care so carers also get a break
3. Improved emotional, practical and financial support for carers
4. Improved medical and social care for people with dementia with regular checks
5. Improved dementia training for all frontline health and care staff

## TEWV update shared April 2024

Please find below some very brief feedback in relation to items within the report. We would be happy to expand on our comments if this would be helpful.

**"Delirium meant delay to diagnosis"** – The clinical team may make a decision to delay diagnosis if it is decided it would be clinically appropriate to wait.

**"Memory assessment suspended when patient admitted to hospital"** – this could be clinically appropriate, decision could be made on a case by case basis.

**"Mobility issues prevented people participating"** - we offer home visits for those who are unable to attend clinics.

**"Feedback generally indicated people were left to fend for themselves after their initial diagnosis."** – Our agreed process is to offer a referral to Dementia Forward. The individual would be transferred from the Memory Assessment Service to care of their GP who can escalate to the Community Mental Health Team if they feel this is appropriate.

**"Feedback about gaps in coordination on discharge from hospital and a long wait for practical support at home"** – discharge meetings should be in place to agree levels of care and support needed, it's acknowledged that there's an issue accessing social care input.

**“Some people found the diagnostic process confusing. Four people didn't even realise they were being given a diagnosis;”** – We value feedback from those who use our services in order to make improvements. We will feed this back to the team who deliver diagnosis.

**“Some people reported having ‘no formal support: people generally had to source information themselves’, ‘just given leaflets and left to fend for themselves.’”** - We offer a referral to Dementia Forward to support this.

# Health and the Cost of Living – May 2023

**Full report can be found here:** https://bit.ly/HealthCoLMay23

| | Report recommendations | Made to | |
|---|---|---|---|
| H1 | Consider ways of measuring and monitoring the health impacts of cost of living rises across the York population, for example monitoring over time the levels of people admitted to hospital who are malnourished. | York Population Health Hub | The population health hub has committed to doing an annual cost of living pack. The next one is due to be November 2024. The Hub will include food bank data and A+E attendance data for a range of issues (for example respiratory conditions which is linked to cold homes). We feel that malnourishment is a difficult to measure (we have been advised it would also pick up eating disorder admissions) and any trend may not truly reflect deprivation (i.e. obesity is also known to rise in people experiencing depression). York PHH has published its second report on the effects of the cost of living crisis on health. Work is ongoing with York Hospital to monitor the impact of the COL crisis on admissions to hospital for malnutrition and an ICB |

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| | | | analyst has been tasked with producing data on this |
| H2 | Consider ways of making sure everyone has access to advice and information, not just those living in known areas of deprivation in the city. This must include access for those in the outer villages and those experiencing digital exclusion. | City of York Council and Advice York | See comments on the accessibility report and the City has a digital inclusion partnership which is looking at skills development and access to technology |
| H3 | Consider the findings from the pilot of heating help for those with long term conditions in Gloucester, and whether opportunity exists locally to support those most at risk through winter pressures funding. | York Health and Care Partnership | CYC have discussed the Gloucester pilot with Energy Catapult. The funding for warm homes on prescription, even with a limited / targeted approach, would be prohibitive. However an active programme has been set up between public health and housing in CYC to target housing adaptations / retrofit / insulation measures to those with certain clinical conditions, including funding new work, and also proactive targetting of certain households to |

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| | | | register for the Household Support Fund<br><br>Further update 01/07/2024<br><br>A GP fellow who worked with us developed guidance for Ant Dean's team around diagnoses which would make a social housing resident more vulnerable / prioritised for retrofit.<br><br>Household Support Fund comms was targeted via SMS messages from GP practices to patients with respiratory health issues last winter with 18 people making a successful application through this route.<br><br>Public Health and Healthy and Sustainable Homes Teams (CYC) are leading a winter warmth grant scheme in 2024/25 around cold, damp and mould.<br><br>The warm homes on prescription project led by Energy Systems Catapult in partnership with public health / ICB *is* now starting this winter – further public updates shortly. |
| H4 | Continue to make strong representations to challenge the | York Health and Care Partnership | |

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| | perceptions of York as an affluent city, and speak out for our residents who are currently struggling. This must include making sure colleagues across the wider Integrated Care System are fully sighted on the particular issues York residents are experiencing. | | |
| H5 | Collectively recommit to the council motion to recognise socio economic status. | City of York Council, York Health and Wellbeing Board, York Health and Care Partnership | The council includes low income as a protected characteristic in its equalities impact assessments. |

# Breaking Point: A recent history of mental health crisis care – June 2023

**Full report is published here:** https://bit.ly/BreakingPointJun23

Participant recommendations

| | Participant Recommendations | Made to |
|---|---|---|
| B1 | Increased provision of preventative care so that fewer people end up in crisis in the first place | York Health and Care Partnership / York Health and Wellbeing Board |
| B2 | Lower level support; decrease the threshold for support so that people don't have to end up in crisis before they get support | York Health and Care Partnership / Tees Esk and Wear Valleys NHS Foundation Trust |
| B3 | Improved follow up after discharge or after calling the crisis line so that crisis is not a revolving door and people do not repeatedly find themselves in crisis | Tees Esk and Wear Valleys NHS Foundation Trust |
| B4 | Strengthening the crisis line alongside promoting the second line for those who need support but are not in crisis | York Health and Care Partnership / Tees Esk and Wear Valleys NHS Foundation Trust |
| B5 | Clarify what constitutes 'crisis' for both service users and professionals. | Tees Esk and Wear Valleys NHS Foundation Trust |

| Healthwatch Recommendations | Made to |
|---|---|
| Reinstate and strengthen the Mental Health Crisis Care Concordat to clarify care pathways, provide clear minimum performance standards for all those working in services, and make sure members of the public can access the right help and support at the right time delivered by appropriately trained professionals. | NYP, TEWV, CYC, Y&SHNHSFT, voluntary sector partners, YAS |
| Review existing resources, support services and gaps in the pathway and identify the most effective ways to deliver support and fill gaps, including those best provided by the VCSE sector. | YHCP, TEWV, CYC |
| Restructure approaches to coproduction to make sure everyone's views and experiences are heard and influence service design and delivery. This must include working with external partners to facilitate involvement for those who cannot engage directly. Consideration must be made of the resource implications for VCSE organisations to make this possible. | TEWV |
| Learn from schemes improving people's experiences of crisis response / changing the system to identify ways to invest in and maintain those that work (for example, the positive feedback about police street support). | YHCPEC / MHCCC |
| Make sure workforce plans reflect the specific challenges for attracting health and care staff to York (including lack of affordable housing, transport). Work together locally to learn from historical examples such as the Rowntree Housing model and how this fits with Local Plans. | HNY ICB |
| Embed a compassionate culture towards all people experiencing mental ill health. | YHCPEC / YHWB |

## Update to recommendation 1 from York & Scarborough Hospital NHS Foundation Trust

There are several initiatives we are working on, in collaboration with TEWV colleagues and other partners, to strengthen the Crisis Concordat.

1. Multi-agency collaboration via the Trust Mental Health Steering Group, which reports quarterly to the Patient Experience Subcommittee

2. Service Level Agreement is in place with TEWV for them to monitor our performance in relation to Mental Health section activity

3. A digital mental health risk assessment has been piloted and implemented in the Emergency Department (ED) at Scarborough in February 2024, to inform effective care planning – the tool is to be rolled out in Q1 at York ED 2024/25

4. Anti-ligature room is available at York in the extended ED, suitable for assessing patients presenting with mental health needs

5. Plans are being developed to convert an additional room in York ED to be better suited to assess patients' physical health needs, where they also have mental health concerns

6. Anti-ligature room has been designed into the new build ED at Scarborough hospital

7. Referral processes are in place from ED and adult inpatient wards to psychiatric liaison teams on both acute hospital sites – work ongoing to ensure processes are consistent between sites

8. A training needs analysis is being developed to map existing training provision and identify gaps in knowledge and skills

9. Mental Health Awareness training sessions are being delivered by local MIND trainer

10. Specific Mental Health training in relational complexity and trauma has been delivered by TEWV to ED colleagues at both Scarborough and York, in conjunction with partner colleagues from York Ending Stigma – additional sessions are planned for the York site to maximise attendance

11. Plans are in place for York Ending Stigma to deliver a facilitated training session to share lived experiences between service users and staff members, initially at the Scarborough site and then plan to repeat at York. This will focus on the sharing of a film, co-produced with service users with lived experience, followed by a facilitated and supported learning discussion and signposting to staff regarding additional support.

12. Two Conflict Resolution trainers have been appointed to offer staff enhanced training, above and beyond our statutory and mandatory requirements of Conflict Resolution Training. The training supports the Restraint Reduction Network requirements and includes: Positive Approaches to Behaviour; Safer De-Escalation; Personal Safety and Disengagement; and Redirection and Guiding

13. Funding has been provided by City of York Council Public Health and a programme manager appointed to scope out the requirements for an Alcohol Care Team, in line with ambitions contained within the NHS Long Term Plan – the ambition is that the work will include a baseline review of the Alcohol Withdrawal Pathway, supported by TEWV colleagues

14. A 'twinning' relationship has been fostered between a ward at Foss Parke hospital and ward 37 in York hospital, to share training and improvement ideas – the aim is to promote improved mental health care for patients in ward 37 and improved physical health care for patients in Foss Parke.

