Notice of a public meeting of
Health and Wellbeing Board

To:	Councillors Runciman (Chair), Brooks, Cannon, Craghill,	
	Martin Farran	Director of Adult Social Care, City of York Council
	Jon Stonehouse	Director of Education, Children and Skills, City of York Council
	Tim Madgwick	Deputy Chief Constable, North Yorkshire Police
	Kevin Curley	Acting Chief Executive, York CVS
	Siân Balsom	Manager, Healthwatch York
	Julie Warren	Locality Director (North) NHS England
	Martin Barkley	Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust
	Patrick Crowley	Chief Executive, York Teaching Hospital NHS Foundation Trust
	Rachel Potts	Chief Operating Officer, Vale of York Clinical Commissioning Group
	Dr Mark Hayes	Chief Clinical Officer, Vale of York Clinical Commissioning Group
	Mike Padgham	Chair, Independent Care Group

Date: Wednesday, 21 October 2015

Time: 4.30 pm
Venue: The George Hudson Board Room - 1st Floor West Offices (F045)

A G E N D A

1. Introductions

Items for Discussion

2. Declarations of Interest (Pages 3 - 4)

At this point in the meeting, Board Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda. A list of general personal interests previously declared is attached.

3. Minutes (Pages 5 - 18)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 15 July 2015.

4. Public Participation

It is at this point in the meeting that members of the public who have registered their wish to speak can do so. The deadline for registering is:
Tuesday 20 October 2015 at **5.00 pm**.

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

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

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

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

5. **Annual Report-Safeguarding Adults Board** (Pages 19 - 80)
This report provides information on the work of the Safeguarding Adults Board over the course of 2014/15. A summary of the report can be found at Annex A of this report and the full annual report at Annex B.

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

6. **Verbal Position Statement on Mental Health Facilities in York**
Ruth Hill, Director of Operations, from Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Mark Hayes, Chief Clinical Officer and Rachel Potts, Chief Operating Officer, from Vale of York Clinical Commissioning Group will provide a verbal position statement to the Board following the recent closure of Bootham Park Hospital.

7. New Children and Young People's Plan 2016-19
(Pages 81 - 86)
This report provides Board Members of the Health and Wellbeing Board with a brief progress update on the production of York's new Children and Young People's Plan 2016-19.

8. Healthwatch York Reports (Pages 87 - 208)
This report provides the Health and Wellbeing Board with comments on the two previous Healthwatch reports presented to the Board in July, which were "Who's Who in Health and Social Care" and "Consistency and Confidence in Patient Led Assessments of the Care Environment (PLACE)".

Also included is information on two new Healthwatch reports on "Accident and Emergency Department and Alternatives" and "Discharge from Health and Social Care Settings".

9. Update on Integration (Pages 209 - 224)
This report presents an update on developing integration, which captures various elements of our joint plans to develop services that maximise the health and wellbeing of our population.

Items for Information

10. Annual Report of the City of York Safeguarding Children Board 2014/15 (Pages 225 - 248)
This report will give the Health and Wellbeing Board (HWBB) an indication of key areas of work undertaken by the Safeguarding Children Board during 2014/15. A copy of the report is at Annex A to this report.

11. Forward Plan (Pages 249 - 252)
Board Members are asked to consider the Board's Forward Plan for 2015/16.

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

Democracy Officer:

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

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

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

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

☎ **(01904) 551550**

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Agenda Annex

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

Remit

York Health and Wellbeing Board will:

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

York Health and Wellbeing Board will not:

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

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Agenda Item 2

Health & Wellbeing Board
Declarations of Interest

Patrick Crowley, Chief Executive of York Hospital
None to declare

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

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

Mike Padgham, Chair Council of Independent Care Group

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

Siân Balsom, Manager Healthwatch York

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

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City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	15 July 2015
Present	Councillors Runciman (Chair), Brooks, Cannon and Craghill, Guy Van Dichele (Director of Adult Social Care CYC) Julie Hotchkiss (Acting Director of Public Health - CYC) Tim Madgwick (Deputy Chief Constable, North Yorkshire Police) Jon Stonehouse (Director of Children's Services - CYC) Siân Balsom (Manager, Healthwatch York), Mark Hayes (Chief Clinical Officer, Vale of York Clinical Commissioning Group) Rachel Potts (Chief Operating Officer, Vale of York Clinical Commissioning Group) Mike Proctor (Deputy Chief Executive, York Teaching Hospital NHS Foundation Trust (Substitute for Patrick Crowley)
Apologies	Chris Butler (Chief Executive, Leeds and York Partnership NHS Foundation Trust) Patrick Crowley (Chief Executive, York Teaching Hospital NHS Foundation Trust) Mike Padgham (Chair of Independent Care Group) Julie Warren (Locality Director (North) NHS England)

1. Introductions

Introductions were carried out.

2. Declarations of Interest

Board Members were invited to declare any personal or disclosable pecuniary interests that that they might have had in the business in the agenda, other than those listed in their standing declarations. None were declared.

3. Minutes

Resolved: That the minutes of the Health and Wellbeing Board meeting held on 11 March 2015 be signed and approved by the Chair as a correct record subject to the following insertion;

- Julie Warren- Locality Director (North) NHS England under apologies.

4. Public Participation

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

John Yates made a number of comments in relation to Agenda Items 14 (Healthwatch York Reports) and 9 (Update made on Progress to Health Inequalities). He commended Healthwatch on the information they had provided in the reports and felt that they provided an excellent service and that partners should ensure that they maintained communication and financial arrangements with them. In relation to Action 9, about alcohol use and smoking in the Health Inequalities report, he made a comment about the large space given over to cheap alcohol in supermarkets and about how replacement cigarettes were based on nicotine rather than tobacco.

In response, Julie Hotchkiss, the Acting Director of Public Health stated that there were licensing regulations that stipulated that alcoholic products be placed at the back of the shop.

She added that although e-cigarettes did not contain carcinogens and tar caution must still be taken before they were deemed to be safe.

Tim Madgwick, the Deputy Chief Constable of North Yorkshire Police reported that one local authority, Ipswich reduced access to high strength alcohol which had helped in the short term but did not translate in the longer term. He felt that there had been mixed messages about the harm that alcohol had caused and that an alcohol strategy was needed to provide a clear message, as current statistics showed that binge drinking in York was above average for the size of the city.

5. Patient Story

Two users of the HEAL (Health Exercise Activity Lifestyle) Programme were in attendance to discuss with Board Members their experiences of COPD (Chronic Obstructive Pulmonary Disease) focused physical activity sessions at Clifton Moor.

The two users shared their personal experiences with COPD. One previously had been admitted to hospital at last three times and year and has not been admitted since starting the session, she could even use stairs now. She underlined the social aspect that the sessions gave to users who might not otherwise have the time or opportunity to do so with people in a similar situation.

The other user informed the Board that he started attending the sessions as he kept being readmitted into hospital over the winter. His physio suggested that he attend the sessions. Since attending his admissions to hospital have greatly reduced.

The Council's HEAL Development Officer informed the Board that a number of groups had been set up for conditions such as COPD and practice nurses and GPs could refer patients to the sessions. It was noted that there was one class a week and an average attendance of nine people. Both service users felt that it would be useful to increase the number of sessions on offer as they were so beneficial.

6. Children and Young People's Emotional Health and Wellbeing

Board Members considered a report which set out the vision and strategy for supporting the emotional and mental health of children and young people in York.

The six recommendations in the report had been proposed to secure the continued good progress of the local strategy to improve the emotional and mental health outcomes for children and young people in York.

It was noted that the task and finish group referred to in recommendation v could be a working group of either the Children's Trust Board (YorOK Board) or the Health and Wellbeing Board.

Discussion took place on the report during which different Board Members shared their experiences of their agencies' interactions with children and young people in York.

Several concerns were raised which included;

- Whilst there was a huge amount of good work going on in the city we could not afford to become complacent
- Issues of extremism and safeguarding responsibilities.
- Training for colleagues across all agencies
- Limited capacity particularly for out of hours services
- Anxiety around transitions

Board Members welcomed a multiagency approach but noted that it needed to be adopted in difficult financial circumstances. They were however optimistic about the change in the provider of the Child and Adolescent Mental Health Services (CAMHS). They felt it was important to look at the wider context, develop a shared approach to commissioning that demonstrated impact and ensure that children with a mental health condition were not criminalised in any way.

Resolved: (i) That the multi-agency CAMHS Executive group be endorsed as key reference point for the commissioning and development of comprehensive CAMHS services for the City of York.

(ii) That there is a clearly delineated City of York analysis and proposal set out in the wider VOYCCG (Vale of York Clinical Commissioning Group) Transformation Plan.

(iii) That this plan should seek to maximise the potential of the strong multi agency partnership to address gaps and strengthen further the preventative early intervention approach already well established in the City.

(iv) That contract monitoring arrangements for the delivery of the new CAMHS (Child and Adolescent Mental Health Services) specification by Tees, Esk and Wear Valleys NHS Foundation Trust should include some direct representation from the CAMHS Executive Group (in addition to direct health commissioners).

(v) A task and finish group be established to consider revised governance arrangements across the VOYCCG and CYC in relation to the future delivery of multi agency CAMHS. Such an arrangement should reflect the rapidly changing policy landscape and to ensure that the current high level of engagement from across the community of wider children's services (including schools) is sustained.

(vi) That a further report on the progress of this work be presented to a future meeting of this Board.

Reason: So that the Board is kept informed of the work that is being undertaken to support the emotional and mental health of children and young people in York.

7. Update on the Healthy Child Service 0-19 years

The Board received a report which provided them with an update on the transfer of the Healthy Child Programme 0-5 years from NHS England to City of York Council on 1 October 2015 and the proposal to establish an integrated 0-19 Healthy Child Service for York.

Officers highlighted that gaps existed where there could be greater integration around;

- Emotional wellbeing- it was particularly important to start bonding parenting work, pre birth.
- Children's healthy weight- it was often difficult for families to understand the importance of healthy weight and there was work to do over sensitive communication, as there was no co-ordinated family approach to tackle childhood obesity.
- School nursing was only commissioned up to age 16 and this meant that there was a gap for young people.
- There was a greater need for improvement in data sharing and to unpick some of the barriers that are stopping this from happening effectively

It was noted that the YorOK Board were overseeing this programme of work but a further report would come to the Health and Wellbeing Board in the future.

Resolved: That the contents of the report be noted.

Reason: So that Board be apprised of the progress being made for the transfer of the Healthy Child Programme 0-5 to City of York Council on 1 October 2015 and plans for the establishment of an integrated 0-19 Healthy Child Service.

8. Safeguarding Children-Update June 2015

Board Members considered a report which updated them on key safeguarding activity. They also received a report from the Independent Chair of York Safeguarding Children Board.

The Independent Chair, Simon Westwood, commented on the gaps in safeguarding activity in the city and added that he was concerned by capacity and the short term nature of support for victims of domestic abuse. However he was heartened, having listened to the debate on the previous reports on this agenda to hear that partnership working was strengthening and agendas were being aligned.

Tim Madgwick spoke about how the Police were often confronted with having to make judgments on cases with large amounts of data in a rapid amount of time.

Jon Stonehouse reported that the Council's waste operatives had recently been trained to spot signs of child sexual exploitation. It was felt that it was important for awareness training to be offered to a number of other people such as those who worked in bars and pubs.

Discussion then took place on information sharing and the significance of an agreement from agencies to do so, and how this worked in practice. The Chair thought that this was an issue that the Health and Wellbeing Board should look at and requested that each Board Member send their protocols on information sharing to the Health and Wellbeing Partnerships Co-ordinator along with details about what barriers they faced on sharing this information. The Board would then receive this information at a future meeting.

In addition to this there was discussion around:

- The Annual Report of the Children's Safeguarding Board needed to be received and minuted by the Health and Wellbeing Board at their October meeting
- Tranistions is an area that needs to be included in the refresh of the Joint Health and Wellbeing Strategy

Resolved: (i) That the report be noted.

(ii) That protocols on information sharing be sent to the Health and Wellbeing Partnerships Co-ordinator and considered at a future meeting of the Board.

(iii) That the Annual Report of the Children's Safeguarding Board be received and minuted by the Health and Wellbeing Board at their October meeting

Reason: To ensure that strategic leadership for safeguarding children is strengthened and that key priorities are shared and understood.

9. Update made on Progress to Health Inequalities

Board Members received a report which provided them with an update and information on progress made towards the actions on 'Reducing Health Inequalities' as outlined in the 'Improving Health and Wellbeing in York- Our Strategy 2013-16'.

Julie Hotchkiss added to the report and informed Board Members that;

- The Sport and Active Leisure Team in Public Health ran a Deaf Badminton club.
- The term 'Healthwatchers' was no longer being used.
- On Action 9- the Alcohol Needs Assessment would be coming to the Board in October.
- The Chair of the Board, Councillor Runciman, had agreed to Chair the Tobacco Alliance.

Discussion took place over the matters within the report. Comments and questions raised included;

- The National Living Wage would not apply to under twenty fives.
- Where were the risks of inequality most acute?
- The inequality of health reflected poverty.
- There needs to be a mechanism for the voluntary sector and the public to challenge and feed into the health inequalities agenda; it is essential that we co-develop and co-design to reduce health inequalities in the city

It was noted that some of these concerns could be addressed within the forthcoming refresh of the Joint Health and Wellbeing Strategy.

Resolved: That the report be noted.

Reason: To keep the Health and Wellbeing Board up to date with progress made against delivering on the Health Inequalities theme of the Joint Health and Wellbeing Strategy.

10. Update on the Better Care Fund

Board Members considered a report which asked them to note progress made and to support the implementation and delivery of the Better Care Fund plan.

Rachel Potts, Chief Operating Officer of the Vale of York Clinical Commissioning Group stated that early indications showed that there was an increase in hospital admissions but this needed to be put in the context of integration. Individual schemes were reducing admission numbers but this was not translating across at system level.

Discussion of the paper indicated that the Board wished to be more involved in the broader context of the integration work and that a paper should come to a future meeting of the Board.

Resolved: (i) That the report be noted and the strategic direction of travel for the Better Care Fund and wider system integration be supported.

(ii) That a paper on the wider integration programme come to a future meeting of the Board.

Reason: To be kept informed of progress on the Better Care Fund programme.

11. Performance Update July 2015

Board Members considered a report which asked them to note the latest available performance figures for the indicators agreed at the December 2014 meeting.

Officers reported that the low proportion of adults with a learning disability having a health check figure was a recording issue and the evidence suggested that anecdotally this figure was much higher.

Some Board Members felt that longer term indicators should be measured as it would give a better sense of outcomes.

Resolved: That the latest performance data for the agreed suite of indicators be noted.

Reason: To monitor the latest performance information for the Health and Wellbeing Board.

12. Joint Health and Wellbeing Strategy Refresh

Board Members considered a report which asked them to approve the process and timescales for the Joint Health and Wellbeing Strategy and Refresh.

Councillor Runciman agreed to be the Board's lead to work with Officers on Strategy development.

Resolved: (i) That Option B be approved to allow the refresh process to start immediately.

(ii) That Councillor Runciman be the Board's lead in the work.

Reason: To allow for the Joint Health and Wellbeing Strategy process to commence.

13. Governance Arrangements for the Health and Wellbeing Board

Board Members received a report which updated and reminded them of their current governance arrangements.

Resolved: That the report be noted.

Reason: To remind Board Members of the remit of the Board and their duties in relation to deputies.

14. Healthwatch York Reports: Patient Led Assessments of the Care Environment (PLACE), Who's Who in Health and Social Care

The Board received two reports from Healthwatch York; Who's Who in Health and Social Care and Consistency and Confidence in Patient Led Assessments of the Care Environment (PLACE).

It was agreed to have a discussion on the reports at the next meeting. Siân Balsom informed the Board of an upcoming PLACE inspection and a meeting she would be having with NHS England and the Department of Health in respect of this.

Resolved: That the reports be noted and discussion of the reports be deferred until the next meeting.

Reason: To keep Board Members up to date with the work of Healtwatch.

15. Forward Plan

Board Members were asked to consider the Board's Forward Plan for 2015-16.

Resolved: That the Forward Plan be approved.

Reason: To ensure that there is a planned programme of work in place.

16. Urgent Matters

The Chair reported that she had recently spoken to Professor Dianne Willcocks, Chair of the Fairness and Equalities and Board (FEB). She was intending to ask FEB to look at undertaking a piece of work around Healthy Lifestyles and Fitness at Work in order to be able to brief the Health and Wellbeing Board in six months time and bring a full report in a year's time. Siân Balsom confirmed that she would be the link between the Health and Wellbeing Board and FEB in this work.

Vote of Thanks

It was announced that this would be the final meeting for Guy van Dichele and Julie Hotchkiss. The Chair thanked them on behalf of the Board for all their hard work, and wished them well for the future.

Councillor C Runciman, Chair
[The meeting started at 4.30 pm and finished at 6.40 pm].

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Health and Wellbeing Board Action Grid
Starting 15th July 2015

Action Number	Date Allocated	Action	Responsible	Date Required	Progress
HWBB 001	15.07.2015	HWBB to receive the Annual Report of the Children's Safeguarding Board at their October 2015 meeting	TW	05.10.2015	Added to the agenda for 21.10.2015
HWBB 002	15.07.2015	Protocols on information sharing be sent to the Chair of the Board	All to provide and TW to Co-ordinate	31.10.2015	In progress
HWBB 003	15.07.2015	HWBB to receive a paper on the wider integration system	TW to Co-ordinate and to add to the Forward Plan	05.10.2015	Added to the agenda for 21.10.2015
HWBB 004	15.07.2015	Add Healthwatch York PLACE Reports and Who's Who in Health & Social Care to the Forward Plan	TW	16.07.2015	Complete

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Health and Wellbeing Board **21st October 2015**
Report of the Director of Adult Social Care

Annual Report – Safeguarding Adults Board

Summary

1. This report provides information on the work of the Safeguarding Adults Board over the course of 2014/15. A summary of the report can be found at Annex A of this report and the full annual report at Annex B.

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

Background

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

Main/Key Issues to be Considered

4. The Annual Report is for information only but clearly sets out the work the Board carried out over the course of 2014/15.

Consultation

5. This report is for information only.

Options

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

Analysis

7. This section is not applicable to this report.

Strategic/Operational Plans

8. This topic relates to the theme of the CYC Council Plan "Protect vulnerable people".

Implications

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

Risk Management

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

Recommendations

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

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

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator Public Health Team Tel: 01904 551714	Martin Farran Director of Adult Social Care
	Report Approved ✓ **Date** 07.10.2015

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A – Summary of Safeguarding Adult's Board Annual Report

Annex B – Safeguarding Adults Board's Annual Report

Annex A

City of York Safeguarding Adults Board (CYSAB)
Annual Report 2014/15
Summary

The role of CYSAB

CYSAB is a partnership of people and organisations across York that leads on safeguarding work to prevent adults being abused or neglected.

Members of the board work together to make sure that arrangements are in place to keep people safe. The members of the board represent these organisations:

- Healthwatch York
- Leeds & York Partnerships NHS Foundation Trust
- NHS England
- North Yorkshire Police
- City of York Council
- York Teaching Hospital NHS Foundation Trust
- Stockton Hall
- York CVS
- NHS Vale of York Clinical Commissioning Group
- NHS Partnership Commissioning Unit
- The Retreat
- Independent Care Group

Work over the past year

The Care Act

In April 2015, the Care Act made it the law for each local authority area to have a Safeguarding Adults Board. CYSAB has looked at the way it operates to make sure that it meets the new requirements. It has put in place new policies and procedures for **Safeguarding Adults Reviews** and **Lessons Learned Reviews**. These would be carried out when an adult who has care and support needs has suffered serious neglect or abuse and there is concern about whether people have done the right things to protect them.

The Care Act also outlines a new approach, called **Making Safeguarding Personal**, which makes sure that people can make choices about what they want to happen from a safeguarding activity.

The CYSAB worked with independent advocates to help people, who couldn't make decisions themselves, describe how they wanted to be protected when abuse or neglect might have taken place. The council was then able to understand the best approach to helping them in the way they preferred. In most cases, people were able to achieve what they wanted to happen. This approach is now part of how the council works to safeguard adults.

CYSAB has worked with the council to improve the **information, advice and guidance** to help keep people safe from abuse. The Connect to Support portal has been updated to give more information on keeping people safe, including how to report neglect or abuse, advice on domestic violence, bogus traders, online safety and community safety.

To follow the **Winterbourne Concordat**, CYSAB members worked together to identify vulnerable people who are currently placed outside the area, but who might be better able to enjoy a safe and high quality of life back in York. 7 people have been helped to move back to York and 15 others are receiving help and support to move back in the future. For those people still living out of the area, new processes have been put in place to make sure their support and treatment is reviewed and the requirements of the Mental Capacity Act are met.

Self Assessment

The CYSAB needs to be able to understand the progress organisations are making in safeguarding adults. A self-assessment framework has been developed which members of the board complete for their organisation to show where they are strong and where there are things to improve. All partners have completed this assessment.

It has shown that, overall, organisations are able to safeguard adults well, but there are a few areas where improvements can be made:

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

Internal Audit

To make sure that everything that needs to happen to be ready for the Care Act has been done, the internal audit team looked at progress.

The internal audit report found that preparations were well underway and there was confidence of the progress made. Two areas where there could be improvements in the future were:

- Processing of Deprivation of Liberty cases is a manual process which could be improved through the greater use of IT.
- The information on the Safeguarding Adults Board website could be made more useful.

Training

The training provided by the Workforce Development Unit has been developed to include a broader range of opportunities. This has meant that an increased number of people have benefited from training in a larger number of areas.

Feedback on training showed that almost everybody who attended thought the training was Good or Excellent.

Key statistics

City of York Council received 1058 alerts in 2014/15, which is an increase from 912 the year before. When an alert is received, the council makes an assessment which looks at the risk and whether it can be resolved. If it can't be resolved, a referral is made for further investigation.

294 individual adults at risk were referred for further investigations into the alleged abuse. Almost two-thirds of these investigations related to women.

In most cases, the person is at risk from someone they know, in their own home. However, an increasing number of people were seen to be at risk in their care home or nursing home.

Serious Cases and Lessons Learned

No serious case reviews needed to be carried out in 2014/15.

However, there were two cases where somebody who was receiving services from the council, NHS or other services had died where more information was needed to see if lessons could be learned to stop similar things happening in the future.

These lessons learned reviews will be reported on in next year's annual report.

Progress against the Strategic Plan

CYSAB has a strategic plan which outlines its work up until 2017. Good progress has been made against each of the actions identified.

Under the Care Act, the board needs to have a plan which has been consulted on by both Healthwatch and the local community. To make sure CYSAB's plan meets this requirement, Healthwatch is developing a strategy to work with the community, which will then help CYSAB develop a new plan to be ready by 2016.

ANNEX B

Safeguarding Adults Board

Annual Report 2014/15

ANNEX B

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	• "Tracy"	16/17
	• "Daniel"	17
9.	**New Strategic Plan for 2016 onwards**	**18/**
10.	**Annex 1 Board Membership**	
11.	**Annex 2 Board Attendance**	

12. Annex 3 April 2014 to March 2017 Action Plan:

March 2015 update

13. Contributions from individual member organisations:

- **Garrow House***
- **Healthwatch York**
- **Independent Care Group**
- **Leeds & York Partnerships NHS Foundation Trust**
- **NHS England**
- **NHS Vale of York Clinical Commissioning Group with North Yorkshire & York Partnership Commissioning Group**
- **North Yorkshire Police**
- **Stockton Hall**
- **The Retreat**
- **York CVS**
- **York House***
- **York Teaching Hospitals NHS Foundation Trust**

(*=represented by The Retreat at the SAB)

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

I am very pleased to introduce this Annual Report, having first taken up my appointment on 1 April 2013. I would comment that those readers who saw the 2013 Report will find much which is new in this one, including a formal input from each organisation represented at the SAB.

One of my roles has been to establish productive relationships with the organisations which are represented at the SAB and to ensure that we are working to a shared agenda with the right people around the table. That agenda has been dominated this year by our preparations for the implementation of the Care Act 2014, of which safeguarding is one small but vital part. There are some 500 pages of Statutory Guidance on implementation of the Act, though the SAB has only had to concentrate on the fifty pages in Chapter 14!

We became a statutory body on 1 April 2015, on a par for the first time with the Children's Board and we believe that we are on track to deliver assurance to the citizens of York that everything which should be in place either is or is in the process of being implemented.

In order to progress our thinking we established a Board sub-group of key members and together we have spent the past few months clarifying and agreeing our constitution, membership, memorandum of understanding for each member and much more besides, including multi-agency procedures. We have also thought carefully about the size of the Board and have developed a clear and shared view that increasing its size and complexity in response to the Act would almost certainly be a mistake.

As a result the current Board has sixteen members drawn from twelve key organisations operating in the City of York. They can be seen in Appendix 1 and include City of York Council, Healthwatch York, the Independent Care Group, Leeds & York Partnerships NHS Foundation Trust, NHS England, NHS Vale of York Clinical Commissioning Group, North Yorkshire Police, Stockton Hall, The Retreat, York CVS, York Teaching Hospitals NHS Foundation Trust and York & North Yorkshire Partnership Commissioning Unit.

It is our intention to ensure that senior representation from the housing sector will be added imminently to the SAB, but we do not anticipate any further changes in the short to medium term. Further, and given the level of organisational turbulence which has affected NHS organisations in particular during the past three years, I am particularly grateful for the level of engagement we have achieved with them, and also with voluntary sector and private sector hospitals treating NHS patients.

I am pleased to say that York is fully engaged in the national pilot of "Making Safeguarding Personal" (MSP), the new approach which underpins the Care Act 2014 and which requires that the individual exercises as much choice and control as possible in determining and achieving the outcomes they want from safeguarding enquiries, rather than having passively to accept safeguarding being "done" to them by the Local Council and its staff. Section 3 of this Report contains two anonymised

case studies which briefly illustrate how MSP differs from more traditional approaches.

One of the requirements of the Care Act is that the SAB Annual Report must contain details of any Safeguarding Adults Reviews (SARs) which have been conducted when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the individual. The findings of SARs must be included, as must actions taken or intended in relation to those findings. I can confirm that there have been no SARs during 2014/15. However, there have been two deaths where a lesser level of enquiry known as Lessons Learned has been initiated, and there are some details of the cases in Section 8 of this Report. They do illustrate the challenging nature of safeguarding work and the complexities of supporting individuals in particular circumstances.

The SAB does have a separate website which was generally recognised as not fit for purpose, as Internal Audit concluded (see Section 4) and at the time of writing it is in the process of migrating to the City of York corporate one. When that process has been completed, citizens of the city will hopefully be reassured by the information they can glean about the SAB and its work.

It may also be reassuring to know that every SAB meeting starts with reflecting in confidence on a particular case involving a real individual, to ensure that the Board never forgets that it is vulnerable people who are always the focus of its work. Our meeting minutes are always published on our website once they have been approved by the subsequent SAB meeting. There are four SAB meetings a year at West Offices, though because of the sensitive and confidential nature of much of our work they are not open to public scrutiny like Council Cabinet meetings, for example. That is not unique to York but common across the country.

I trust that you will be interested, informed and also reassured by the contents of this Report. Thank you for reading it.

Kevin McAleese CBE

Independent Chair, City of York Safeguarding Adults Board

2. The Board's Work and its Philosophy

York Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city in order that individuals and agencies contribute effectively to the prevention of abuse and neglect. It is a multi-agency board whose role is to plan strategically and ensure the safety of vulnerable adults within the City of York Council's geographical area. It has been in existence since November 2008 and has a strong focus on partnership working. The work of the Board includes the safety of individuals in local health services, local care and support services and prisons and approved premises

A list of board members in attached in Annex 1.

3. Work Undertaken in 2014/2015

Making Safeguarding Personal

This year saw the second phase of York's implementation of Making Safeguarding Personal. Making Safeguarding Personal is the national approach now embedded in the Care Act 2014 which ensures that the individual exercises as much choice and control as possible in determining and achieving the outcomes they want from safeguarding enquiries.

City of York Council and its partners on the Board worked with a cohort of 30 people who did not have the mental capacity to make decisions about how they wanted to be safeguarded against abuse or neglect where there was an allegation that abuse or neglect had taken place.

By engaging with independent advocacy at an early stage, those professionals involved in helping to safeguard the adult at risk were able to understand what these individuals wanted from a safeguarding intervention. In the majority of cases the people lacking capacity were able to achieve the outcomes they wanted.

Making Safeguarding Personal (MSP) has become an embedded philosophy throughout City of York Council's safeguarding adults work. The two case studies below illustrate how this has worked:

Case Study 1- Jane

Jane has physical disabilities and lives in a nursing home .She told her social worker that a friend had taken money from her. Taking an MSP approach, the social worker talked to Jane about the options she had and what she wanted to happen. Jane wanted to be able to talk to her friend, get her money back, maintain the friendship, and have support should she find that there were difficulties in the relationship in the future.

The social worker helped Jane and her friend to have a discussion about the missing money through mediation meetings. Her friend apologised and gave Jane her money back. Jane managed to maintain the relationship in the knowledge that she would

have the support of a social worker to help resolve future issues if she needed it. Had a traditional investigation into theft from a vulnerable adult been launched, Jane may have been in a position where she was being asked to pursue an allegation against her friend which may not have given her the outcome she wanted.