15. The Trust has funded a Lead Professional post for Complex Needs to provide additional leadership and oversight to the Mental Health care agenda in the acute setting

16. The Trust has appointed a team of 3 Admiral Nurses to support the care of those living with dementia (jointly funded by Dementia UK) I hope this information provides assurance of our commitment to partnership working and collaboration, to improve the mental health care of patients who access our services.

## Update to recommendation 1 provided by North Yorkshire Police

The Crisis Care Concordat has been reinstated under the new title - NY & Y Mental Health Crisis Care Implementation Delivery Group. It is incredibly well attended and North Yorkshire Police are fully integrated members of the group. Through the group NYP have highlighted and discussed with all attendees Right Care Right Person, the important role of our MH Triage Team within the Control Room, and alongside colleagues within the OFPCC (Wendy Green) we have shared guidance on 'Working effectively with North Yorkshire Police' so partners can understand our roles and where their services link in.

Through this group we are able to have input, awareness and share learning across our organisations around what other organisations can offer and pathways in to those services. Attendees have a clear understanding of each other's services and through this we are able to update our Service Directory and use that on an operational basis, this enables officers to signpost people to appropriate agencies and third sector organisations where necessary. We will continue to attend and actively contribute into that group.

The Group is aligned with a range of other meetings that focus specifically on aspects of Mental Health, Dual Diagnosis and urgent and emergency care. The NYP Working together, supporting Right Care, Right Person Forum is a multi agency meeting at operational level looking at how services are working together in the delivery of Right Care, Right Person including reflective practice sessions related to case studies and identifying good practice and learning from

these. A Right care Right Person Strategic Workshop was held in April 2024 by North Yorkshire Police alongside system partners which has now led to the formulation of a multi-agency strategic oversight group.

## Update to recommendation 1 provided by Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

The crisis concordant meeting across North Yorkshire and York has been developed and is titled North Yorkshire & York Mental Health Crisis Improvement and delivery Group. The meeting is aligned with a range of other meetings with specific focus on aspects of urgent and emergency care which are attended by all partners. This includes:

- Working together, supporting Right Care, Right Person (A multi agency meeting at operational level looking at how services are working together in the delivery of Right Care, Right Person including reflective practice sessions related to case studies and identifying good practice and learning from these).

- TEWV Urgent and Emergency Care Board (This is an internal board within the trust working across the whole trust area to develop urgent and emergency care services, ensure they reflect best practice and support there local delivery at place. There is a stakeholder event planned involving people who use services, partner organisations and trust staff towards the end of May).

- Right care Right Person Workshop (North Yorkshire Police are leading a workshop at the end of April with system partners to develop the strategic overview and ownership within the system of Right Care, Right Person and its delivery in line with national guidance).

- Multi Agency Mental Health Act Legislation Operational Group (This meeting has been reinstated and led by TEWV first meeting 12 April 2024. The meeting is a forum to monitor the use of the Mental Health Act and partners responsibilities within the Act across North Yorkshire and York. The meeting is also intended to be place of support for agencies in the use of the Mental Health Act and how we can further develop knowledge, skills and working practices across all agencies).

There are national performance standards in place in relation to many aspects of mental health urgent and emergency care and the reporting against these and development of local standard will be developed within the meeting structures.

We are working to strengthen the relationship between the mental health urgent and emergency care work and the wider urgent and emergency care board within North Yorkshire and York and also the urgent and emergency care work within Humber and North Yorkshire ICB.

**Update for recommendations 2 and 3 from TEWV**

The identification of existing resources and how changes in the current model of service delivery support the overall support for people who need access to urgent and emergency mental health is in progress. The relaunch of the mental health hub in York and the subsequent required changes to the way current services are structured is part of the York Delivery Boards work and will be reported into the York Mental Health Partnership. Through the work of the Joint Delivery Board and the Mental Health Partnership all partners including VCSE and people who use services will work together to continue to identify gaps in service provision and explore how these can be addressed by the most appropriate organisation.

The Trust has now established a co-creation board which includes people who use services and staff. The co-creation board works with service user groups across trust services to ensure that the Trust continues to develop and sustain how we work in in partnership with people who use services, carers and local communities in all our work. The board also works alongside the Care Group Board in ensuring that co-creation is evidenced in the development of new services or service changes. The Trust uses feedback from people who use our services and local communities to improve the services we offer and peoples experience of them.

Feedback includes, as examples, a monthly summary of contacts with Healthwatch, Friend and Family Test, Patient Rated Outcome Measures, PALs and Complaints, Service User Groups, contact with governors and partnership meetings. The Trust's role within community mental health transformation is a partner in its delivery and again the community transformation is co-created and progress reviewed by partners (including people who use services and carers) working in collaboration. The trust's Director by lived experience continues to work to identify opportunities to further develop or strengthen our relationships between services and people who may or currently use them.

# Independent Evaluation of the Pilot Pathway for Adult ADHD and Autism Assessment – August 2023

**Full report can be seen here:** https://bit.ly/IndependentAug23

## Responses from Humber and North Yorkshire Health and Care Partnership, April 2024 added in the table below

| | Recommendation | Response received |
|---|---|---|
| E1 | Review the referral criteria, working with leading academics within neurodiversity. | The referral criteria has remained under review throughout the pilot and the ICB has already implemented adjustments based on user and clinical feedback, for example; direct referrals for people under the care of secondary mental health services where it is identified there is a barrier to making a mental health diagnosis. Further adjustments are in development with The Retreat's specialist clinicians and TEWV based on experience and learning from the pilot including feedback from the neurodivergent community. |
| E2 | Review all the feedback available, involving from relevant and appropriate partners. | The ICB's Communications, Marketing and Engagement Team undertook engagement events in December 2023, which, alongside Healthwatch York's report 'Pilot pathway for Autism and ADHD: Independent evaluation August 2023,' has provided further insight to inform the development of the referral pathway and wider support needs. |

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| | | The ICB is responding to feedback to improve accessibility of the online platform for people without digital access. Individuals will be supported to register their referral on the online platform and join the assessment waiting list by phone, SMS text or email to the ICB Referral Support Service who will enter the required referral information on behalf of the individual. The ICB is also planning training and awareness raising of neurodiverse conditions for staff in primary and secondary care so they are able to fully support and understand their needs. |
| E3 | Commit to investing in meaningful community engagement throughout the commissioning cycle. | The ICB has listened to the experience of users throughout the pilot period. Focus groups have taken place in early April 2024 to continuously develop the service in response to feedback and intelligence from communities as a result of the engagement with people with lived experience. The feedback will also be shared with system partners in the development of other strategies, for example the All-Age Autism Strategy and Commissioning Strategy to ensure a system-wide response. |
| E4 | Commit to providing the resources necessary to support those not able to access the pathway in its current form, communicating | The ICB is actively working on a new development to provide people without digital access to support by phone, email or SMS text. Future communications will be co-produced with the neurodiverse community. |

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| | how this will be provided. | |
| E5 | Investigate the use of the Do-It Profiler as a digital health technology in accordance with guidance and legislation. This should include the completion of a clinical risk assessment and equality/discrimination assessment. | Clinicians and commissioners researched the use of the Do-IT Profiler as a digital neurodiverse tool and an EQIA has been undertaken, including aspects of clinical safety. In addition, as a requirement of GDPR, the ICB as data controller, has undertaken a Data Protection Impact Assessment to demonstrate how it will comply with data protection law and in doing so identify and minimise data protection risks.<br><br>The pilot has been approved by the Humber and North Yorkshire System Ethics Panel.<br><br>The ICB is leading a collaborative working group to explore the Adult Autism / ADHD referral pathways across the ICB.<br><br>Do-IT Solutions, has Cyber Security Plus Certification. In line with The General Data Protection Regulation (GDPR,) regarding associated consent and storage of data, Do-IT Solutions ensure that data is stored whilst giving the option for people to choose to delete their data at any point. All data is stored in the UK on Microsoft who also have ISO 27001. |
| E6 | Provide effective 'waiting well' initiatives that are accessible to all, working in partnership with | The ICB has gathered feedback from communities as a result of the engagement with people with lived experience in relation to the ongoing referral pilot, including pre-diagnosis support. The ICB is exploring options for training and raising awareness of neurodiversity in primary and |

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| | others to understand what would produce the best outcomes for people for the best price. | secondary care, and is exploring options for face-face and open access support in community settings for people with or without a diagnosis, alongside online options. The ICB is sharing this feedback with partners developing the All-Age Autism Strategy which will consider neurodiversity as a whole to create inclusive communities. Similarly the York Connecting Our City Neurodiverse Working Group provides opportunities to work together as a system and co-create solutions for ND support.<br><br>Data from the online platform can help the ICB and partners develop the most relevant programmes and workshops for people needing support, including targeted information about functional skills such as time management, organisation, dealing with anxiety and low mood and understanding local pathways to services. |
| E7 | Implement a strategy for neurodiverse service market growth, ensuring a preventative approach to commissioning and delivering. | The ICB works with system partners collaboratively in the interests of the city's population to embed integrated working and agree priorities within joint local strategies, with a key focus on prevention and managing demand for services. The huge rise in demand for assessment and support as a result of greater awareness of neurodiverse conditions requires this system-wide approach across health, care and society as a whole.<br><br>The development of an All Age Autism Strategy for York along with the ongoing mental health transformation programme provides the opportunitiy to recognise, understand and |