Case Study 2- Brian

Brian is 85 and receives a direct payment so that he can be supported with care needs related to his physical frailty and memory problems. His family do not live locally but have supported him by finding him a carer who lives in his home. Brian was not very happy with the service he was getting, felt that the carer was prioritising other jobs and interests had neglected him. His family thought that Brian's view might be to do with his cognitive problems and felt the carer was doing a good job.

Taking an MSP approach, the social worker talked to Brian who, although thankful for his family's help, wanted to make different arrangements for his care. He was not interested in pursuing an allegation against the carer. The social worker supported him to understand what the options were and how he might go about considering them, helping him to gain the mental capacity to make choices about his care and support. The social worker also helped him to explain to the family what he wanted.

Following a short stay in a respite care home Brian has ended his contract with his previous carer and has gone on to choose a different support package.

Self-assessment

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

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

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

4. Care Act Implementation

The SAB established a subgroup with key members of the Board to ensure a successful transition to its statutory status. In addition, a number of specific activities were undertaken in preparation.

Policies and Procedures

In preparation for the introduction of the Care Act 2014, the City of York SAB has developed its constitution, memorandum of understanding and register of interests

for its members. These documents give clarity and underpin the important statutory work of the Board. The SAB has also developed local policies for undertaking safeguarding adults reviews and lessons learned. These policies have ensured that the Board has a robust process in place for carrying out a review where an adult with care and support needs has suffered serious neglect or abuse and there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.

The multi-agency policy and procedures were updated at the start of 2014 and work continues in redrafting these to promote best practice in light of the Care Act.

Information, Advice and Guidance

This year has seen an improved offer to the public in terms of information and advice to help safeguard adults from abuse as this has become a statutory duty under the care act. The Connect to Support portal has been re-launched with improved content on 'keeping people safe.' This now also includes advice and guidance on domestic violence, bogus traders, online safety and community safety information from the police, in addition to how to report neglect and abuse.

www.connecttosupport.org

Partnership with the community

A series of workshops were run in January and March 20125 prior to the implementation of the Care Act for community groups, the voluntary sector and independent providers. Feedback from these events demonstrated that they have provided a valuable forum to help those working with adults at risk in the community understand their roles and the support they can expect from City of York Council and the SAB and signposted them to the series of resources which will help them implement the new approaches.

www.scie.org.uk/care-act-2014/safeguarding-adults

Winterbourne Concordat

City of York Council, the Partnership Commissioning Unit and the Vale of York Clinical Commissioning Group have worked together to identify vulnerable people from York who are placed out of the area for whom a move back to the York area may be the best way to enable then to be safe and enjoy the highest quality of life possible.

Over the past year, seven individuals have been helped to move back to York and plans are in place to make arrangements for accommodation and support for another fifteen people. For people who are remaining living out of York additional safeguards have been put in place to ensure that their support and treatment is reviewed and the Mental Capacity Act and its safeguards are followed.

Internal Audit

As part of the preparation for implementation of the Care Act, the internal audit service conducted an investigation into the readiness of adults safeguarding arrangements. The purpose of this audit was to provide assurance to City of York management that procedures and controls within the system had ensured that:

• The Safeguarding Board was moved onto a statutory footing
• A policy was introduced in relation to serious case reviews
• Relationships with partners and the new duties to co-operate over the supply of information were implemented
• There is a suitable system in place for processing Deprivation of Liberty cases
• There were sufficient resources to complete the increased number Deprivation of Liberty cases

The audit did not include procedures for Statutory Local Authority Deprivation of Liberty cases.

Key Findings:

Following the introduction of the Care Act 2014 considerable amounts of work have been put into ensuring that Safeguarding Adults processes in York are robust and fit for purpose. In addition the council has been suitably responsive to the significant additional demands in relation to Deprivation of Liberty cases following on from the Supreme Court judgement.

The Safeguarding Board has developed a constitution and memorandum of understanding between all members to ensure that the statutory board and its members comply with the duties placed upon them by the Care Act, and has developed an assurance framework which has been completed by all members. This enables the partnership to have an overview of how well members are undertaking their Safeguarding Adult responsibilities and respond accordingly.

The council has a policy for serious case reviews which enables a methodology of lessons learned which can be applied to cases which would not reach the threshold. This is being used to enable the partnership to gain learning from incidents which would otherwise not take place.

The council has and continues to review and adjust their Safeguarding Adults board in response to the developing guidance and information available regarding the requirements of the Care Act, and approved a policy in relation to serious case reviews. Development of the working relationships between partner organisations on the board has been undertaken. The council has participated in regional and national programmes and developed their process around Making Safeguarding Personal principles, a key part of the Care Act.

The main issue raised in the audit is that procedures for processing Deprivation of Liberty cases are heavily reliant on manual inputs, including identifying cases due for review. This is time consuming and there is a greater risk of review dates not being identified, especially given the large increase in the amount of Deprivation of Liberty cases. There is the potential for greater use of IT systems to support the staff and make the processes more robust for the increased number of cases.

The other findings of the audit related to the future development of the Safeguarding Adults board and improvement to the information available on the internet in relation to Safeguarding Adults in York.

Overall Conclusions

It was found that the arrangements for managing risk were good with few weaknesses identified. An effective control environment is in operation, but there is scope for further improvement in the areas identified. Our overall opinion of the controls within the system at the time of the audit was that they provided Substantial Assurance.

Work is already under way to address the remaining issues raised in the audit.

5. Performance and activity information

Alerts and Referrals during the year April 2014 – March 2015:

Alerts

The Safeguarding Adults Return is the national set of performance indicators which City of York Council use to report on their performance on safeguarding adults. **City of York Council received a total of 1058 alerts in this period**. An alert is recorded when the council is informed about a concern that a vulnerable adult may be at risk of abuse or neglect. This figure is an increase from 912 alerts in the previous year. All alerts trigger an assessment from City of York Council aimed at reducing the risk for the adult at risk and preventing further harm. Where the council is unable to resolve the concerns at this stage a referral is made for further investigation

Referrals

Following this assessment, **294 individual adults at risk were referred for further investigations** into the alleged abuse.

Tables 1, 2 and 3 below show the breakdown by age, gender and ethnicity. These figures show a far higher proportion of investigations into abuse of women at risk.

75%of adults at risk where an investigation was undertaken were previously known to the Council Social Services.

Tables 4, 5 and 6 show the nature of risk and the type of support the adult at risk needs. Because some people have more than one safeguarding investigation and are at risk from multiple types of abuse, the figures in these tables total more than the 294 adults at risk.

While the highest categorised source of risk remains people at risk in their own home from people known to them, residential and nursing care homes continue to be a

growing area where the council investigates allegations of abuse. In 2014-2015 the council investigated 91 allegations in care homes compared to 79 the previous year.

The highest support need for people is physical support. This includes older people with frailty who also have cognitive problems including dementia.

Outcomes

All the tables below are drawn from the national dataset the Council is required to submit nationally. Table 7 and 8 show the outcomes reached for safeguarding investigations concluded within 2014-2015. The total numbers in these tables include investigations that were completed by 31st March 2015

This year has seen more allegations of abuse being fully substantiated with 92 in 2014-2015 compared to 70 the previous year.

A total of 121 allegations were either partially or fully substantiated during 2014-2015

Action was taken to reduce the risk following 255 investigations and in 233 instances the risk to the individual was reduced or removed.

Adults at risk with safeguarding investigations by age:

Table 1	Number of individuals by age					
Classification	18-64	65-74	75-84	85-94	95+	Age Unknown
Already known	73	30	46	61	9	0
Previously unknown	43	4	12	9	3	4

By Gender:

Table 2	Number of Individuals by gender		
Classification	Male	Female	Gender Unknown
Already known	83	136	0
Previously unknown	21	52	2

By Ethnicity:

Table 3	Number of individuals by ethnicity					
Classification	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	No Data
Already known	212	0	1	1	0	4
Previously unknown	60	0	1	2	0	11

By Support Reason:

Table 4	Number of individuals by primary support reason						
Classification	Physical Support	Sensory Support	Support with Memory & Cognition	Learning Disability Support	Mental Health Support	Social Support	No Support Reason
Already known	159	6	2	36	37	43	15
Previously unknown	8	3	1	4	15	3	45

By Source of Risk

Table 5	Source of risk		
Type of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical	29	44	1
Sexual	4	21	2
Psychological and Emotional	23	30	1
Financial and Material	13	49	6
Neglect and Omission	84	15	3
Discriminatory	1	1	0
Institutional	2	0	0

By Location of Risk

Table 6	Source of risk		
Location of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Care Home	77	13	1
Hospital	20	19	2
Own Home	33	99	5
Community Service	17	6	1
Other	9	23	4

Actions Taken and Results

Table 7	Source of risk		
Action and Result	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	33	39	2
Action taken and risk remains	1	21	0
Action taken and risk reduced	56	75	7
Action taken and risk removed	66	25	4

Outcome Reached

Table 8	Source of risk		
Conclusion	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Fully Substantiated	52	37	3
Partially Substantiat	9	20	0
Inconclusive	46	49	6
Not Substantiated	49	30	3
Investigation Ceased	0	24	1

6. Training

Developments

2014/2015 has seen significant developments by City of York Council Workforce Development Unit in the field of adult safeguarding. The prospectus including all safeguarding training can be found at www.yorkworkforcedevelopment.org.uk

- Training for care homes and hospitals to carry out their function as managing authority for deprivation of liberty safeguards has been extended from a half to a full day course in light of the increased need to use these safeguards.

- Train the trainer has been developed with six Safeguarding sessions delivered and one Mental Capacity Act session. Trainers have fed back twice yearly to monitor the success of this approach. This will increase to quarterly in 2015/2016.

- A Safeguarding learning needs analysis has been sent out to gain further detail on the learning and development needs of the Adults Safeguarding Board. This is based on the requirements of the Care Act and national competencies.

- New updated E-Learing safeguarding and MCA modules have been commissioned from Kwango.

- A new course on working with self-neglect has been commissioned and is available.

- In order to measure the impact of training workforce development unit have piloted an approach of contacting delegates 6 months after their training had taken place to ask more detailed questions about the impact the training has had on their day to day practice. This approach will be further refined in 2015/16.

- Safeguarding and the Care Act training sessions have been delivered as part of the implementation of the statutory safeguarding responsibilities that come with the Act.

The Training Offer 2014/15

During 2014/15 our Safeguarding and Mental Capacity Act training was provided by Community Links. Below shows a breakdown of courses that took place over 2014/15 and the number of course run.

Safeguarding

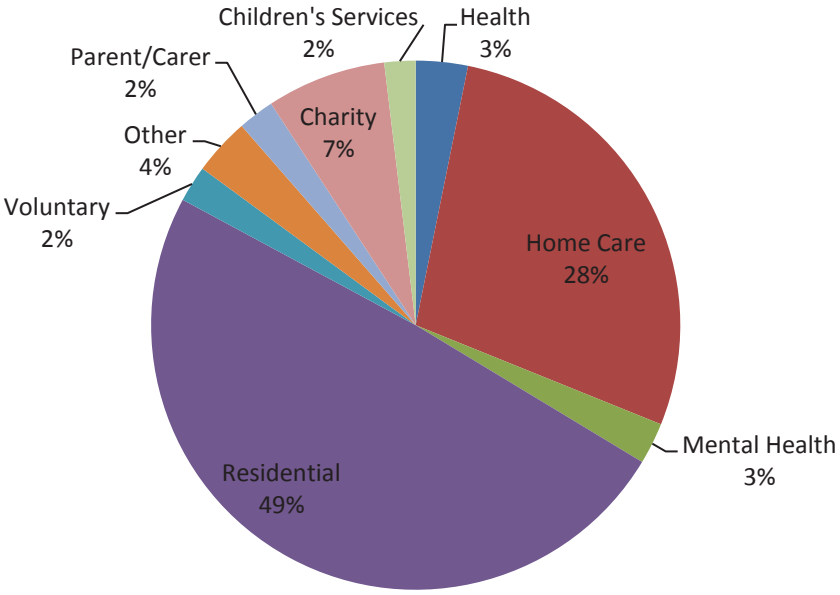
Level of Training	Number of Sessions
Safeguarding Level 1	9
Safeguarding Level 2	5

Safeguarding Level 3	2
Safeguarding Level 4	2
Safeguarding Train the Trainer	3

Mental Capacity Act

Level of Training	Number of Sessions
Mental Capacity Act Awareness Level 1	7
Mental Capacity Assessment and Best Interest Decision Making for Practitioners Level 2	3
Deprivation of Liberty (DoLS) Roles and Responsibilities for Managing Authorities (Care homes and hospitals) (Level 3)	2
Mental Capacity Act Complex Decision Making for Practitioner and Managers (Level 4)	2
Mental Capacity Act Train the Trainer	1

Analysis of CYC External Partner Attendees



Training Evaluations

The safeguarding training provided through City of York Council continues to be well regarded by those attending, with a high proportion of good and excellent ratings as shown below.

Safeguarding

Course	Feedback comments	Poor	Satisfactory	Good	Excellent
Safeguarding Level 1	529	0	0	108	421
Safeguarding Level 2	213	0	3	56	154
Safeguarding Level 3	75	0	0	25	50
Safeguarding Level 4	12	0	0	3	9
Safeguarding Train the Trainer	76	0	0	19	76

Mental Capacity Act

Course	Feedback comments	Poor	Satisfactory	Good	Excellent
MCA level 1	316	2	3	80	231
MCA level2	56	0	1	26	29
MCA level 3	23	0	0	6	17
MCA level 4	43	0	1	13	39
MCA train the trainer	53	0	1	13	39
MCA case law	20	0	0	7	13

Care Act Safeguarding

Course	Feedback comments	Poor	Satisfactory	Good	Excellent
Care Act Implications for Safeguarding	172	0	6	71	95

7. Strategic Plan for 2014/2017 and Actions Achieved

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

A. Make sure safeguarding is embedded in corporate and service strategies across all partners
B. Ensure good partnership working
C. Focus on prevention of abuse

D. Respond to people based on the Personalisation approach, and with a clear focus on outcomes

Appendix 3 shows the progress which has been made against each of the themes during 2014/15.

8. Serious Case Reviews and Lessons Learned

There were no Serious Case Reviews needed to be conducted during 2014/15.

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

Briefing Paper on the case of "Tracy"

The Incident and the lead up to it:

Tracy was born in 1978 and had a long history of mental health issues complicated by substance misuse and suspected domestic abuse and sexual exploitation. Tracy didn't readily engage with services and had moved repeatedly between York and London in the months before her death.

Tracy was taken by 999 ambulance to the Emergency Department of York Hospital on 17 October 2013 following self-harm resulting in lacerations to her arms, legs and neck. She had an open wound to the neck caused by self-harm using glass, and was under the influence of alcohol and possibly other substances.

Following clinical review the patient was admitted to the High Dependency Unit overnight and then transferred to the Short Stay Ward the following morning. Because of her agitated state Tracy was admitted to a side room of the Ward with an en-suite toilet, with checks being made to ensure that there were no items in the room which might be used for self-harm purposes. Approximately two hours after transfer she was found hanging from the cistern toilet chain. CPR was commenced but was found to be futile and the patient was pronounced dead 25 minutes later.

The subsequent Coroner's Inquest recorded an Open verdict.

Briefing Paper on the case of "Daniel"

The Incident and the lead up to it:

6th November 2014 at 11:30 – the LYPFT Crisis and Access Service (CAS) contacted the North Yorkshire Police Control Room at Fulford Police Station following reports that Daniel had jumped off a high wall near the centre of York. Witnesses saw him walking unsteadily along an elevated platform in the centre of York. He was seen to climb over the railings, then lean back and let go of the railings and fall approximately 40 feet to the floor. He was taken to York District Hospital but could not be resuscitated and death was confirmed at 1127hrs. A note expressing his intention to take his own life was found in his pocket.

Daniel had a job and was receiving counselling support there. He was well supported by his employer throughout this period. He had a history of engaging reasonably well with mental health services and was frequently open about his suicidal thoughts and plans to act them out. In the period leading up to his death Daniel had made several suicide attempts where he was found to be carrying a suicide note and was the subject of a number of welfare checks.

To date there has not been a Coroner's Inquest on this case.

Because of the timing of the two briefing papers the enquiries and actions they generated will be reported to the Board in June 2015 and so will feature in the next Annual Report.

9. New Strategic Plan for 2016 onwards

One of the consequences of the Care Act 2014 is that Safeguarding Adults Boards have to establish a Strategic Plan "*having consulted both the local Healthwatch organisation and having engaged with the local community*". Neither of these were done when the 2014/17 Plan was established, nor was there any requirement to do so.

The Board is clear that a different method needs to be employed to ensure that its new Plan is fully compliant with Care Act 2014 requirements. As a result the Board has commissioned York Healthwatch to develop an engagement strategy with the local community in York, which will feed directly into the new Strategic Plan which will be in place by April 2016.

10. Contributions from individual member organisations:

ANNEX B

Annex 1: Members of City of York Safeguarding Adults Board, March 2015

	Name	Title	Organisation	Address
1	**Sian Balsom**	Healthwatch Manager	**Healthwatch York**	Priory Street Centre, 15, Priory Street, York YO1 6ET
2	**Lindsay Britton**	Head of Safeguarding (Adults & Children),	**Leeds & York Partnerships NHS Foundation Trust**	2150 Century Way, Thorpe Park**, Leeds**, West Yorkshire, LS15 8ZB
3	**Bruce Bradshaw**		**NHS England, NY and Humber Area Team**	Unit 3, Alpha Court, Monks Cross, York, YO32 9WN
4	**Det Supt Nigel Costello**	Police lead on Vulnerable Adults	**North Yorkshire Police**	Newby Wiske Hall, Newby Wiske, Northallerton, DL7 9HA
5	**Cllr Linsay Cunningham**	Cabinet lead for Health	**City of York Council (CYC)**	West Offices, Station Rise YORK YO1 6GA
6	**Guy Van Dichele**	Director of Adult Services	**CYC**	West Offices, Station Rise, York YO1 6GA
7	**Beverley Geary**	Chief Nurse	**York Teaching Hospital NHS Foundation Trust**	Wiggington Road, York YO31 8HE
8	**David Heywood**	Social Work Manager	**Stockton Hall**	The Village, Stockton-on-the-Forest, YORK YO32 9UN
9	**Kevin McAleese CBE**	Independent Chair, York Safeguarding Adults Board		Home address
10	**Michael Melvin**	Acting Assistant Director	**CYC**	West Offices, Station Rise, YORK YO1 6GA
11	**Melanie McQueen**	Deputy Chief Executive	**York CVS**	Priory Street Centre, 15, Priory Street, York YO1 6ET
12	**Christine Pearson**	Deputy Designated Nurse, Safeguarding Adults	**NHS Vale of York CCG**	West Offices, Station Rise, YORK YO1 6GA
13	**Janet Probert**	Director of Partnership Commissioning	**Partnership Commissioning Unit (PCU)**	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
14	**Maggie Scott**	Director of Operations	**The Retreat**	Heslington Road, York, YO10 5BN
15	**Steve Wilcox**	Designated Professional for Adult Safeguarding	**PCU**	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
16	**Keren Wilson**	Chief Executive	**Independent Care Group**	10 North Park Road, Harrogate, HG1 5PG

ANNEX 2: City of York Safeguarding Adults Board

Membership and Attendance 2014/15

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

Organisation	Designation	June 2014	Sep 2014	Dec 2014	March 2015	Nominated representative or substitute
	Independent Chair	Y	Y	Y	Y	100%
City of York Council	Director of Health & Well-being	Y	Y	NA	NA	100%
	Director of Adult Social Care	NA	Y	Y	A	50%
	Assistant Director , Adult Assessment and Safeguarding	Y	Y	Y	Y	100%
	Safeguarding Service Manager	Y	NA	NA	NA	100%
	Cabinet Member for Health, Housing and Adult Social Services	Y	Y	Y	A	75%
Healthwatch York	Manager	Y	Y	Y	Y	100%
Independent Care Group	Chief Executive	Y	Y	Y	Y	100%
Leeds and York Partnership NHS Foundation Trust	Lead Clinician for Safeguarding Adults	A	Y	A	Y	50%
NHS England, North Yorkshire and Humber Area Team	Director of Nursing & Quality	Y	A	A	Y	50%
North Yorkshire Police	DCI, Protecting Vulnerable People Unit	A	Y	Y	Y	75%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	A	Y	Y	75%
	Designated Professional for Adult Safeguarding	A	Y	Y	Y	75%
The Retreat	Director of Operations	Y	Y	Y	Y	100%
Stockton Hall	Social Work Manager	Y	Y	Y	Y	100%
Vale of York CCG	Executive Nurse	Y	A	Y	Y	75%
York & North Yorkshire Probation Trust	Area Manager (Public Protection)	Y	NA	NA	NA	100%
York CVS	Partnerships Manager	NA	Y	A	Y	66%

ANNEX B

Organisation	Designation	June 2014	Sep 2014	Dec 2014	March 2015	Nominated representative or substitute
York Teaching Hospital NHS Foundation Trust	Chief Nurse	Y	Y	Y	Y	100%
Overall Board attendance		**88%**	**82%**	**81%**	**89%**	

Chair's comments on Board attendance:

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

However, there are inevitably operational pressures on individuals as well as annual leaves to be allowed for, given that the SAB only meets four times a year. In the ideal world the thirteen partners would each have achieved 100% attendance records. During 2014/15 a total of seven of them did just that and I hope we will increase that number significantly during 2015/16.

I am grateful to the senior representatives of each organisation listed in Appendix 1 who have given so much time, energy and commitment to the work of the Board.

Annex 3: 2014/2017 Strategic Plan and Action Plan Outcomes for 2014/15

Objective	Action		Timescale for completion	Lead	Outcomes
A	**A. Make sure safeguarding is embedded in corporate and service strategies across all partners.**				
A1	Ensure key strategic plans evidence that adult safeguarding is a priority and is being addressed.	Partners to identify key strategies and include in annual reports to Boards	**March 2015**	**All**	Partners to confirm this is being addressed
A2	Ensure a robust interface with Community Safety Plans	Engage with Domestic Violence strategy Board. Improve information sharing on Domestic Abuse Engage with Community Safety Board regarding Hate Crime, safe	**March 2015 March 2016**	**Chair and CYC safeguarding Lead**	**Both are now members of the Board. Chairs report includes feedback. CYC lead officer met on 27 May and further guidance has**
B	**Ensure good partnership working**				
B1	Ensure that all partners are signed up to, and working in line with Multi agency procedures and practice. **Procedures' to be reviewed for Care Act readiness**	Annual check for changes and updates Full review every 3 years Seminar/event for voluntary sector groups Development day to consider thresholds and demand	**December 14, 15 16 December 16 March 15 March 15**	**All CYC CYC and Voluntary sector Chair**	**CYC Audit will look at care act readiness. CYC Audit is underway and includes cooperation with partners. Update will come June 2015 Development day held Nov 2014 Care Act compliant**
C	**Focus on prevention of abuse**				
C1	Raise awareness and empower community to keep people safe	Review of Adult Safeguarding Adults website Annual radio or Press interview/article on Adult Safeguarding Develop information for the community Ensure housing and support providers, drug and alcohol service, A&E can access	**March 15 Annual March 15 Annual review of training attendance**	**CYC Chair CYC CYC**	**Website under review March 2015**

ANNEX B

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

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

Garrow House

Garrow House

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

Further to the e-learning, all staff at Garrow House, clinical or otherwise, undertake face-to-face internal training using materials provided from head office (and that all Turning Point employees are required to undertake) that is facilitated either by the unit's safeguarding lead, or by members of Turning Point's 'risk and assurance' team. This training builds upon the e-learning training, re-capping the 'awareness' issues already touched upon, and adding a focus on the mechanics of the safeguarding policy, namely alerts and referrals. This training takes place as part of the induction process, and is then refreshed yearly. At the time of writing 89% of staff have completed this training within the last year.

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

Regarding evidence of impact: I as the safeguarding lead do notice that new starting support workers, nurses and other staff seem more confident of flagging up issues and making alerts about issues for which they are unsure of or cautious about. Furthermore the training is quite good at drilling into staff the procedure, in a very clear manner, for how alerts may become referrals, which in turn may become investigations etc, and of their role as frontline staff within that process.

April to June 2014: three alerts. Two of historical sexual abuse, both referred to CYCAST and police informed, one of lending/borrowing of personal items inappropriately with peers.

July to September 2014: two alerts. First of patient borrowing of money from a peer, some suspicion of financial abuse. Referral to CYCAST made. Second of historical

sexual assault: Referral to CYCAST and police informed.

October to December 2014: two alerts. First, threat of violence from one patient towards another peer. Referral to CYCAST made. Second, visit from family member alleged to have abused patient as a child thirty years ago.

January to March 2015: two alerts. Both historical allegations of sexual abuse. Referrals to CYCAST and police informed.

Analysis: nine alerts over the course of the full year, with seven referrals to CYCAST. Averaged out this is less than one a month. Six of the nine alerts pertained to historical allegations of sexual abuse, where no ongoing substantive risk of harm was present. However, were of the opinion that generally, unless the allegations have been made before and we know that for certain, a referral should go in to CYCAST in such cases as good practice.

Two alerts pertained to inter-peer borrowing of small amounts of money; these were relatively trivial incidents that were dealt with within the service.

There was only one incident that actually encompassed some significant contemporary risk to a known individual. This was dealt with quickly by transferring the PATCH onto another unit.

New database system of recording safeguarding alerts and referrals that is clearer and stores all details of alerts/referrals (both historic and present) in one place for ease of access.

Review of safeguarding polices in light of Care Act 2014.

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Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

Healthwatch York

Enter & View / Community Champion volunteers trained to Level 1
13 through 3 internal training sessions
2 through CYC WDU session at Haxby Hall

Staff members
1 accessed Level 1 Train the Trainer through CYC WDU
3 received Level 1 alerter training through internal training sessions

Also attended – Safeguarding and the Care Act session provided by City of York Council, and the Care Act Legal Framework for Managers. These were very informative.

Benefits
Volunteers reported increased awareness and understanding of what to look for. They are now more confident discussing concerns below safeguarding levels with staff at provider organisations, and have stated that they would flag safeguarding issues if required.

We have not raised any safeguarding alerts this year.

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Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

1. Independent Care Group (ICG)

We are the representative body for independent care providers in York and North Yorkshire.

ICG keeps its members informed on all matters connected to Safeguarding including Safeguarding training and Mental Capacity Act which is offered at no charge from CYC. It keeps members informed of DBS news.
ICG gives information on Safeguarding training and how to access it on its website.

ANNEX B

Leeds and York Partnership NHS
NHS Foundation Trust

Partner Agency Annual Safeguarding Report 2014/15

LYPFT contribution to the Effectiveness of Safeguarding arrangements in Leeds

Partner Agency: Leeds and York Partnership NHS Foundation Trust

Report Author: Lindsay Britton/Richard Hattersley- Head of Safeguarding

1.0 Executive Summary

In 2014 our Executive Lead and lead for adult safeguarding moved to new positions in new areas. This presented an opportunity for some creative thinking around the safeguarding structure in order to respond to increasing pressures, and resulted in a creation of a Head of Safeguarding for adults and children. This relieves some of the pressure on the new Executive Lead Anthony Deery and allows for greater cohesion of the safeguarding agenda in the Trust. We have strengthened our governance arrangements with the appointment of a none executive director for safeguarding and a multi agency safeguarding committee.

We have actively contributed to the emergence of the new font door safeguarding hub and are working with the multiagency team to share information around adult mental health to protect victims of domestic abuse.

LYPFT submitted its' Savile report in line with other NHS organisations for publication by the Department of Health in Feburary 2015. We are working through our internal and nationally driven recommendations.

The major challenge for the LYPFT safeguarding adults team is to respond to the Care Act 2014. We aim to actively respond to the Leeds, York and North Yorkshire safeguarding board's recommendations on the implementation of the Care Act. But also to work proactively to ensure the Care Act is fully understood and implemented by staff in the Trust, to better safeguard adults who may be at risk whilst in our care.

The Trust has aimed to maintain a low threshold for raising safeguarding concerns and actively works to develop a robust understanding amongst its staff base for safeguarding intervention. This has been reflected in a strong partnership with Adult Social care partners over the years.

Work is underway to embed an understanding of 'Making Safeguarding Personal' within the Trust, to put the service user at the centre of the safeguarding process.

2.0 Introduction

The Trust Safeguarding team have dealt with significant numbers of advice calls from staff over the year, this is evidenced in a detailed data base from which a qualitative and quantitative report is presented to the Trust Wide Safeguarding Committee. Documentation around this has been refined as a result of an audit earlier this year.

The Trustwide Safeguarding Committee is now well developed and has representation from partner agencies thus ensuring transparency of practice.

We work closely with our partner agencies across the locality to ensure we fulfil our child protection, adult protection and domestic abuse responsibilities. Our Head of Safeguarding is the lead for PREVENT.

LYPFT have a safeguarding structure comprising strategic oversight by the Director of Nursing, a Head of Safeguarding for adults and children, Named Doctors for safeguarding adults and children and 2 Deputy Named Nurses/trainers and 2 safeguarding adult practitioners. We are looking to recruit a trainer,a deputy Head of Safeguarding and another adult safeguarding specialist, a business case has been approved.