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| | | celebrate neurodiversity more widely, and for all neurodivergent people to be empowered and enabled to have equal access to effective services, support and fulfilling lives. |
| E8 | Immediately amend the pilot in accordance with legislation and best practice. | The pilot phase is informing the steps we can take towards a sustainable model, in the context of the changing rises and patterns in demand seen nationally for adult ADHD and autism services. There is an urgent need to address this by deploying existing resources as effectively and efficiently as possible. This requires a different approach which takes account of the latest clinical practice, innovation, and national recommendations.<br><br>The ICB is leading a Collaborative Pathway Task Group to explore the Adult Autism / ADHD referral pathways across the ICB and ensure alignment of approaches for the diagnosis of Autism and ADHD. The Task Group will work as a collaborative across the Humber and North Yorkshire area to share access to tailored diagnostic services. The group will engage with local communities and collaborate with advocacy groups, support organisations and individuals with lived experience to incorporate their views into the pathway. |
| E9 | Conduct an audit of commissioning to ensure full legislative compliance and | The pilot approach has been discussed widely including by the Humber and North Yorkshire System Ethics Panel in May 2023. The practicalities of managing an unprecedented increase in demand for assessments is complex. The ICB has maintained the level of service by working with the |

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| | learn from mistakes made. | specialist provider to pilot changes to the commissioned pathway and prioritise those people with the greatest need. As this is a pilot phase, the ICB is continually amending the pathway in response to learning. The Healthwatch evaluation and subsequent work has been invaluable to learn how best to undertake meaningful engagement through face to face and virtual focus groups with our communities. |

# Urgent Care – October 2023

**Full report can be seen here:** https://bit.ly/UrgentCareOct23

**These recommendations were made for guidance only to the commissioning organisation, to inform their own urgent care work programme.**

General recommendations

- Share praise with staff to make sure they know people appreciate and value the service they are providing.
- Develop systems to provide better information about waiting times and where someone is in the queue. This could include a text/buzzer system to alert people when their turn is approaching.
- There needs to be a system whereby people on holiday or at home from university can still access GP services, including medication prescribing, rather than having to rely on the Urgent Treatment Centres (UTCs).
- Set up better cooperation and communication between UTCs. Someone seen at one UTC and redirected to York or Scarborough UTC should be confident that information has been shared and that they will be prioritised on arrival at the next UTC and not made to start the process again.
- Improve sharing of healthcare records and data so clinicians are fully informed and don't have to rely on patients to know their full medical history, allergic reactions etc.
- Explore the approach to triage to see if there is a way it could be done to redirect people who do not need urgent care; to direct people straight to x-ray if that is needed and to ensure appropriate prioritisation including for older people, very young children, carers and people with comorbidities.
- Explore digital alternatives, including video appointments, for people with a minor illness.

- Address barriers for women, and particularly young women, attending urgent care so they feel their issues are taken seriously.
- Make sure all facilities are autism informed and autism friendly and staff have autism awareness training.
- If not available, provide waiting areas specifically for children.
- Provide distractions for people while waiting, e.g. televisions, books or magazines etc. Provide mobile phone charging facilities.
- Provide water fountains or similar in all waiting areas.
- Make sure there is always a source of food and drink available, including when shops and cafés are closed.
- When refurbishing waiting areas, investigate options for having colour coded seating or clear waiting areas for different services where there is more than one service catered for by one waiting area.

Communication specific recommendations:

- Make sure information about the facilities available at each UTC and when they are available is widely publicised for people to access in advance and on arrival at the UTC.
- Continue to share information about the options for people who have an urgent health issue. This should be promoted through GP practices, part of on hold messages for GP practices and NHS 111, available at pharmacies as well as online. Make sure similar information is shared with healthcare professionals and particularly where people who have long-term conditions might need specialist care out of hours so there is clarity on where someone should go.
- GP practices should provide clearer information about what they are able to help with in terms of urgent care and how quickly someone might get an urgent appointment. There should be more communication between the UTC providers and GPs to make sure GPs are providing appropriate urgent care and not just sending people to UTCs as a default position.

Site specific recommendations: York

- Carry out an audit of signage, involving service users, to make sure it is clear how to get to the UTC/A&E.
- Provide clear information about where people need to go to book in and that they are confident they are on the waiting list for urgent treatment.
- Work with NHS 111 to make sure both services are clear on what is available via York UTC and the opening times of different services. Make sure there is clarity on whether NHS 111 should book appointments at York UTC and that if this is appropriate, there is a consistent approach.
- Review the triage system to make sure everyone is asked if they need pain killers and about any underlying health conditions that could impact on their treatment/prioritisation.
- Investigate an approach to parking charges to ensure people waiting for urgent care have a limited cost to pay no matter how long they have to wait. Make sure car parking is available close to the UTC/A&E and includes dedicated parent and child parking.

Site specific recommendations: other UTCs

- Malton – make sure there is a way to attract a receptionist (buzzer/bell) if no-one is at the desk.
- Malton, Scarborough and Selby – make sure there is a way to offer more privacy at reception or an option for a more private space for people to explain their symptoms if needed.
- Scarborough – explore options for more blue badge car parking close to A&E/UTC.

**For future research and engagement**

- Make sure all appropriate staff are aware and supportive of the engagement plan and outline before the project commences.
- Where possible, do not carry out engagement during times when services are in flux due to building works. The responses, while very rich, often provide feedback on a situation that will change in the short term and thus is not as useful as it might be.

- Make sure there is sufficient time in the project to gain sufficient feedback from all sites.

## York Health and Care Partnership update received April 2024.

"The Healthwatch Urgent Care Report made sure we heard people's voice in the best way we could, with impartiality. The report told us what we suspected, that patients experienced a disjointed system that was difficult to navigate. When read with the York GP snapshot report, this helped identify that a fully integrated urgent care service was of real value to patients.

We are now working towards a single blended urgent care model, with our local hospital and local GPs working together to develop a seamless service for people across York, Scarborough, Malton, Whitby, and Selby. The first stage of this has seen the GP Out of Hours (GP OOH) contract awarded to local GPs (NimbusCare) and York Hospital taking over responsibility for delivery of the Urgent Treatment Centres (UTC) from 1st April 2024. York Hospital is working closely with local GPs to jointly staff the Urgent Treatment Centre. Both GP OOH and York UTC now use the same clinical record system, which is also used by the majority of GPs in York.

This is a huge step towards improving cooperation and communication, not only between UTCs (as recommended by Healthwatch) but also with GP Out of Hours, and the patient's own GP clinical record.

With the new services operating only since 1st April, its early days but we have already seen a number of significant improvements as a result of local partners working together collaboratively. We aim to present a more detailed report in June 2024."

# Community Pharmacy – February 2024

**The full report can be seen here:** https://bit.ly/CommunityPharmacy2024

No recommendations made.

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## Summary workplan for 2024/2025

healthwatch York

| Priority Area | Description and activity |
|---|---|
| Exploring access to care | Access to GP services – work to understand what matters to people with regards to GP access. |
| Exploring access to care | Recruiting and supporting volunteers aged 16-25 to hold peer conversations about what matters to young people when it comes to health and care services. |
| General engagement | Healthwatch York Awareness Survey 2024. Contract requirement to demonstrate that local people feel we accurately represent their views. For launch at our Annual Meeting. |
| Connecting with key initiatives | Offering support for engagement around York's Neurodiversity Strategy. |
| Emerging issue | Gender health – beginning work to explore this, with a view to this being a key priority area for 2025/26. |
| Explaining the system | Using our magazines to provide insight into different aspects of the health and care system. |
| Ongoing work | Signposting service – listening to people in York, understanding their experiences, connecting them with advice and information services as required. |
| Ongoing work | Readability work – continuing to encourage local providers and commissioners to 'sense check' their information work through our panel of volunteers. |
| Ongoing work | Improving our website to provide easy to access information around key signposting questions. |
| Work to re-establish | Working with Healthwatch North Yorkshire on developing our Care Home visiting programme. |
| Additional areas to consider | Supporting plans for engagement across Humber and North Yorkshire. This includes work with or for the Integrated Care Board and work with ADASS Y&H around mystery shopping. |
| Additional areas to consider | Working alongside the city's Universities to support opportunities for people in York to be involved in national research. |

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Annex D:

# An independent evaluation of the service provided by Healthwatch York During the period April 2023 to March 2024 from the Stakeholders' Perspective

June 2024

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Contents Page

## 1. Executive Summary

Healthwatch York continues to advocate for York residents, ensuring their voices inform local health and social care services. This year has seen developments in Healthwatch York's role within the evolving health and care landscape.

Key successes include:

Increased integration into the Humber and North Yorkshire Integrated Care System, with Healthwatch York recognised as a strategic partner in new initiatives.

Reports on pressing issues, including the "Breaking Point" mental health crisis care report, providing insights into service gaps and user experiences.

Greater focus on co-production, shown by work on the cost-of-living crisis with public health partners.

Enhanced partnerships across health and social care, including collaboration with York & Scarborough Teaching Hospitals NHS Foundation Trust on patient engagement.

Continued emphasis on addressing inequalities, highlighted in reports on accessible information and the cost-of-living crisis impacts.

Despite budgetary constraints, Healthwatch York has maintained its influence. Stakeholders value their ability to engage diverse communities, challenge decision-makers, and offer insights into service user experiences.

Looking ahead, Healthwatch York is encouraged to develop system-wide engagement strategies, explore collaborative opportunities across the Integrated Care System, and focus on health inequalities and emerging issues like digital healthcare access.

Healthwatch York remains an important partner to the local health and care system, contributing to improvements through its independent perspective and community connections.

## 2. Context

Healthwatch York provides the means for local people to influence health and social care services, hospitals, care homes, GP surgeries, home care services and many others. Healthwatch York helps people to become involved in shaping these services. It provides information about local services, improving and increasing access; signposts to independent complaints advocacy; listens to views about local services and makes sure these are considered when services are planned and delivered.

Healthwatch York has been in place since 2013. It is a project that sits within the independent charity York CVS, with a ‘Steering Group’ that acts as an advisory board. Ultimate accountability sits with the Trustees of York CVS.

Healthwatch York operates under a contract from City of York Council, with the equivalent of 2.5 full time equivalent paid staff and 33 volunteers, who carry out roles as Engagement Volunteers, Research Volunteers, Readability Volunteers, Representatives, Enter and

View Volunteers, Communications Volunteers, and members of the Steering Group. Healthwatch York also has volunteers who are Care Home Assessors, though this programme has been on hold since the pandemic.

Healthwatch York's Mission Statement:

"Healthwatch York puts people at the heart of health and social care services, enabling you to be heard. We believe that together we can help make York better for everyone".

Healthwatch York's aims are;

- Healthwatch York is responsive to the needs of York residents.
- Healthwatch York understands what is happening in relation to health and social services in York.
- Healthwatch York speaks up about the provision of health and social care services in York.
- Healthwatch York uses the reviews, words, and stories of service users to show the impact of health and social care services in York.
- Healthwatch York involves the public in the work they do.
- Healthwatch York advocates for people's active involvement in their health and social care.
- Healthwatch York provides an effective service for the people of York using health and social care services.
- Healthwatch York understands what is happening in relation to health and social services in York.
- Healthwatch York reaches new people and partners.

The purpose of this evaluation is to explore:

- the value that stakeholders have placed on Healthwatch York's contribution to the local health and care system
- how Healthwatch York has been able to meet its aims and outcomes.
- suggestions from stakeholders for Healthwatch York's focus in the coming year.

Healthwatch York provided a list of key stakeholders with whom they have worked during the past year. The sample came from statutory, and voluntary and community sector organisations within health and social care. Interviewees are listed in Appendix A.

Information has also been taken from this year's publications which are listed in Appendix B.

## 3. Reflections on progress: recommendations from last year's evaluation.

### *a) Continuing to remind statutory services of the importance of putting the public first.*

Healthwatch York consistently advocates for public involvement in health and social care services. Respondents agreed that the team has worked to ensure public sector partners engage York's residents in developing integrated service delivery models. This commitment is demonstrated by their mental health report[i], which holds statutory bodies accountable and keeps the public voice central to service planning and delivery.

Healthwatch York's regular presence in strategic discussions and ability to bring public perspectives to decision-making tables has reinforced its role as a critical friend to statutory services, promoting public engagement in York's health and social care landscape.

### *b) In light of budget reductions, considering collaboration with other Healthwatch organisations across the ICS region.*

Healthwatch York has explored collaborative opportunities across the Integrated Care System (ICS) region, referencing regional initiatives and investigating national safeguarding practices.

The team's understanding of local needs is valuable, particularly in challenging perceptions of York as uniformly affluent. The urgent care project[ii] exemplifies a successful partnership with other Healthwatch organisations across North Yorkshire.

Resource constraints limit Healthwatch York's capacity for full regional engagement. Additional funding would enable more participation in ICS-wide initiatives, encouraging greater pooling of expertise and resources. While the team has begun regional collaboration, there's scope to further develop this approach, balancing local priorities with broader regional objectives.

### *c) Continuing to be responsive to changing needs, ensuring joined-up services, and amplifying residents' voices.*

Healthwatch York serves as an intermediary between residents and services. Respondents highlight the team's ability to bridge the gap, positioning themselves in service change discussions. The organisation's role as a critical friend is valued. The team brings an external perspective to services that might otherwise become overly introspective under pressure.

The stability of Healthwatch York's team has been recognised as a strength this year. In a landscape of frequent commissioner turnover, the team provides a consistent point of contact, enhancing their effectiveness in building relationships and driving change.

Healthwatch York continues to catalyse improvements in York's health and social care sector through collaborative efforts and shared insights. Its commitment to amplifying resident voices and promoting joined-up services reinforces its role in driving positive change in the community.

## 4. Findings

### *4.1 The value that stakeholders have placed on Healthwatch York's contribution to the local health and care system*

Healthwatch York is a community-focused organisation, well-connected to the local population and voluntary sector. Team members advocate for local people and are respected by stakeholders for their knowledge and approachability. Healthwatch York offers both an overview of the health and care system and detailed insights on various topics, gained through their network of staff, volunteers, and contributors. Their ability to interpret public feedback for strategic purposes is highly valued. This comprehensive understanding is attributed to their "well-established network of people who work for them, report to them and volunteer for them."

Healthwatch York effectively represents the voices of those using local services, particularly in safeguarding and mental health services. Their access to a diverse range of patients allows them to provide a broad spectrum of views. The public's positive interaction with the team indicates established trust. Their independence allows the team to "connect with patients without an 'agenda', in a way that commissioners are unable to." This enables them to "confront statutory partners in a professional way, which individuals do not generally feel confident enough to do."

Stakeholders have praised the team's reports for their detail and wide engagement. While commissioners often view Healthwatch York through these reports, those working with them operationally recognise the team's comprehensive understanding of the system. These reports, especially on mental health services, have highlighted significant service gaps. Despite the challenging findings for commissioners, Healthwatch York maintained its reporting integrity. This is attributed to the team's independence and ability to connect with patients without bias.

A key strength of Healthwatch York is their network within diverse communities, allowing them to gather honest feedback from often underrepresented groups and to amplify diverse voices. As one partner observed, "The reach, and gathering 80% of the public view, is probably the easy part, the more difficult part is the hard-to-reach groups... They have got a network which reaches in and is trusted enough to get an honest response from them."

Healthwatch York's work brings "a level of democratic accountability" to health and social care. They effectively "pick up issues that other health professionals might not be as aware of," such as the impact of the Autism and ADHD pathway on the community. As one stakeholder noted, "I think there is a bit of telling it how it actually is rather than how it needs to be." The organisation's approach has expanded public engagement for some partners: "Prior to working with them, we didn't have public access/perception."

*"A grassroots people's champion organisation. It is very connected to the local population and local VCFS. The team are advocates for local people and are very well thought of" Ashley Green (Chief Executive, Healthwatch North Yorkshire)*

*"Healthwatch York has a knowledge and understanding of the system that matches any senior system leader's oversight. They have a helicopter view of the system and also in-depth views on many topics that they have gained through well- established networks of people" Gary Young (Deputy Director Provider Transformation, York Health and Care Partnership).*

### 4.2 How Healthwatch York has been able to achieve its outcomes:

***Outcome 1: Health and Social Care Services in York have been improved and/or influenced by the impact of the public, patient and carer voice, as a direct result of Healthwatch York's intervention.***

Healthwatch York is a champion for co-production and co-design, and it constantly reminds the system of that by acting as a good critical friend. Its reports are submitted to the Health and Wellbeing board, which then evaluates the recommendations and assesses how they align with, and contribute to, the strategic landscape.

Safeguarding boards face challenges when trying to effectively link patient voices to strategic change. Patient input can be diluted or lost when translated into official language and individuals can find it difficult to understand how their input is influencing changes. Healthwatch York is working towards people being able to trace their concerns or suggestions in official documentation through to the change taking place. This requires a long-term, inclusive approach built on trust.

The ADHD and autism report[iii] provided valuable feedback to commissioners. The pathway and engagement approach with neurodivergent communities has improved following the report, with the community now more involved in discussions and commissioners more aware of the key issues.

*"There is no one else who articulates better the voice of people than Healthwatch York. I have worked with them for over a decade, and they have been consistent in that".* *Tim Madgwick (Chair, Safeguarding Adults Board)*

*"We've had a good experience of working with Healthwatch who add significant value to the health system in York as a critical friend. As a result, we're actively thinking about how else we can work together to improve health outcomes".* *Shaun Macey (Assistant Director of Primary Care Transformation & Pathways)*

*"Healthwatch acts as a critical friend for all parts of the health system in York- they're also a champion co-production and remind us how important it is to involve people"* *Tracy Wallis (Health and Wellbeing Partnerships Coordinator, Public Health)*

***Outcome 2: Healthwatch York ensures easy access to appropriate support, advice and information for customers, carers and the wider community when they are faced with health and social care choices.***

Healthwatch York recognises the challenges of accessing information in an increasingly digital world and the team provide advice and information accessibly, catering to a wide spectrum of people. One stakeholder observed, "What officialdom is putting out is very difficult for people to get to grips with... now everything is online. The online world isn't as easy or accessible to everyone if wanting to raise a concern." In response, the team "facilitates that face-to-face element which means that they can then act as an advocate or a scribe."

Their support is particularly valuable for those navigating multiple services. As one interviewee explained, "If they have multiple needs e.g. mental health, safeguarding and addiction... the combined effort of partners is sometimes quite confusing... Healthwatch is there for them."