3.0 Effectiveness of Safeguarding Arrangements

- Safeguarding Performance
  - Summary and analysis of quantitative data
  - Summary and analysis of qualitative data

- Quality of safeguarding practice
- Attendance and engagement in the Safeguarding Health Action Group including shared lessons learned and audit findings.
- Active engagement in the LSAB performance and quality sub group.
- Active engagement in the YSAB Sub group.

- Safeguarding is represented at Trust Incident Review Group.

- Findings from Internal Reviews

- Findings from External Inspections and Reviews

- Summary analysis of the effectiveness of safeguarding arrangements
  - Strengths
  - Areas for improvement

- Summary of lessons learnt, actions taken and impact on practice / multi-agency working / outcomes for C&YP.

Work throughout 2014/15

- The need to improve on the consistency of staff recording has been identified in an audit of paris (clinical electronic notes) in relation to the LYPFT safeguarding data base.
- A designated safeguarding section has been embedded into the clinical recording system and guidance has been broadly circulated to staff with guidance as to how to use.
- Improved incident reporting via implementation of a DATIX risk management system. The safeguarding adult practitioners have an overview of this system where safeguarding has been noted as a need on the risk form.
- Development of a robust recording system dealing with safeguarding queries to LYPFT safeguarding staff which will mean the service user records are updated with the relevant information and recommendations.
- Better monitoring of compliance for mandatory safeguarding training via the Oracle Learning Management data system.
- A non executive director allocated to safeguarding.
- A new Executive Lead as member of the SAB.
- New performance reporting for Trust Safeguarding Committee.
- We included a mandatory mental capacity act element to our safeguarding training following a CQC inspection recommendation from November 2014.
- A data report is shared with ASC at the end of the financial year detailing cases investigated and coordinated for 2014-15.

Audit

- We have complied with the actions from an internal audit by an external company and shared via our safeguarding committee.
- We audited against how our staff act on safeguarding adults advice and are progressing these actions

Projected work through 2015

- April 2015 brought the formal introduction of the Care Act. For the LYPFT this has brought a change to how cases at a defined level of

risk previously investigated within the Trust, are now to be sent directly to ASC as lead agency. Work is underway to ensure all staff have updated clear guidelines for raising a concern, and partner agencies (ASC) have strong lines of communication with the (LYPFT) Safeguarding Adults advisors with which to make enquiries within the Trust as directed by Adult Social Care.

- Adopt and link in all policy and practice in line with the Care Act 2014. Including making Safeguarding training compliant with the Care Act.
- To work with the Health Community via health Action groups and time limited project groups to better understand and implement the Care Act. For example to better understand the concept of self neglect as it is described in the Act and its implications for mental health services.
- Improve the links between the DATIX incident reporting system and the identification of safeguarding issues via a central safeguarding team email address.
- Embed 'Making Safeguarding Personal' into the work of the Safeguarding Adult team, ensuring all cases subject to enquiry are based on the outcomes wanted by the adult at risk and that those wishes inform what interventions are taken.
- Implement the Savile recommendations relevant to our organisation.
- Ratify a prevent policy.
- The LYPFT safeguarding team have contributed full IMR reports to 8 Domestic Violence Reviews since 2014. A number of such reports will be completed and published during 2015, the team will be ensure full engagement with this process and implement any lessons leant fully.
- Widen our training offer to include specialist sessions on supervision and domestic violence.
- Health Wrap PREVENT training is being rolled across the Trust, dates are now available for booking to December 15. Basic PREVENT awareness is covered in the Safeguarding Level 2 training.
- There is a need to Train more Health Wrap PREVENT trainers and ensure all areas of the Trust are covered giving good access to staff for this training.
- To develop a bespoke training pack (level 3) for senior clinical staff across the Trust to better enable senior clinical staff to provide safeguarding supervision and guidance within their clinical teams and settings.
- Safeguarding Adult training and mental Capacity training were delivered together during 2014. However it has now been agreed that Mental Capacity Act training will be delivered in a stand alone module to avoid any confusion to staff and to give enough time to be able to better deliver this training.
- Work with Safer Leeds to provide ongoing support and strengthen the Front door safeguarding hub.
- To ensure representation at the Domestic Violence safeguarding Hub (Leeds) on a daily basis where resource allows.

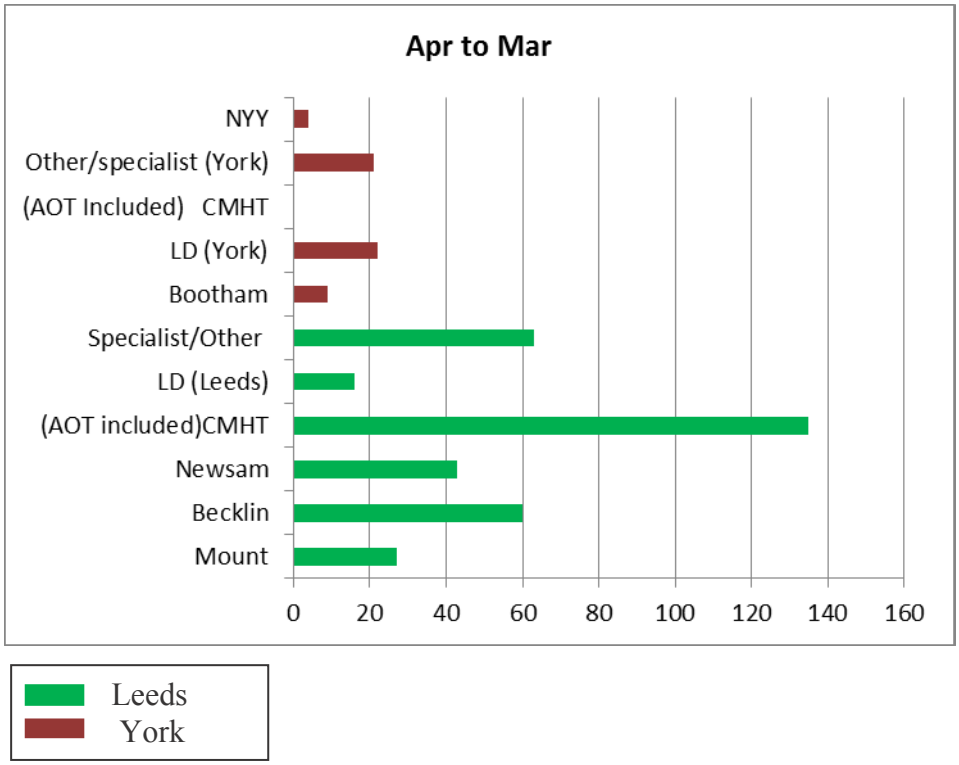
Audit

- HR audit against staff compliance with safer recruitment
- MCA/DoIs- how do we know staff practice in accordance with procedures?
- Prevent- staff awareness.

Review areas for audit within safeguarding Adult practice consider a repeat of the 2014 case note audit.

- Safeguarding Performance

Safeguarding Adults Referrals and Advice
April 2014 – Mar 2015 (cumulative annual)



- Learning from complaints and compliments

We have a PALS (Patient advice and liaison service) which deals with our enquiries and a complaint lead. Any safeguarding issues would be drawn to the attention of the safeguarding team.

We evaluate training, take comments on board and make changes accordingly.

We have an internal incident reporting system which aims to pick up serious issues or incidents. These are shared with the team and progressed with relevant actions. This has been transferred to a new more effective DATIX system.

We have begun to bring good practice cases to our safeguarding committee to look at the quality of learning from these as well as addressing failings and concerns.

4.0 Responding to emerging issues

- The LYPFT safeguarding team aim to be fully compliant with the Care Act in 2015. Training has been updated and work is underway with partners within ASC to agree a clear pathway for staff to raise concerns via Social Services contact centre. This involves a change in pathway for staff within Leeds clinical services a plan is in place to provide information and support to staff in reporting concerns.

- The challenge for the LYPFT for 2015 is to ensure a continued low threshold for safeguarding advice being rung through to the team for advice (currently evidenced by the safeguarding data base) whist ensuring that the Trust is fully compliant with the Care Act. The Trust Safeguarding team will retain a strong presence within the Trust, it is envisaged that significant numbers of advice calls will be taken by the team, though all Safeguarding concerns raised to an enquiry will be reported to ASC as lead agency.

- A CQC issue raised in a recent review was that York clinical areas had some confusion regarding how to refer or raise an alert (cause an enquiry to be made). A Trust Wide website 'banner' has advertised City of York safeguarding team number. This will be further reviewed at the point where commissioning arrangements are clear for the York and North Yorkshire region.

- A Safeguarding Adult training Plan has been developed to include a stepped approach to training from level 1 (on line) 2 face to face and 3 face to face enhanced training for senior clinicians who may be involved in supporting the safeguarding process.

- A Communication on the Trust website has been sent to all staff regarding PREVENT training. This is now being booked onto and will be monitored as to numbers of staff having completed this training. In the event of numbers not reaching a reasonable and agreed threshold of staff having completed the training by October 2015 then a plan will be formulated to increase take up.

- The Safeguarding Adults practitioners attend CHANNEL meetings and include PREVENT enquiries on the safeguarding data base.

- Bespoke Safeguarding Adult training is currently being planned for

Dementia services in York if successful this can be offered to other clinical services.

- Mental capacity Training is being led by the Mental Health Legislation Team. The Safeguarding Adults practitioners are working closely with the MHLT to ensure all staff are aware of and compliant with the 'Cheshire West' ruling. In 2014-15 a Mental Capacity module was added to the level 2 safeguarding adult training though this is to be split in July 15 to ensure clarity of message and ensure all clinical staff have access to such training.

- The Safeguarding team have begum to develop a protocol for making safeguarding personal, agreeing to use the Adult Social care form given to service users to identify what the individual wants as an outcome in the process. This will be monitored in 2015 to ensure compliance with the MSP model.

- Domestic violence support remains a priority in 2015, with the start of the DV Hub the team are committed to a daily input and will continue to work with staff to consider DV as an issue to consider in assessment an treatment for our service users.

- The team will continue to engage with 'Claire's Law' panel through 2015.

5.0 Partnership Working

Our Executive Lead, Director of Nursing is now the LSCB board member and Head of Safeguarding is deputy. We have consistent representatives for the learning and developments, policies and procedures, performance management and CSE sub committees.

We are beginning to collate our compliance with board attendance within our performance reporting.

We have agreed a shared process for a member of the team to represent at the front door safeguarding hub for 2 hours on a daily basis. It is envisaged this will be a significant role for 2015 and should be seen as a good practice example of how the LYPFT is committed to partnership working in line with the Care Act 2014. Strong links are in place across LYPFT and ASC safeguarding teams this has been enhanced by the employment of a second safeguarding practitioner in 2014.

6.0 Workforce Development

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

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

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

Training Evaluation

Questions are rated on a scale of 1 to 5.

Leeds Training – Nov 14 to March 15

Overall rating are as follows:
5= 75.1%
4= 18.8%
3= 6.1%
2= 0%
1= 0%

York Training – Nov 14 to March 15

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

The evaluation was based on a number of measures from suitability of venue to content.

The evaluation process was begun in November 2014.

7.0 Summary of achievements in 2014/15 and emerging themes

Partnership working with Social Service colleagues to implement the Care Act 2014.

Updated training plan for safeguarding Adults level 1/2/3 training model. Contribution to front door safeguarding hub.

Significant resource contribution to safeguarding DV Hub and MARAC. Governance arrangements.

Audit completion.

Performance reporting, the Safeguarding Team provide a comprehensive report to the Trust Wide Safeguarding Committee.

Joined up working with front door and data collection and analysis on our multiagency contribution.

Full representation at SAB meetings.

Strengthen the Trust Wide safeguarding Committee to increase the quality of reporting and continue to maintain the open nature of the group with representation from key partner agencies and Senior clinical staff representing Trust wide services.

A move to unify and build on the strengths of the Safeguarding Adult and Child teams into a strong Safeguarding Unit for the Trust.

8.0 Challenges for 2015/16

Effective recruitment to address shortfalls in training provision and the growth of safeguarding role in Domestic Violence reviews, HR processes and advice calls.

To continue to be responsive to the increasing safeguarding agenda.

To continue to raise awareness of safeguarding within the Trust and health Community in Leeds and York.

Improve outcome measuring and performance reporting to reflect trends.

To ensure safeguarding strengthen links with risk reporting and has clear pathways for reporting to include clear guidelines for reporting to LYPFT risk/CQC/ASC and CCG partners.

Notes
There will be a maximum word count in the document of 3,000 words.

Please can signed off Partner Reports be sent to LSCB BU by ***Thursday 4 June 2015***

Lindsay Britton, Head of Safeguarding

ANNEX B

NHS England Yorkshire & the Humber contribution to Local Safeguarding Adult and Children Boards Annual Report 2014-15

The overall responsibilities of NHS England in relation to safeguarding

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

NHS England responsibilities in relation to direct commissioned services

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

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

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

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

Sharing learning from safeguarding reports

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

Training programme for general practice

Designated safeguarding professionals are jointly accountable to Clinical Commissioning Groups and NHS England. They have overseen the provision of level 3 training for primary

care medical services. Training sessions have been provided on a locality basis rather than to individual practices. The main source of training for other primary care independent contractors has been via e-learning training packages.

Assurance of safeguarding practice

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

Standard Operating Procedure: Safeguarding Incidents

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

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

NHS Partnership Commissioning Unit

Commissioning services on behalf of:
NHS Hambleton Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

The PCU is a relatively small unit and all staff place a high priority on keeping up to date their mandatory training. Adult Safeguarding is also central to the work of the PCU and its focus on monitoring and maintaining the quality and performance of NHS providers so that apart from 100% compliance on level 1 training we can report a healthy engagement with safeguarding from our colleagues in other functions in our day-to-day work.

The PCU Safeguarding Adults Team provides advice and guidance to all NHS and private sector providers in the VoY CCG catchment area and work collaboratively with the City of York Safeguarding Team. These are the figures for York cases in 2014-15 where the PCU have been the lead investigative agency:

- Number of new alerts received – **17**
- Number of investigations required for the above alerts – **14**
- Number of new low level concerns opened – **4**
- Number of cases opened pre 1st April 2014 but closed during the period 1st April 14 – 31st March 15 – **5**
- Number of cases (opened and) closed during the period – **15**

Safeguarding Adults PCU
In August 2014 the Designated Professional for Adult Safeguarding took up post at the PCU. The workload and outputs of the partially newly recruited team was reviewed and a programme of development was initiated. The main focus of this was to focus the work of the team onto a specific safeguarding function rather than quality and performance and safeguarding. Of course quality and performance are still integral to ensuring services are safe but the team needed to change emphasis in order to properly respond to serious safeguarding concerns and fulfil their role as main partners in multi-agency safeguarding.

Whilst the performance of providers will always be a central focus, along with the services funded by Continuing Health Care (CHC), the team's central focus is to ensure the CCGs and the services they commission and monitor are properly connected to the prevention and response initiatives that address the whole safeguarding agenda; ie the types of abuse that occur in the homes and communities of the populations the CCGs serve as well as the hospitals and care homes. Team developments in these areas and on-going improvements to information sharing and support and liaison with partner agencies has led to the team and its safeguarding work gaining a higher profile across the health economy.

The Vale of York CCG now has a Link Safeguarding Officer at the PCU and in January appointed its own Deputy Designated Nurse Safeguarding Adults. This ensures good knowledge of the localities and their services and allows for effective relationships to develop with key CCG staff. If a major safeguarding issue arises the team can also act flexibly to ensure resources are focused on the area of need. Effective team building and team working is key to this and two development days took place in late 2014 culminating in a new strategic approach and revised operating procedure.

In response to a spate of recent reports on investigations into institutional failures to protect the vulnerable in society; Operation Yew Tree, Winterbourne, Mid-Staffs and Rotherham. The PCU Safeguarding Team have ensured that their on-going service development is in accordance with national drivers influencing clinical and safeguarding practice. The Care Act (2014) which becomes statute on 1st April 2015 has also influenced team development and their new operating procedures reflect the language and frameworks within the Act.

There is now a joint action plan on Winterbourne between the different agencies, in place to address key objectives, this is monitored via a multi-agency approach with representation from the lead stakeholders in this area, and covers both the Local Authorities. The action plan is currently monitored via the two SABs.

Suicide Prevention

North Yorkshire County Council, City of York Council and Partners have produced this suicide prevention implementation plan in response to the government's Preventing suicide in England a cross-government outcomes strategy to save lives (2012) and the subsequent Preventing suicide in England: one year on first annual report on the cross-government outcomes strategy to save lives (2014). Suicide prevention has also been identified through the Safeguarding Adults Board and the Safeguarding Children's Board.

We are at the point of appointing to the above post which will be funded on a multi-agency basis between North Yorkshire County Council, Public Health and the Police, the post will be hosted by the Partnership Commissioning Unit (PCU). The post holder will be accountable to and line managed by the Designated Professional for Adult Safeguarding at the PCU although operationally they will be part of the Public Health senior team working with the Director of Public Health to deliver the Local Authority's vision, goals and core values in relation to suicide prevention. The post holder will be instrumental on delivering on actions within the North Yorkshire Suicide Prevention

Implementation Plan.

MCA/DoLS

The PCU Safeguarding Team bid successfully for NHSEngland funding to develop the awareness of the legal framework around the Mental Capacity Act (2005) The Year 1 programme (2013-14)raised the profile of MCA/DoLS with CCG leads and managers engaging key staff with the complexities, risks and legal requirements of the legislation. Year 2 of the project will provide front line staff with tools, materials and training in order to understand how to operate safely within the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) legal framework.

The 'Cheshire West' Supreme Court Judgement has brought MCA/DoLS into focus with the interpretation of what constitutes continuous supervision. This has placed the Local Authority and Court of Protection under some pressure as hospitals and care homes have a legal responsibility to apply for a DoL if someone is subject to 'continuous supervision' what, when and how to do this remains very challenging for front line staff.

The PCU Safeguarding Lead issued guidance to GPs and care homes on the special considerations when issuing death certificates when someone has died whilst subject to a deprivation of liberty.

Contributions to CoY SAB

The Designated Professional for Adult Safeguarding for City of York CCG at the PCU is the Chair of the Safeguarding Adults Review Group (formerly known as the Serious Case Review Group) Two cases have been submitted and subject to the Lessons Learned Review process.

Individual Board Member organisation's contribution to 2014/2015 SAB Annual Report.

North Yorkshire Police

Training regarding Safeguarding Adults is built into all of NYP's initial training programmes in a number of different ways for new PC'S , SC'S and PCSO's. All Police Constables and all new recruits (PC, PCSO, SC) complete a Vulnerability Training Package. The aim of the training is to ensure that Police Officers and PCSOs understand their responsibilities and duty of care to vulnerable people and the actions that must be taken to reduce identified risk. The package looks at vulnerability in relation to adults with factors such as alcohol and drugs and age.

Vulnerable Risk Assessment Training focuses on identifying those individuals that are Vulnerable and at risk in local communities, how to complete the Vulnerable Risk Assessment and what referrals need to be made and to whom.

WRAP (Workshop to Raise Awareness of Prevent) has been rolled out to all existing PCSO's and is to be rolled out to Police Officers and Special Constables this year. This assists officers to identify those that may be at risk of radicalisation because of vulnerability.

All new staff are required to complete the online learning package pertaining to Mental Health and Vulnerability and PC and SC courses follow this up by scenario based lessons and discussion on recognising and responding appropriately to adults as risk.

NYP's SC's have all had training on Human Trafficking and responding to people who have Autistic Spectrum Disorder.

North Yorkshire Police has changed the Control Strategy to have more of a focus upon cross-cutting themes such as victim vulnerability. As part of this intelligence structure a number of problem profiles have been reviewed including Missing and Absent, Prostitution and Modern Slavery / Human Trafficking.

NYP has undertaken a review and re-published its Safeguarding Adults procedure in light of changes to legislation within the Care Act.

The force has produced a Domestic Abuse Action Plan. This is available via the NYP website and has been developed using ACPO guidance and incorporating recommendations from HMIC. NYP is also leading on the alignment of performance data relating to domestic abuse across a number of partner agencies.

The Domestic Violence Disclosure Scheme (DVDS), also referred to as "Clare's Law", started in York and North Yorkshire in March 2014 as part of the national rollout**.** This was followed by the successful implementation of Domestic Violence Protection Notices (DVPN) / Domestic Violence Protection Orders (DVPO) at the end of June 2014.

Following research into victim needs, the Police and Crime Commissioner has commissioned and implemented a Victim Services Unit to help the most at risk and vulnerable people. Through the new services, more victims of domestic and sexual abuse, as well as those who have suffered as a result of serious crime, receive help from an independent adviser. The advisers provide the emotional and practical support that victims need to cope with what has happened and get back to normal as soon as possible.

The force has produced a number of safeguarding bulletins which are circulated forcewide. Topics which have been included within these publications have included safe use of the internet, grooming and sextortion.

NYP has an established Hate Crime Working Group and have recently held a multi-agency workshop.” We Stand Together” is a police-led campaign to show that we (and others) stand united against hate crime.

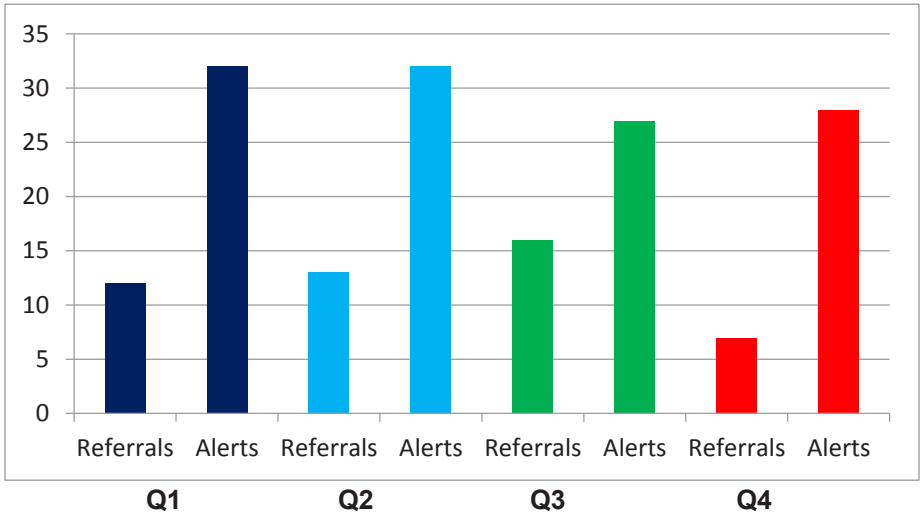
ANNEX B

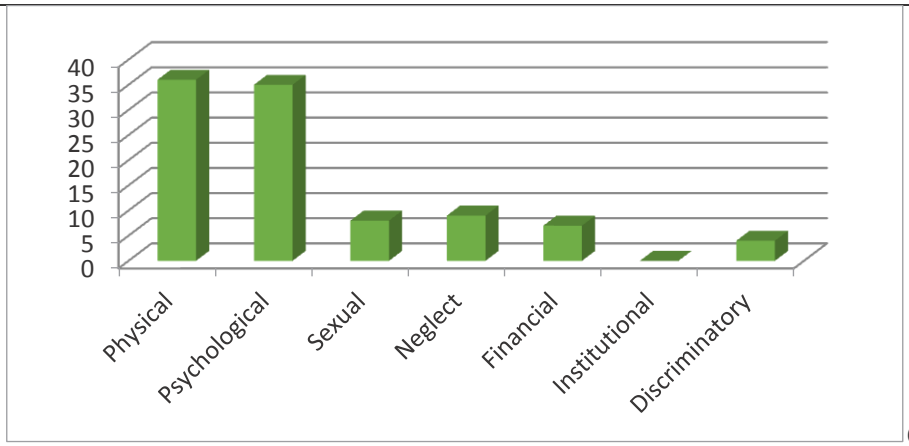
Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

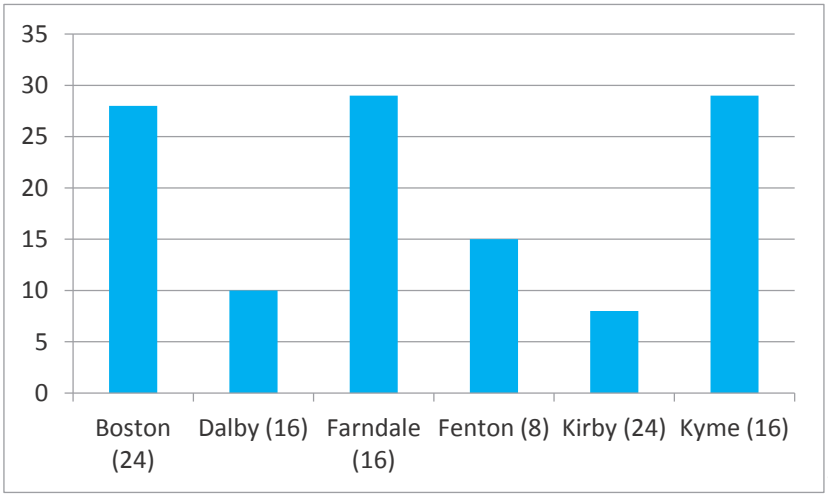
Stockton Hall Hospital

Partnerships in care

All newly recruited members of staff receive level 1 safeguarding adults' awareness training during the induction course. Furthermore, there is a standard for clinical and non-clinical staff to attend annual statutory/mandatory safeguarding training. The compliance for the year was 83.4%. Non-clinical staff members are provided with safeguarding training to address their specific needs; these sessions are delivered on a quarterly basis in order to ensure full compliance. Senior managers and clinicians have had the opportunity to attend Level 3 safeguarding investigator training which is delivered by Community Links on behalf of City of York Council. Two internal Level 3 safeguarding investigator training sessions, provided by an external facilitator, were attended by 20 senior clinical and management staff, bringing the total number of staff trained to 41. The expectation is that all senior staff will participate in Level 3 training every three years.







The hospital's Safeguarding Lead provides regular verbal feedback from the Board to the monthly Senior Management Team meetings. Written reports are provided, as required. A quarterly report, including data and analysis, is completed for the organisation.

The organisation and the hospital policies have been amended to incorporate changes from the Care Act 2014. This has included the development of a revised Safeguarding Adults presentation for Statutory/Induction training purposes. A presentation has also been developed to summarise the key points of the Care Act regarding safeguarding practices to be used at clinical governance meetings.

The government's PREVENT strategy is being supported through a training programme to ensure that all qualified clinical staff are trained within 12 months.

The agenda for Patient Safety Meetings has been reviewed to include a requirement to allocate link workers for the alleged victim and the person alleged to have caused harm in order to elicit their views in making safeguarding personal.

An audit of the incident recording systems identified a lack of synergy with safeguarding. An action plan has been developed in order to improve safeguarding documentation across the hospital. The Referrals and Clinical Governance Meetings have been utilised to address the key issues regarding recording safeguarding activities. The Out of Hours Safeguarding Protocol is being amended accordingly.

Ongoing participation in the Safeguarding Implementation Group, with the other independent hospitals, has included a review of the changes being implemented for the Disclosure and Barring Service. Referrals have been actively considered following safeguarding investigations into alleged staff misconduct. The organisation's Legal Department has issued guidance in that regard.

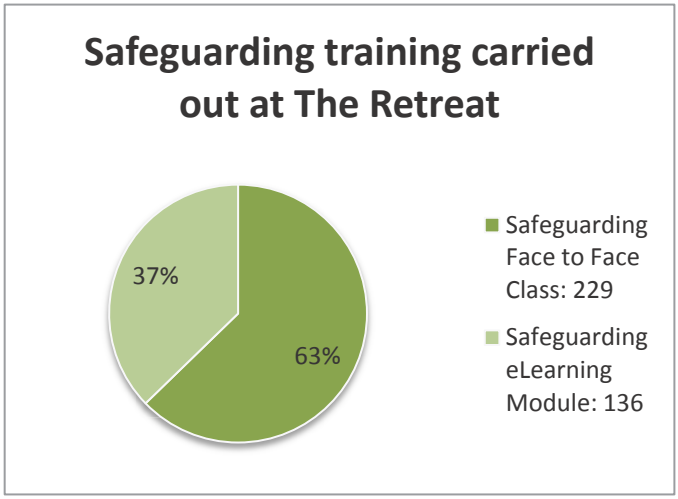
Safeguarding Adults alerts are now being discussed daily at SMT briefings and weekly at Referrals Meetings, thus improving organisational responses following the raising of a concern.