Healthwatch York's visibility and accessibility has been highlighted: "Healthwatch York is very visible in community centres, libraries, leaflets, 1-2-1 support and advice. They have produced excellent guides especially around mental health that are online and printed, with regular updates."

Many residents view Healthwatch York as a first port of call. One professional shared, "Healthwatch York is the first place I would tell people to go to... I usually carry their newsletter around with me in my bag as a resource."

Their work on accessible information[iv] was particularly praised for improving access for people with specific needs.

*"The public have a poor understanding of Community Pharmacy Services- working with Healthwatch has helped improve this greatly".* *Ian Dean (CEO, Community Pharmacy North Yorkshire).*

***Outcome 3: Individuals, groups and communities know about Healthwatch York, and feel that Healthwatch York has accurately reflected their views.***

Healthwatch York chairs the Voice of The City group and had a strong role in the Multiple Complex Needs network articulating the importance of those with several challenges who are trying to get a diagnosis in order to access support.

The March 2023 dementia report [v]was seen as a good example of how Healthwatch York was able to include active lived experience engagement activity with the dementia community, and partners highlighted 'brilliant work around access to pharmacy, GPs and dentistry'.

Hospital patients and mental health service users have had their views reflected in Healthwatch York's reports with York's Disability Rights Forum (YDRF) being a good example. A very tangible achievement of the ADHD and Autism report is that the Integrated Care Board is now actively and meaningfully engaging with YDRF in a way that they haven't been until now. Healthwatch York has worked closely with YDRF, their members and the public about access to assessment and support. They understand the local need and are then able to reflect that to AHDH and Autism services.

*"Having Healthwatch conduct an independent survey gave us confidence that what people were telling us about our services was real, not just because they liked us…we're doing the rights things and working with Healthwatch York verified this!"* *Ian Dean (CEO, Community Pharmacy North Yorkshire).*

***Outcome 4: Healthwatch York works effectively at a strategic level, particularly through its place on the York Health and Wellbeing Board.***

Healthwatch York is actively involved in key strategic forums, including the Health and Wellbeing Board, Mental Health partnerships, and the Integrated Care Board (ICB). As one stakeholder noted, "They are there where they need to be, not just at subgroup level, and very vocal at all meetings." Their city-wide reach gives them a broad understanding of local issues.

Healthwatch York consistently contributes to strategic planning, often matching or exceeding larger organisations' input. "They were more consistent in terms of their contributions, which, considering the level of funding they get, are outperforming the larger bodies," observed one interviewee.

Their annual planning reflects public needs and aligns with wider strategies. Recent work, such as GP practice staff interviews, has provided valuable insights into service quality.

The team brings useful perspectives to various forums, including the York Health and Care collaborative. One stakeholder commented, "Since the formation of the ICB board, we've had a York Place Board with the CEOs from around the system and Sian is there representing Healthwatch. She is perfectly happy and comfortable to be completely vocal in making sure that the patients' views are represented."

Healthwatch York plays a key role in regional collaboration, chairing the partnership of six Healthwatch organisations in the Quality Surveillance Group.

While Healthwatch York tends to focus on areas needing improvement, some stakeholders suggest they could also highlight positive aspects of services. As one interviewee pointed out, "I think it would help in the partnership sense with the health community, to know that NHS professionals are feeling like Healthwatch York is recognising what they are doing that is good as well as pulling them up for the things that they think are not good enough."

*"Healthwatch York makes a vital contribution to the strategic and development work in York and across the wider Humber and North Yorkshire Integrated Care Partnership" Stephen Eames (CEO, Humber and North Yorkshire ICS)*

*We need to move away from acting as individual organisations and view ourselves as a system of services. Healthwatch York is great at reminding us not to work in silos" Tracy Wallis(Health and Wellbeing Partnerships Coordinator, Public Health)*

### *Outcome 5: Healthwatch York is a well-managed, inclusive organisation with clear lines of governance, structure and communication*

Healthwatch York is recognised as a valuable organisation within the health and care system. Stakeholders praise the team's professionalism and commitment to their mission. "Healthwatch York is transparent and collaborative. Sian is open and easy to work with. Her team members are all collaborative. Communication is very good," noted one interviewee. This view is shared by various partners, who see Healthwatch York as an important contributor to the system.

Despite resource limitations, the organisation is commended for its effectiveness at both grassroots and strategic levels. Their persistence in challenging situations is particularly valued alongside the team's ability to maintain independence while collaborating closely with partners. As one partner commented, "The operation and organisation of Healthwatch York is outstanding... there can be a conflict of interest, but they manage that really well."

Many stakeholders believe Healthwatch York is underfunded, with one stating, "For every penny we give them in resource, I think partners regard them as giving excellent value for money."

Overall, it is viewed as an organisation that consistently delivers quality work despite resource constraints.

*"Healthwatch York is something for York to be proud of". Gary Young (Deputy Director Provider Transformation, York Health and Care Partnership).*

*"Healthwatch York is transparent, we share challenges across the geographical patch. Sian is open and easy to work with and the team members are all collaborative" Ashley Green (Chief Executive, Healthwatch North Yorkshire).*

### *4.3 Suggestions for improved working between Healthwatch York and its partners*

Stakeholders offered various suggestions for enhancing Healthwatch York's impact and collaboration with partners:

***Funding and resource allocation:***
Many emphasised the need for increased and more stable funding for Healthwatch York. As one stakeholder noted, "If people stop and look at what would be a healthy city in the widest sense, we will have a buoyant and very well-funded Healthwatch programme… and everyone would benefit from that." There were calls for a collective approach to advocating for Healthwatch York's budget, rather than relying on the team alone to make the case.

***Leveraging Healthwatch York's expertise:***
Partners suggested utilising Healthwatch York's experience and networks more effectively, potentially as an alternative to external consultants for public engagement. One interviewee pointed out, "If they use the experience of Healthwatch York and give some resource they would get better results than hiring external consultants."

***Focus on prevention and health inequalities:***
Several stakeholders proposed that Healthwatch York could play a larger role in addressing prevention and health inequalities. One suggested, "Helping us better understand health inequalities - 'levelling up' of health outcomes. How do we tackle this across the city? Non-medical interventions..."

***Exploring new service models:***
There were calls for Healthwatch York to be involved in shaping future services, including new staffing models and community-based services. One stakeholder asked, "How could we help GP's do more to address social health and wellbeing issues (less reliance on the medical model)?"

***Maintaining Independence:***
Partners value Healthwatch York's impartiality and encouraged them to maintain this while seeking more opportunities to work with providers. As one interviewee put it, "Keep doing what they are doing. Look for more opportunities to work with providers whilst being really rigid in maintaining their impartiality."

***Advocacy for marginalised groups:***
Some suggested Healthwatch York could focus more on those who don't access care until crisis point. One stakeholder noted, "They could do more raising the voice of those who don't access until crisis point. They are the most marginalised group in our city."

***System-wide engagement:***
There were calls for Healthwatch York to be more involved in strategic conversations across the health and care system. One interviewee envisioned, "…ideally be part of all strategic conversations and have budget/resource to get in the middle of conversations and look for opportunities to support system with direct insights."

***Technology and innovation:***
Some suggested Healthwatch York could explore new technologies in healthcare delivery, with one stakeholder proposing they "Conduct more surveys and reviews on opportunities for care outside hospital and/or the use of new technologies i.e. AI in the delivery of healthcare."

### *4.4 Reports produced*

Healthwatch York has produced a range of impactful reports covering various aspects of health and social care in York. These reports are widely regarded as well-structured, informative, and based on good data with appropriate sample sizes.

The mental health report was particularly notable, described as "a significant piece of work" that was "quite painful to read" but "powerful," reflecting traumatic experiences of individuals with mental health needs. It highlighted important issues in mental health provision.

The Autism and ADHD report also made a significant impact, leading to multiple speakers addressing the Health and Wellbeing Board on these issues. It was described as "a rallying cry" that challenged the system.

Other notable reports included those on urgent care, dementia care, and the health impacts of the cost-of-living crisis[vi]. These reports often identify systemic shortfalls and provide guidance for potential transformation projects.

Healthwatch York's reports are valued for their longevity and ongoing relevance. As one stakeholder noted, "The beauty of the reports is that they never go away. They are a snapshot in a moment in time... You can be confident that not much has changed and I can still read it as though it's today."

The team has been commended for their sensitive approach to anonymising data when necessary and for their efforts to balance negative and positive experiences in their reporting. They also produce practical resources, such as information on holiday opening times[vii] for pharmacies and health settings.

However, some stakeholders suggested that certain reports, like the dementia report, could benefit from wider dissemination. There's also a call for better partnership in sharing their publicly useful information across other bodies.

*"The ADHD and Autism report held up a mirror to us regarding our initial approach. The neurodivergent community is now the main partners in our conversations. The pathways and our approach around engagement have improved as a result"* *Shaun Macey (Assistant Director of Primary Care Transformation & Pathways)*

*"It's sometimes hard to achieve a balance with reports, as people often only report on negative experiences. Healthwatch work hard to hear and highlight what does and what doesn't work well for people"* *Shaun Macey (Assistant Director of Primary Care Transformation & Pathways)*

### *4.5 Commitment to EDI (Equality, Diversity, and Inclusion)*

Healthwatch York demonstrates a strong commitment to equality, diversity, and inclusion in their work. This commitment is evident in their approach to various health and social care issues, particularly in mental health, disability, and neurodiversity.

Their work on mental health has been noted for addressing the needs of individuals who may have been excluded from services due to complex needs. Their efforts extend to various forms of disability issues, with stakeholders observing that Healthwatch York consistently articulates their commitment to inclusion.

The organisation's work with diverse communities, including Gypsy and Traveller communities, and people with dementia, has been highlighted. Their ADHD-focused work has been praised for its inclusive approach.

Healthwatch York's previous work on accessible information was described as "really solid", providing a good example of how inclusion recommendations can be implemented. Their efforts have been instrumental in helping other providers understand issues through "soundbites from people", making complex issues more relatable.

Stakeholders value Healthwatch York's ability to capture and convey lived experiences, seeing this as a valuable resource for the city. Their work on urgent care was specifically mentioned for successfully reaching more diverse groups.

While Healthwatch York's work on autism and ADHD has been commended for promoting inclusivity across agencies, some stakeholders suggested areas for potential expansion. These include more focus on LGBTQ+ issues, particularly around the mental health needs of young adults, and addressing equity of access for those living non-conventional lifestyles.

Overall, the organisation is seen as playing a crucial role in ensuring all patient voices are heard and reminding health partners to consider these perspectives in their decision-making processes. As one stakeholder put it, "They make sure that patients' voices are heard and making sure that health partners think of the patient voice more than they do."

*"The team have strong relationships to highlight where there are major risks to an individual. They are sufficiently well connected to get a response. They don't give up on folk, they keep going back to them. At its most extreme, they save lives"* *Tim Madgwick* (*Chair, Safeguarding Adults Board)*

*"Their previous work on making information more accessible has had a direct impact on the Council - we're about to start releasing updates based on our work with Healthwatch on accessibility"* *Tracy Wallis (Health and Wellbeing Partnerships Coordinator, Public Health)*

### *4.6 Suggestions from stakeholders for Healthwatch York's focus in the coming year*

***a) Demonstrating impact of individual voices:***
Several stakeholders stressed the need to show how individual testimonies influence policies and strategies. As one put it, "The one thing I would like to see is the evidence of new pieces of work where the actual word and voice of individuals can be traced through to new plans and strategies." This could involve tracking specific cases, such as safeguarding concerns, from initial reports to service improvements.

***b) Waiting times and access to services:***
There was interest in exploring the 'waiting well agenda', investigating the impact of long wait times for hospital procedures on patients' daily lives. One stakeholder suggested, "Survey on A&E attendances - 'front door of the hospital', so accessible in city centre, all necessary."

***c) Digital access and health literacy:***
With the increasing digitalisation of health services, stakeholders highlighted the need to ensure inclusivity. One noted, "Digital access makes people think it is quicker and easier but that is not always the case. It excludes a lot of people." They suggested Healthwatch York could play a role in encouraging health services to involve people in the creation of digital systems.

***d) Focus on underrepresented groups:***
Several stakeholders suggested more attention to specific demographics, including LGBTQ+ communities and students. One mentioned, "Something for LGBTT communities, particularly being a university city. They get hidden."

***e) Social Care navigation:***
There was interest in examining how people navigate the social care system. One stakeholder suggested, "Probably something about shining the light on the funding of social care and how people navigate that system... understanding what people's experiences are at the moment would be a useful starting point to shape that agenda going forward."

***f) Consistent service provision:***
Some suggested longitudinal studies to track changes in service provision over time, ensuring that people who raise concerns can see the results of their input.

***g) Maintaining independence:***
Several stakeholders emphasised the importance of Healthwatch York retaining its independent voice while continuing to work closely with the system.

These suggestions reflect a desire for Healthwatch York to continue its vital role in amplifying community voices, while also adapting to address emerging challenges in the health and social care landscape.

## 5. Recommendations for 2024-2025.

### 5.1 Advocate for sustainable funding

Given Healthwatch York's exceptional value for money and vital role in the city, work with partners to make a strong case for increased, sustainable funding to expand capacity and impact.

### 5.2 Expand collaborative partnerships:

Build on existing relationships to foster more co-creation processes with health and social care providers, ensuring patient voices are integral to service development.

### 5.3 Deepen engagement with underrepresented groups:

Increase efforts to reach and represent LGBTQ+ communities, students, and other potentially overlooked demographics in York.

### 5.4 Explore long-term service provision studies:

Conduct longitudinal studies to track changes in service provision over time, particularly in areas like social care navigation and mental health services.

### 5.5 Expand regional influence:

Leverage Healthwatch York’s strong local understanding to contribute more broadly to strategic discussions across the Humber and North Yorkshire Integrated Care Partnership.

## Appendix A: Participants

| | | |
|---|---|---|
| Cllr Jo Coles | City of York Council | Councillor, Westfield Ward and Executive Member for Health and Social Care |
| Ian Dean | Community Pharmacy North Yorkshire | CEO |
| Stephen Eames | Humber and North Yorkshire ICS | CEO |
| Ashley Green | Healthwatch North Yorkshire | Chief Executive |
| Shaun Macey | York Health and Care Partnership | Assistant Director of Primary Care Transformation & Pathways |
| Tim Madgwick | City of York Council | Chair, Safeguarding Adults Board |
| Tracy Wallis | Public Health Team, City of York Council | Health and Wellbeing Partnerships Coordinator |
| Susan Wood | City of York Council | Welfare Benefits and Strategic Partnership Manager |
| Gary Young | York Health and Care Partnership | Deputy Director Provider Transformation |

## Appendix B: Reports

Listening to people with dementia: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/03/Listening-to-people-with-dementia.pdf

York Mental Health and Wellbeing Guide: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/04/MHWguide_Final-draft_pr01-1.pdf

Health and Cost of Living in York: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/06/Health-and-the-Cost-of-Living-in-York-May-2023.pdf

Spring 2023 magazine: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/07/HWY_SPRING2023-low.pdf

Breaking Point. A recent history of mental health crisis care: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/06/Breaking-Point-Mental-Health-Crisis-Care-June-2023-updated.pdf

Independent of the Pilot Pathway for Autism and ADHD: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/08/Independent-evaluation-pilot-pathway.pdf

Executive summary, Pilot Pathway for Autism and ADHD: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/08/Independent-evaluation-pilot-pathway.pdf

Autumn 2023 magazine: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/10/low_res_HWY-Autumn-2023.pdf

Urgent Care report: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/10/Urgent-Care-Report-.pdf

Support Services over the Festive Season: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/12/Christmas-services2-2023.pdf

Winter 2023 Magazine: https://www.healthwatchyork.co.uk/wp-content/uploads/2023/12/HWYmagazine_Winter-2023_4.7Mb.pdf

Community Pharmacy Report: https://www.healthwatchyork.co.uk/wp-content/uploads/2024/02/Final-Community-pharmacy-survey-report.pdf

Spring 2024 Magazine: https://www.healthwatchyork.co.uk/wp-content/uploads/2024/05/Web01_HWY_Spring2024-1.pdf

What we are hearing- Jan to March 2024: https://www.healthwatchyork.co.uk/wp-content/uploads/2024/05/Healthwatch-York-Quarterly-Report-Jan-Mar-24-1.pdf

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[i] *Breaking-Point-Mental-Health-Crisis-Care-June-2023-updated.pdf (healthwatchyork.co.uk)*
[ii] *Urgent-Care-Report-.pdf (healthwatchyork.co.uk)*
[iii] *Executive-Summary-Pilot-pathway-1.pdf (healthwatchyork.co.uk)*
[iv] *Access to Health and Social Care Services for Deaf People - Healthwatch York Report - YouTube*
[v] *https://www.healthwatchyork.co.uk/wp-content/uploads/2023/03/Listening-to-people-with-dementia.pdf*
[vi] *Health-and-the-Cost-of-Living-in-York-May-2023.pdf (healthwatchyork.co.uk)*
[vii] *Christmas-services2-2023.pdf (healthwatchyork.co.uk)*

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**Health and Wellbeing Board** **24 July 2024**

Report of the Director of Public Health

# Update on Goals 8 and 9 of the Joint Health and Wellbeing Strategy 2022-2032

## Summary

1. This paper provides the Health and Wellbeing Board (HWBB) with an update on the implementation and delivery of two of the ten big goals within the Local Joint Health and Wellbeing Strategy 2022-2032. It also includes information on performance monitoring.

2. The Board are asked to note the report.

## Background

3. At the January 2023 meeting of the Health and Wellbeing Board (HWBB) members of the Board agreed a framework for an action plan and a Population Health Outcomes Monitor for the Joint Health and Wellbeing Strategy 2022-2032. This was followed by agreement at the March 2023 meeting of a populated action plan and a Population Health Outcomes Monitor. Over the last six to eight months updates have been presented on **Goals 1 to 7** of the strategy and their associated actions.

4. Today's report provides an update on two further goals:

   *i.* **Goal 8**: Improve diagnosis gaps in dementia, diabetes and high blood pressure to above the national average, and detect cancer at an earlier stage

   *ii.* **Goal 9**: reduce sedentary behaviour, so that 4 in every 5 adults in York are physically active

5. This report also provides information on the **6** associated actions for these two goals along with updates on the agreed key performance indicators associated with the goals.