ANNEX B

The Retreat Yearly Safeguarding Report (2014/2015)

1. Safeguarding training

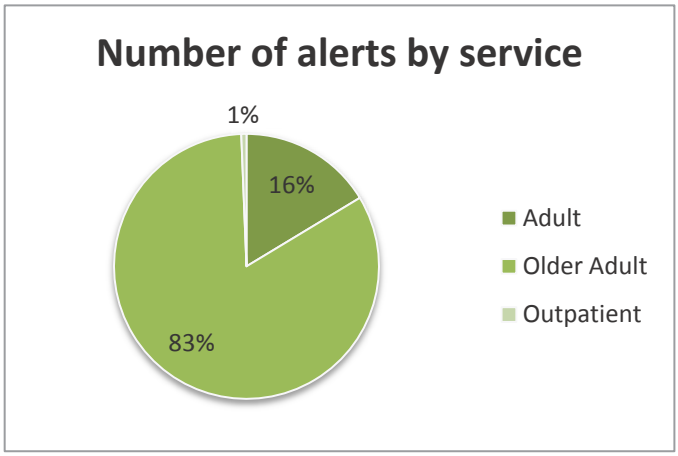
Adult Safeguarding Level 1 (Alerter) Training Compliance for the hospital (inc. Bank) was 100%, the refresher training compliance is: 272 compliant (79%), 71 non-compliant (21%). The safeguarding training level 1 is delivered face to face and as an eLearning module.
Adult Safeguarding Level 2 (Responder) and Level 3 (Investigator) Training Compliance for the hospital was 100%. Adult Safeguarding Level 4 (Chair) Training Compliance for Hospital was 75%, due to problems with accessing the training at WDU.



The impact of the new safeguarding training (revised at the beginning of 2014) has been positive. The rate of reporting low level incidents has improved; also the levels of understanding and confidence have increased among the frontline staff.

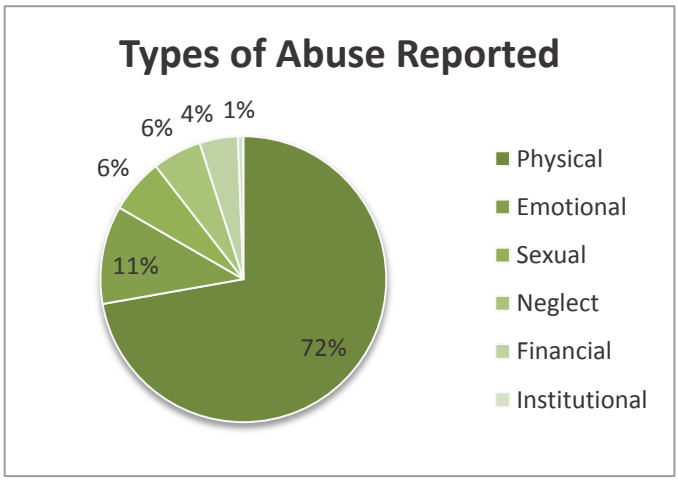
2. Safeguarding alerts and responses

The number of reported safeguarding alerts has been on the rise over the last 3 years: 62 in 2012, 85 in 2013 and 159 in 2014. The number of alerts received is much higher than the previous year (increase of 87%) and as mentioned before this can be associated with an improvement in reporting.

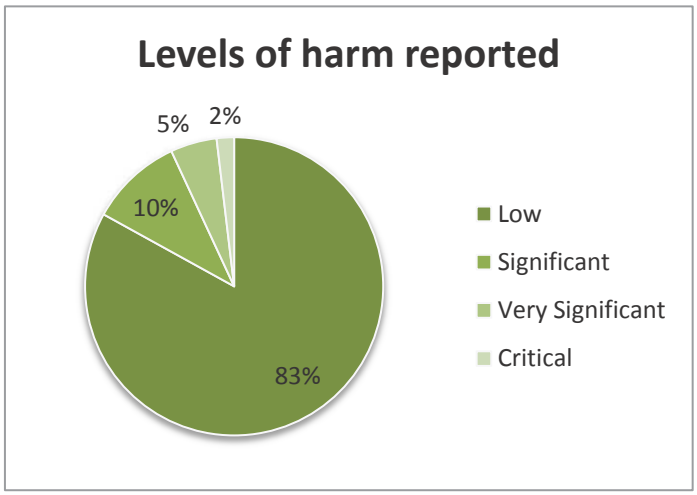


The number of alerts which were later referred to the City of York Council Safeguarding Team and Care Quality Commission did not change much over the last few years: 39 in 2012, 39 in 2013 and 32 in 2014. The number of the referred alerts did not go up with the increase of the alerts.

The new average for the quarter is 38 alerts, in comparison with 21 in the previous year (increase of 85%). The average number of referred alerts per quarter was 8 (9 in previous year), which has been a stable number for the last two years.



The significant majority of alerts: 132 (83%) were submitted within older adult services in comparison to 26 (16%) reported on adult units and 1 (1%) in outpatient service. However when it comes to the referred alerts the figures present a different picture: 72% of cases were from older adult, 28% were from adult services. Further analysis shows that 17% of all alerts submitted within older adults are referred, while in adult services this figure is higher (33%).



The cases of physical abuse account for the majority of all of the alerts: 117; emotional abuse was reported in 18 cases, sexual in 10, neglect in 9, financial in 7 and institutional in 1 case. There were no incidents of exploitation.

The incidents of physical abuse (primarily patient on patient assaults) have more than doubled in comparison to the previous year; however the sexual abuse cases have reduced by almost half. A notable increase of neglect allegations has been noted in comparison to 2013.

Person alleged to cause harm (PATCH) was in 118 cases a current patient of The Retreat, in 22 cases allegations were made against staff, and in 19 cases the PATCH was identified as external which includes family members, friends and ex-patients.

The level of harm in 132 cases was described as low, 16 were described as significant, 8 were very significant and 3 were critical.

Out of 159 alerts 156 met the safeguarding criteria and were either investigated or reviewed by the social work department; 3 alerts (2%) did not meet the criteria, but were still recorded within The Retreat's internal safeguarding database. It is justified to say that the alerts are being made appropriately.

In 119 cases the allegations were proved, in 24 cases they were disproved and in 13 cases the social workers were not able to determine the outcome; 3 investigations (all external) are still pending.

The social work department has improved its own system of monitoring data, which has helped to analyse the safeguarding within the organisation and determine current trends.

The regular safeguarding review meetings which involved practitioners from across the hospital helped to identify other factors e.g. environment, which have had an effect on safeguarding.

3. Achievements in relation to safeguarding

The Retreat's aim in 2014 was to enhance people's involvement, choice and control in the safeguarding process. We have worked with people who use services to ascertain what outcome they want when a safeguarding alert is raised. Our procedure includes the implementation of a safeguarding link role. The safeguarding link role ensures that the adult at risk and PATCH, (where they are also an adult at risk), are fully involved in the safeguarding process. We have developed leaflets for the adult at risk and the PATCH to explain the safeguarding process and the other areas of support that are available to them for example advocacy.

We have rolled out a training programme for people who use our services, to educate them about the safeguarding process. Our aim is to make safeguarding personal, a process that is done with and not to the people who use our services. We have found that the process has become more empowering and that the individual service users are at the centre of the process.

ANNEX B

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

York CVS

Two York CVS's Independent Living Scheme staff members attended Safeguarding level one alerter training as a refresher.

One Adult Safeguarding Alert made by York CVS's Independent Living Scheme.

- We reviewed our organisational Safeguarding Vulnerable Adults Policy In December 2014 and presented this at our internal managers meeting.
- We are actively promoting safeguarding best practice and learning through our Voluntary Sector Forums (older people & long term conditions, learning disabilities, mental health and children, young people and families).
- The Safeguarding Adults Board Chair is presenting the Annual SAB return to the Voluntary Sector Forums.
- We attended the Safeguarding Adults and Children's Board Development Days and completed the annual self assessment documentation.
- York CVS maintained attendance at the Safeguarding Adults and Children's Boards.

ANNEX B

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

YORK HOUSE

A neurobehavioural service for acquired brain injury

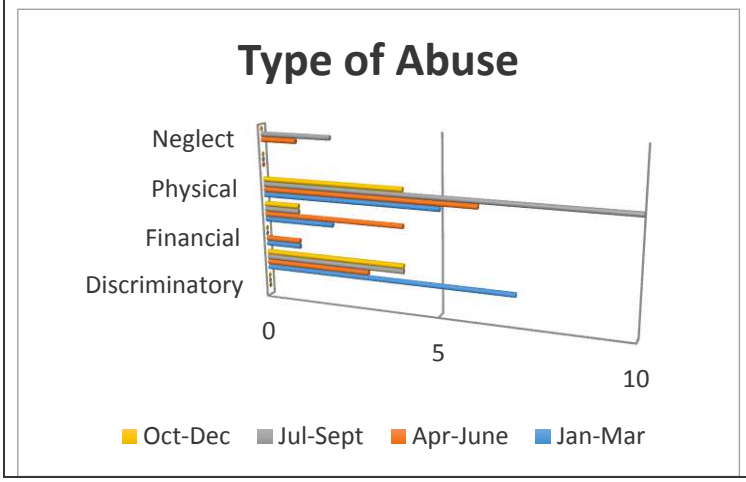
1. The following information shows the number of staff who have completed the SOVA training at York House between April 2014 and March 2015:

Total Staff - 201

Training	Contract (136)	Bank (65)
SOVA	110	17
Training	Contract (%)	Bank (%)
SOVA	81	26

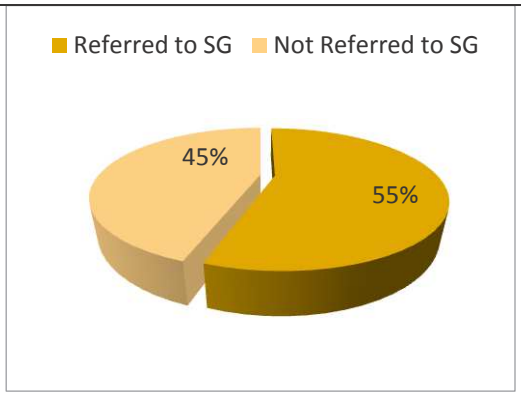
All staff are required to complete a week long comprehensive induction training prior to any shifts being completed, this includes Safeguarding training. All staff must then repeat this training yearly in the 3 day mandatory training program.

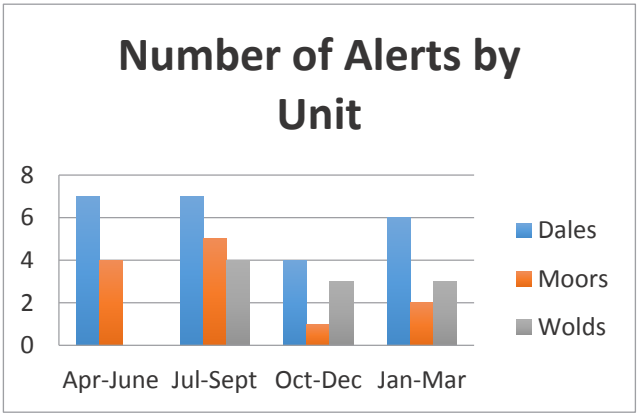
Those staff responsible for overall safeguarding at York House have also completed further training on Level 2,3 and 4 run by City of York Council. Training on the care act implications for safeguarding has also been attended by a member of the governance team at York House and the safeguarding lead which will impact on the induction and mandatory training following April 2015.



The types of abuse reported and dealt with at York House from April 2014-March 2015 are shown in the graph opposite. There have been no incidents of institutional or discriminatory abuse in this period. The most common type of abuse identified in this time frame was physical abuse.

There was 45% of safeguarding cases that were not sent to City of York Council (CYC) for further safeguarding intervention due to it being dealt with in-house through management of risks, protection plans or support measures being implemented. Some of these cases may have been discussed with the safeguarding team to reach the decision not to refer and all are discussed between the York House safeguarding sub-committee. 55% of the cases were referred to CYC, these have now all been closed with all internal and/or external investigations completed.





The alerts by unit tend to follow the same trend throughout the year, with the majority of alerts being from the Dales unit at York House.
This is the assessment unit were all new admissions (excluding females) are generally admitted. The population as a whole is as a result often more challenging and behaviours more unpredictable. As a result staffing levels are higher to ensure adequate support and management. The Moors unit of York House is a slower stream rehabilitation unit and so care plans are more established and service user's behaviors more stable in comparison.
The Wolds unit of York House is intensive long term care needs with a focus on quality of life, however the long term effects of brain injury from this client group and mix of service users can lead to safeguarding issues following conflict.

York House are using the new Disclosure and Barring service, with all new recruits and renewals of CRB's due being dealt with under the new system. This is significantly reducing the time taken to complete checks.

Safeguarding information specifically developed in conjunction with Speech and Language therapists has been produced for our service users including posters for all 3 units. We are now looking at updating this in line the introduction of the Care Act.

Those staff with overall safeguarding responsibilities at York House are continuing to seek out external training and attend the level 2 upwards training delivered by CYC.

York Teaching Hospital NHS
NHS Foundation Trust

Safeguarding Adults Annual Report 2014/2015

Training and awareness raising

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

The Safeguarding Adults Team are all trained to level 3, conducting multi agency investigations and level 4, chairing multi agency case conferences having accessed external training.

There were concerns regarding take –up figures and as a result and with the help of the learning hub these figures are on the increase. To ensure more accessibility the Level 2 training, previous a full day has been transferred to an e-learning package. This will be in place from April 2015.

In addition in light of Cheshire West specific areas of high risk have been targeted for one-off training sessions and a bespoke Prevent training package has been developed and subject to Corporate Learning and Development Director approval will become part of the Statutory Mandatory Programme from April 2015.

In addition the Trust Safeguarding Adults team began in January a monthly “Ward Wander” programme which involves our team visiting departments/wards/units to offer support, tutorials and on the spot review of patient issues.