6. The agreed actions cover the first 24 months of the strategy's 10-year life span.

**Goal 8: Improve diagnosis gaps in dementia, diabetes and high blood pressure to above the national average, and detect cancer at an earlier stage**

7. **Action A19**: deliver an increased number of blood pressure checks and pulse monitoring through GP, community and pharmacy routes, to increase the number of people diagnosed and treated for cardiovascular diseases

8. Progress: The ICB Place team and public health are collaborating on a CVD prevention programme which aligns to regional and national CVD priorities. A Health Housing and Adult Social Care Scrutiny Committee item on the 23rd April 2024 focussed on 'Tackling Cardiovascular and Metabolic Disease' and gives a broad summary of this work and what has been achieved.

9. One example of the programme is the work with Nimbuscare and healthya, to deliver a city-wide hypertension screening project. Three health kiosks have been rolled out in York as part of a groundbreaking initiative to improve the health of the city's population. Free to use, the kiosks measure a person's height, weight, BMI, blood pressure, heart rate, and oxygen saturation. Three locations have been identified and kiosks are now live in areas of relative deprivation. These include Tang Hall Community Centre, Morrisons Foss Islands, and Energise Leisure Centre in Acomb.

10. The health kiosk provision aims to build upon the existing NHS Community Pharmacy Blood Pressure Check Service, with 31 pharmacies currently providing this service in York delivering nearly 8,000 checks so far. Working with Community Pharmacy North Yorkshire LPC, the health kiosks act as a feeder into the pharmacy blood pressure check service from more deprived parts of the city, by offering an initial check outside of a clinical setting.

11. Health Innovation Yorkshire and Humber have committed £40k to fund the scheme's evaluation. Work on this is underway and is being performed by the York Health Economics Consortium (YHEC).

12. In total, 141 patients have used the health kiosks at least once. This represents 256 individual health assessments. Thus far, 8% of patients have provided a high BP reading (>=140/90). Additionally,

29% of patients have been identified as Obese (BMI >=30 or >=27.5).

13. Whilst initial throughput has been promising, the team are conscious that to make a meaningful difference to diagnostic rates, overall utilisation must increase. Initial communication and marketing of the project has been intentionally limited to ensure that the system does not become overwhelmed. With increased confidence in the backend processes, the team are now ready drive footfall with a several intentions:

    - An SMS campaign targeted at patients most at risk of hypertension.
    - A 'train the trainers' programme, upskilling staff at sites to promote the kiosk.
    - An increase in local marketing materials to be displayed in general practice and online.
    - A cardiovascular disease event to be held at York Designer Outlet to coincide with the national Know your Numbers week.

14. **Action A20**: increase the number of people identified with diabetes through targeted NHS Health Checks

15. Progress: NHS Health Checks in York are delivered under contract from the local authority by Nimbuscare. Since the contract began in October 2021, 5,249 health checks have been delivered to York residents. 62% of these health checks were delivered to people who are living with one or more of the following: the 50% most deprived wards in York, or current smoker, or currently obese or currently diagnosed with anxiety or depression. At present, the data is not available to as to how many of these health checks were coded with a high-risk marker for diabetes, however systems are being put in place to allow for the detection of this measure going forwards.

16. **Action A21**: support the implementation of the Dementia Strategy

17. Progress: the following work has taken place to support the implementation of the Dementia Strategy:

    i. Develop the work of the Ageing Well partnership to ensure greater public awareness about dementia and increased understanding to reduce stigma.

- We have had two events in York to increase awareness and ensure there is effective signposting through a multi-agency approach. This was at the launch of the strategy in September 2022 and then one year on in September 2023.
- We carried out a range of social media messaging as well as promoting dementia events during national dementia week in May.

ii. Develop a dedicated space for information and advice about Dementia on Live Well York (an information and advice community website for all adults in the city).

- A dedicated dementia page has been created on Live Well York.

iii. The York Population Health Hub has conducted a deep dive into the Dementia Diagnosis gap in York and will shortly be publishing this work on the JSNA website.

iv. Ensure that information, advice and guidance is readily available, accessible and provided in different formats, including in person.

- Live Well York provides dementia information through an information page; service directory; what's on directory. This can be translated immediately into a wide range of languages and has an audio tool through a wide range of languages
- Any of the pages on Live Well York can be put into a personal booklet and sent electronically as a PDF or printed and posted. There are different print sizes to choose from.

v. Establish a framework for dementia training to ensure all people receive training relevant to their role so that the whole workforce has the right skills, behaviours and values to support people living with dementia.

- Dementia Forward are working with Access Able and the commissioner to provide dementia training for accessible venues to ensure people with dementia have a positive experience. These venues will then be awarded a dementia friendly symbol.

vi. Contribute to the work of the Ageing Well Partnership, meeting an objective of the City of York Council's Plan to promote dementia friendly services and buildings.

- Regular updates are provided to the Ageing Well Partnership regarding the progress of implementing and now delivery against the Dementia strategy

vii. Develop information, guidance and advice to address the different stages of the Dementia Well Pathway.

- A dementia pathway is being developed through a co-produced approach ensuring key questions asked by people with dementia and their carers are covered.

18. **Action A22**: reduce the numbers of York patients waiting over 62 days for a cancer diagnosis and achieve the 75% target for the 28-day Faster Diagnosis Standard

19. Progress: For York place GP practice patients, the target for percentage of patients commencing treatment within 62 days of referral was met in March 2023; however, the Faster Diagnosis Standard, which sets a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred urgently for investigation of cancer (including those with breast symptoms) and from NHS cancer screening, was not (72.2% vs target 77.3%). There are continued impact of diagnostics delays on cancer performance.

20. 24/25 Humber &North Yorkshire cancer alliance funding planning is ongoing, and York and Scarborough Hospital have developed a range of plans to support earlier diagnosis, faster diagnosis and operational performance. Cancer site pathways are being reviewed against Best Practice Timed Pathways (BPTP) to achieve the Faster Diagnosis Standard. A specific improvement workstream has been set up to support Urology, and mapping is underway with Skin and Head and Neck to review streamlining opportunities.

21. The most recent cancer screening data (2023) shows that York's breast cancer screening coverage is better than the national average (72.5% vs 66.2%), and bowel cancer screening coverage is better than the national average (77.1% vs 72.0%); however cervical cancer screening coverage in the young age group (25-49) is lower than the national average (64.6% vs 65.8%). Regular public communications

around cancer screening are released from ICB and public health comms teams to support call-recall systems.

**Goal 9: reduce sedentary behaviour, so that 4 in every 5 adults in York are physically active**

22. **Action A23**: ensure that the built environment supports children and young people to access green space to enable increased activity, using the local plan to inform the development of playparks and community spaces through the planning process

23. Progress: The local authority is in the process of updating their Playing Pitch Strategy and Built Facilities Strategy, which are used to audit current provision, grade the standard of provision and forecast future demand requirements. When published, these documents will be used along with the local plan to direct developers to the type of provision required to increase physical activity opportunities. Physical activity and sport guidance is also being included in the Health Supplementary Planning Document, to be published alongside the local plan.

24. **Action A24**: support the implementation of the Physical Activity and Sport Strategy

25. Progress: The Physical Activity and Sport strategy was published in 2022, as a 10-year strategy. An action plan was developed with multi-agency input; however, the lasting effects of the pandemic halted the delivery of much of the action plan. The physical activity strategic group is set to be re-established in the latter part of 2024, to refresh the action plan and set clear aims for the remaining years of the strategy.

26. **Population Health Outcomes Monitor**: this is linked to the ten big goals and is designed to provide board members with a holistic view of whether the strategy is making a difference to the health and wellbeing of York's population, using outcome data rather than data on what health and care services are 'doing'. Today's updates at **Annex B** to this report provide information on **Goals 8 and 9** of the strategy.

**Consultation and Engagement**

27. As a high-level document setting out the strategic vision for health and wellbeing in the city, the new Local Joint Health and Wellbeing Strategy capitalised on existing consultation and engagement work

undertaken on deeper and more specific projects in the city. Co-production is a principle that has been endorsed by the HWBB and will form a key part of the delivery, implementation, and evaluation of the strategy.

28. The actions in the action plan have been identified in consultation with HWBB member organisations and those leading on specific workstreams that impact the ten big goals.

29. The performance management framework has been developed by public health experts in conjunction with the Business Intelligence Team within the City of York Council.

**Options**

30. There are no specific options for the HWBB in relation to this report. HWBB members are asked to note the update and provide comment on the progress made.

**Implications**

31. It is important that the priorities in relation to the new Local Joint Health and Wellbeing Strategy are delivered. Members need to be assured that appropriate mechanisms are in place for delivery.

**Recommendations**

32. Health and Wellbeing Board are asked to note and comment on the updates provided within this report and its associated annexes.

Reason: To ensure that the Health and Wellbeing Board fulfils its statutory duty to deliver on their Joint Local Health and Wellbeing Strategy 2022-2032.

**Contact Details**


| **Author:** | **Chief Officer Responsible for the report:** |
|---|---|
| Tracy Wallis<br>Health and Wellbeing Partnerships Co-ordinator | Peter Roderick<br>Director of Public Health |

| | | | |
|---|---|---|---|
| **Report Approved** | ✓ | **Date** | 12.07.2024 |

**Specialist Implications Officer(s)**
None

**Wards Affected:** **All** ✓

**For further information please contact the author of the report**

**Annexes:**

**Annex A:** Update on Action A19
**Annex B**: HWBB Scorecard (for Goals 8 & 9)

# Annex A:

**Action A19: Deliver an increased number of blood pressure checks and pulse monitoring through GP, community and pharmacy routes, to increase the number of people diagnosed and treated for cardiovascular diseases**

The ICB's York place team are working with Nimbuscare and healthya to deliver a city-wide hypertension screening project. Three health kiosks have been rolled out in York as part of a groundbreaking initiative to improve the health of the city's population. Free to use, the kiosks measure a person's height, weight, BMI, blood pressure, heart rate, and oxygen saturation. Three locations have been identified and kiosks are now live in areas of relative deprivation. These include Tang Hall Community Centre, Morrisons Foss Islands, and Energise Leisure Centre in Acomb.

The health kiosk provision aims to build upon the existing NHS Community Pharmacy Blood Pressure Check Service. Working with Community Pharmacy North Yorkshire LPC, the York place team identified that uptake of the blood pressure check service was low. This is especially troubling for patients living in deprived neighbourhoods, who experience a lower diagnostic rate than patients living in more affluent parts of the city. To bridge the gap, the health kiosks act as a feeder into the pharmacy blood pressure check service, by offering an initial check outside of a clinical setting.

Patient safety is at the heart of the project. Clinical pathways have been agreed with partners from Nimbuscare, ensuring that there are adequate escalation routes. Patients with a blood pressure reading indicative of hypertension are signposted to community pharmacy to commence ambulatory home blood pressure monitoring. Patients detected with an excessively high blood pressure are signposted to same day care GP appointments. In the rare event of a hypertensive crisis, patients are immediately informed to attend A&E or call 999 as appropriate.

Health Innovation Yorkshire and Humber have committed £40k to fund the scheme's evaluation. Work on this is underway and is being performed by the York Health Economics Consortium (YHEC). In total, 141 patients have used the health kiosks at least once. This represents 256 individual health assessments. Thus far, 8% of patients have provided a high BP reading (>=140/90). Additionally, 29% of patients have been identified as Obese (BMI >=30 or >=27.5).

Whilst initial throughput has been promising, the team are conscious that to make a meaningful difference to diagnostic rates, overall utilisation must increase. Initial communication and marketing of the project has been intentionally limited to ensure that the system does not become overwhelmed. With increased confidence in the backend processes, the team are now ready drive footfall with a several intentions:

- An SMS campaign targeted at patients most at risk of hypertension.
- A 'train the trainers' programme, upskilling staff at sites to promote the kiosk.
- An increase in local marketing materials to be displayed in general practice and online.
- A cardiovascular disease event to be held at York Designer Outlet to coincide with the national Know your Numbers week.

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# Health and Wellbeing 10 Year Strategy (2022-2032) 2023/2024

No of Indicators = 8 | Direction of Travel (DoT) shows the trend of how an indicator is performing against its Polarity over time.

Produced by the Business Intelligence Hub July 2024

| | | | Collection Frequency | Previous Years | | | | | | | 2023/2024 | | Polarity | DOT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2016/2017 | 2017/2018 | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | Year | Target | | |
| Goal 08: Improve diagnosis gaps in dementia, diabetes and high blood pressure and detect cancer at an earlier stage | PHE11 | Estimated dementia diagnosis rate (%) for people aged 65+ as recorded on practice disease registers | Annual | NC | 60.40% | 62.20% | 60.50% | 57.20% | 53.20% | 55.10% | 56.10% | - | Up is Good | ◄► Neutral |
| | | Benchmark - National Data | Annual | NC | 67.90% | 67.50% | 68.70% | 67.40% | 61.60% | 62.00% | 63.00% | - | | |
| | | Benchmark - Regional Data | Annual | NC | 71.30% | 71.20% | 71.60% | 70.20% | 63.20% | 63.10% | 65.10% | - | | |
| | | Regional Rank (Rank out of 15) | Annual | NC | 15 | 15 | 15 | 15 | 14 | 14 | 13 | - | | |
| | PHOF192c | Calculated Diabetes Diagnosis Rate | Annual | 77.60% | 78.20% | 79.20% | 77.70% | 77.20% | 80.20% | 82.70% | - | - | Up is Good | ▲ Green |
| | | Benchmark - National Data | Annual | 80.70% | 81.60% | 83.60% | 85.70% | 85.50% | 88.70% | 92.40% | - | - | | |
| | | Benchmark - Regional Data | Annual | 82.60% | 84.10% | 86.10% | 87.80% | 87.80% | 90.80% | 85.80% | - | - | | |
| | PHOF193c | Calculated Hypertension Diagnosis Rate | Annual | 64.60% | 65.20% | 65.90% | 66.40% | 65.90% | 67.50% | 71.40% | - | - | Up is Good | ▲ Green |
| | | Benchmark - National Data | Annual | 68.10% | 69.10% | 70.40% | 72.30% | 71.80% | 73.00% | 76.40% | - | - | | |
| | | Benchmark - Regional Data | Annual | 69.40% | 70.50% | 71.80% | 72.80% | 72.30% | 73.60% | 68.20% | - | - | | |
| | PHOF194 | Percentage of cancers diagnosed at stages 1 and 2 | Annual | 52.59% | 56.26% | 51.82% | 51.13% | 49.51% | 52.60% | (Due Feb 2025) | - | - | Up is Good | ◄► Neutral |
| | | Benchmark - National Data | Annual | 54.60% | 54.32% | 54.56% | 54.88% | 52.35% | 54.42% | (Due Feb 2025) | - | - | | |
| | | Benchmark - Regional Data | Annual | 52.73% | 51.88% | 52.36% | 53.38% | 50.69% | 52.64% | (Due Feb 2025) | - | - | | |
| | | Regional Rank (Rank out of 15) | Annual | 7 | 1 | 7 | 13 | 12 | 8 | (Due Feb 2025) | - | - | | |

# Health and Wellbeing 10 Year Strategy (2022-2032) 2023/2024

No of Indicators = 8 | Direction of Travel (DoT) shows the trend of how an indicator is performing against its Polarity over time.

Produced by the Business Intelligence Hub July 2024

| | | | | Previous Years | | | | | | | 2023/2024 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Collection Frequency | 2016/2017 | 2017/2018 | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023 | Year | Target | Polarity | DOT |
| Goal 09: Reduce the proportion of adults who are physically inactive from 1 in 5 to 1 in 7 | HLTH55 | Access to Healthy Assets & Hazards Index (Persons, All ages) - % of the population who live in LSOAs which score in the poorest performing 20% on the AHAH index | Annual | 5.10% | 5.40% | NC | NC | NC | NC | 3.20% | - | - | Up is Bad | ◀▶ Neutral |
| | | Benchmark - National Data | Annual | 21.20% | 21.1.% | NC | NC | NC | NC | 22.60% | - | - | | |
| | | Benchmark - Regional Data | Annual | 22.20% | 14.10% | NC | NC | NC | NC | 19.90% | - | - | | |
| | | Regional Rank (Rank out of 15) | Annual | 4 | 7 | NC | NC | NC | NC | 1 | - | - | | |
| | PHOF02a | % of adults (aged 19+) that are physically inactive (<30 moderate intensity equivalent minutes per week) | Annual | 18.30% | 13.80% | 15.80% | 17.60% | 21.20% | 15.40% | 16.30% | - | 15% | Up is Bad | ◀▶ Neutral |
| | | Benchmark - National Data | Annual | 22.24% | 22.23% | 21.39% | 22.90% | 23.38% | 22.30% | 22.60% | - | - | | |
| | | Benchmark - Regional Data | Annual | 24.08% | 24.06% | 22.66% | 24.20% | 24.24% | 23.60% | 24.10% | - | - | | |
| | | Regional Rank (Rank out of 15) | Annual | 1 | 1 | 1 | 1 | 3 | 1 | 1 | - | - | | |
| | PHYS08 | % of children in school years 1-11 that are active for 60+ minutes everyday | Annual | NC | 49.20% | 40.50% | NC | 41.81% | NC | NC | - | - | Up is Good | ◀▶ Neutral |
| | | Benchmark - National Data | Annual | NC | 43.26% | 46.81% | 44.89% | 44.63% | 47.20% | 47.00% | - | - | Neutral | ◀▶ Neutral |
| | | Benchmark - Regional Data | Annual | - | 41.27% | 45.88% | 43.22% | 46.40% | 45.70% | 47.50% | - | - | | |
| | | Regional Rank (Rank out of 15) | Annual | - | 3 | 12 | NC | 7 | NC | NC | - | - | | |
| | PHYS12 | Proportion of adults who do any walking or cycling for any purpose at least three times per week | Annual | 57.80% | 60.40% | 56.00% | 60.50% | 58.90% | 55.00% | 59.40% | Due Aug 24 | - | Up is Good | ◀▶ Neutral |
| | | Benchmark - National Data | Annual | 45.70% | 47.00% | 47.20% | 47.70% | 46.00% | 45.60% | 45.80% | Due Aug 24 | - | | |
| | | Benchmark - Regional Data | Annual | 43.60% | 44.20% | 44.70% | 45.90% | 44.60% | 43.00% | 43.00% | Due Aug 24 | - | | |