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

Safeguarding Adults Training Figures 2014/2015
Level 1 1714
Level 2 309
Level 3 1
Level 4 1

Safeguarding Adult Referral/alerts analysis

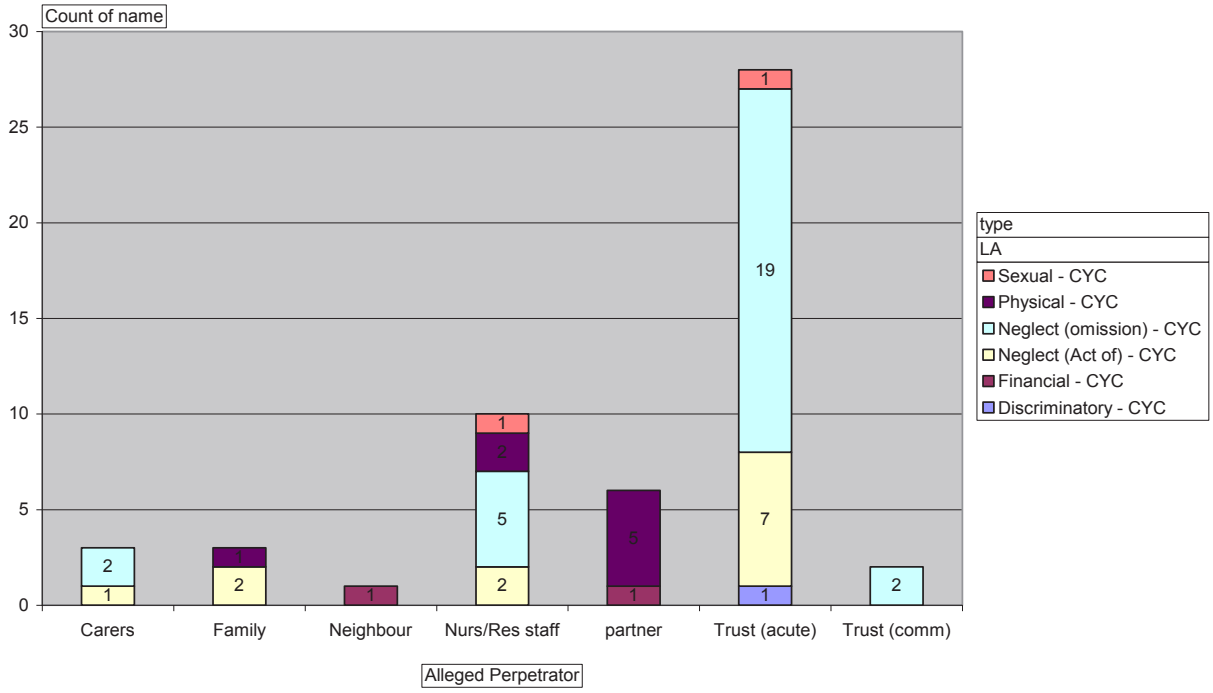
There were 146 Safeguarding Adults alerts received in 2014/2015. This figure relates to **all** alerts referred through the Safeguarding Adults Team raised either **against** or **by** the Trust.

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

Of the 146, 53 were where City of York Council (CYC) was the lead Local Authority.

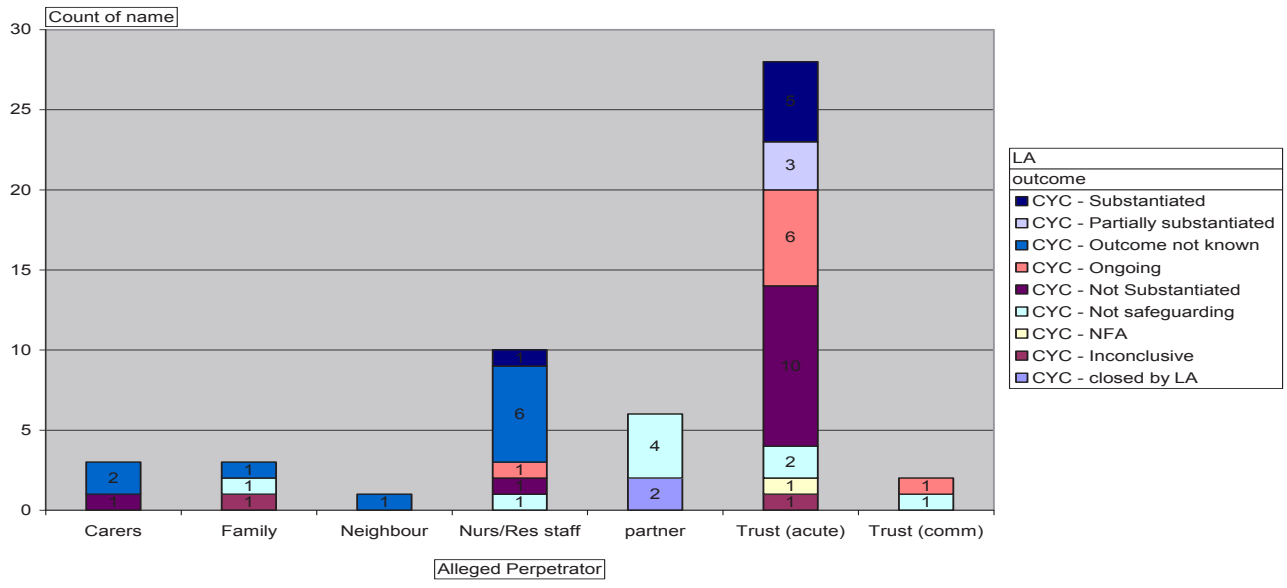
The following data relates only to alerts involving CYC Safeguarding Adults Team. Data is available for other local authorities the Trust serves.

Type and alleged perpetrator (CYC) 2014/2015



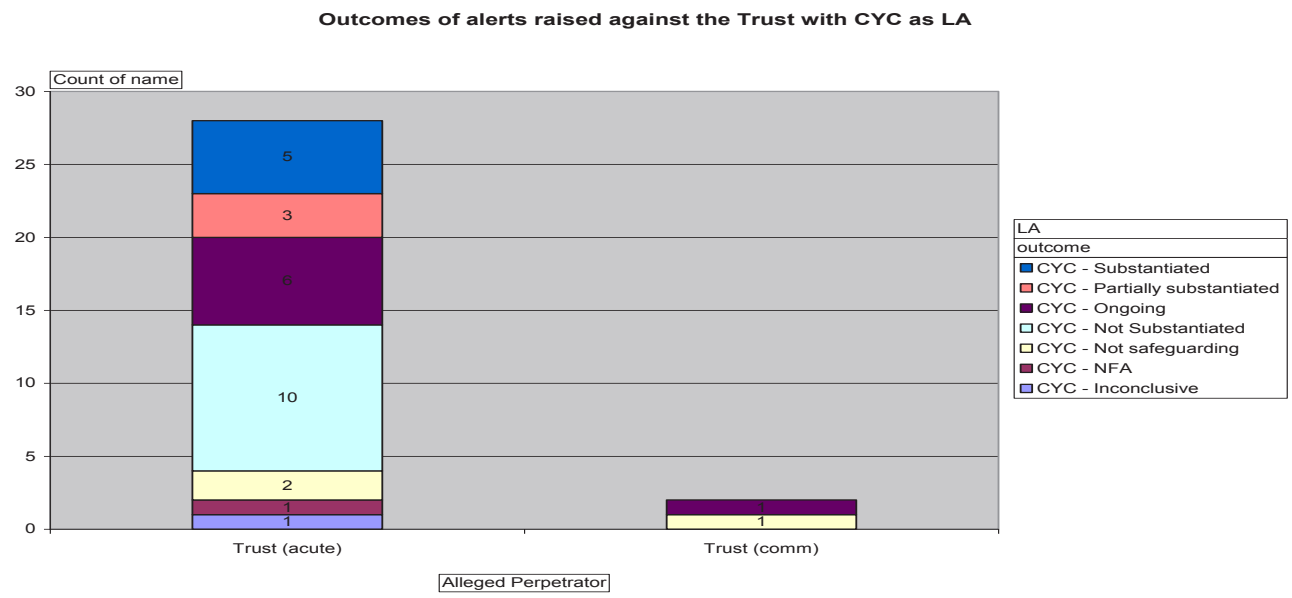
Outcomes for all alerts (both raised by and against the Trust)

Outcomes - All Alerts (against and raised by the Trust) 2014/2015



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

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



Achievements during 2014

1) Resources

The Safeguarding Adults Team consist of:

- ☐ Head of Safeguarding
- ☐ Lead Nurse for Safeguarding Adults
- ☐ 2 x specialist nurse to support staff with the Safeguarding Adults agenda which includes Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)
- ☐ 1 x Learning Disability Liaison Nurse
- ☐ 1 x Learning Disability assistant (Scarborough acute only)

This robust structure, established in 2014, further indicates the commitment the Trust is making towards Safeguarding Adults in our care.

2) Policies and Procedure

Trust policies and procedures include the following:

- ☐ Safeguarding Adults Policy and Procedures (based on Multi- Agency Policy and Procedures) This has been amended provisionally in light of the Care Act but is awaiting final multi agency guidance before complete review.
- ☐ Therapeutic Restrictions Guidance
- ☐ Mental Capacity Act Guidance
- ☐ Deprivation of Liberty Safeguards (DoLS) Guidance
- ☐ Learning Disability Specification

Where appropriate these have been reviewed to include changes from National legislation. A Draft Prevent Policy has been circulated for approval and will be published from April 2015.

3) Learning from Safeguarding Adults Investigations

Thanks to Senior Management support and commitment, the profile of the Safeguarding Adults Team within the Trust has raised considerably. Reports are requested at Board level for progress and concerns raised through the team are reported weekly to the Trust Quality and Safety meeting to ensure high level awareness of concerns.

These measures have greatly improved the commitment to learning from Safeguarding Adults Investigations and as a result Safeguarding Adult Action plans have been the basis for work streams to improve the care delivered. For example:

- ☐ Awareness of need for robust documentation following documentation audit
- ☐ Task and Finish group to develop policies, training and risk management tools to support staff care for patients with Mental ill-health.
- ☐ Close liaison, training and policy development with the Head of Security in respect of vulnerable adults requiring the support of security
- ☐ Matron involvement in delivering actions arising from Safeguarding Adults Investigations.
- ☐ Review of Exclusion Policy
- ☐ Specific Awareness raising Tutorials for staff involved in Safeguarding Adults Investigation.

Nicola Cowley - Lead Nurse for Safeguarding Adults

Approved by Beverley Geary - Chief Nurse

April 2015

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Health and Wellbeing Board 21 October 2015

Report of the Executive Member for Education, Children and Young People and the Director of Children's Services, Education and Skills.

New Children and Young People's Plan 2016-19

Summary

1. This report provides members of the Health and Wellbeing Board with a brief progress update on the production of York's new Children and Young People's Plan 2016-19.

2. Board members are asked to note and comment on progress to date, support the approach set out below, engage in and support the consultation process and receive the final Children and Young People's Plan (CYPP) draft at a meeting in the New Year.

Background

3. The production of the new CYPP has been commissioned by the YorOK Board and the process is being led by the Children's Trust Unit. The Plan sets out the collective strategic vision, aspirations and priorities for children, young people and families in the city. It will sit within a wider strategic multi-agency context and have a strong link with York's Joint Health and Wellbeing Strategy and other key partnership and agency plans. The YorOK Board has endorsed the approach to producing the Plan as set out below.

   The new Plan will be comparatively short with plenty of supporting documentation, analysis and information referenced and available on the YorOK Website.

4. **Timeline**

   - Summer and autumn 2015 - ongoing consultation (including well attended multi agency consultation event on 21 September) ;

- October / November 2015 - Progress update tabled at Health & Wellbeing Board & Children's Safeguarding Board and draft chapters circulated for comment;
- November 2015 - final draft circulated for comment and signed off at YorOK Board;
- December 2015 - final editing / design etc;
- 27 January 2016 – Plan launched at no Wrong Door Conference.

5. **Content**

The content of the Plan will be as follows.

Executive Summary:
- Including supporting statements from the Chair of the YorOK Board, Director of Children's Services, Chair of the Youth Council.

Introduction:
- Ambition and vision
- Consultation headlines
- Priorities
- How we'll know we're making a difference

York on a page:
- People, assets and finance

What the consultation told us

Our priorities:
- Early help
- Emotional and mental wellbeing
- Closing gaps in health and well-being
- Whole family working

YorOK Workforce

Governance
- YorOK strategic infrastructure / Planning Bookcase

CYPP Scorecard

Plan on a page

Partner comments and signatures on a page

6. **Draft ambition and vision statement**

The draft vision for the Plan is set out below; comments from Board members are welcome:

"Children and young people are the heart of our City and of everything we do[1]. We are clear and determined in making York a great place to live for all children, young people and families. We want York to be a place where all children and young people have the best start in life[2], are healthy, happy, have aspirations for their futures, enjoy life and achieve[3]. We want all children and young people to feel that York is a place where equity and equality apply to all. We know we must focus our combined efforts on supporting some children and young people to achieve their full potential, to live healthy lives and attain at levels much closer to the highest achievers."

7. **Priorities and actions**

The heart of the Plan will be based around the four following priority areas which were approved by the YorOK Board in July:

- Closing gaps not only in achievement but in health outcomes;
- Whole family working (including parenting and support for parents);
- Early Help (including early years, early intervention, vulnerable groups);
- Health and wellbeing (including emotional/mental health and physical health).

Safeguarding was also highlighted as a priority however it has been agreed that child safeguarding priorities will be led and overseen by the Children's Safeguarding Board.

Main/Key Issues to be Considered

Consultation

8. Consultation has been taking place through a number of channels with children, young people, parents, carers, practitioners and multiagency partners, who are being engaged to give their views about living and growing up in York. A comprehensive report about the process and key messages is available from the Children's Trust Unit. Some examples of consultation to date include:

- Feedback from partnership forums;
- Focus groups with target groups – These have been run in partnership with student volunteers from the University of York.

[1] Draft Council Plan 2015-19

[2] Vision for 0-19 Healthy Child Service

[3] The Good Childhood Report 2015, The Children's Society

- Online consultation – These can be accessed through the YorOK website here www.yor-ok.org.uk/haveyoursay
- Young researchers – A group of young people will work as researchers over the summer looking into the needs of children and young people.
- E-consultation and through the YorOK Newsletter.

Over the coming weeks, discussion will take place with partners to agree the shared contributions that will deliver our priorities and firming up agreed actions.

Options

9. There are no options for the Health and Wellbeing Board to consider. This report provides information and requests support for the CYPP planning process.

Analysis

10. This report is for information, and therefore analysis of options is not applicable.

Strategic/Operational Plans

11. This report relates to the production of a new Children and Young People's Plan. The Plan will sit within a wider, complex strategic multi-agency context and will reflect a wide range of plans and priorities including the Health and Wellbeing Strategy, Council Plan, Children's Safeguarding Annual Report, 0-19 Healthy Child Service and wider child health outcomes, Police Children and Young person Strategy etc and will reference national strategy where relevant.

Partners are invited to provide details of key documents and reference points as appropriate.

Implications

12. There are no known risks arising from the recommendations below in the following areas:

- **Financial**
- **Human Resources (HR)**

- **Equalities**
- **Legal**
- **Crime and Disorder**
- **Information Technology (IT)**
- **Property**
- Other

Risk Management

13. There are no known risks arising from the recommendations below.

14. **Recommendations**

The Health and Wellbeing Board are asked to:

i. note and comment on progress to date;

ii. support the approach set out in this report;

iii. engage in and support the consultation process;

iv. receive the final CYPP draft at a meeting in the New Year.

Reason: To keep the Board appraised of progress to date and to engage partners in the CYPP planning process.

Contact Details

Author:
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Children's Trust Unit
City of York Council
01904 554039

Chief Officer Responsible for the report:
Jon Stonehouse
Director of Children's Services, Education and Skills
City of York Council
01904 553798

Report Approved ✓ **Date** *07.10.2015*

Wards Affected: **All** √

For further information please contact the author of the report.

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Health and Wellbeing Board 21 October 2015
Report of the Interim Director of Public Health

Response to Healthwatch Reports

Summary

1. This report provides the Health and Wellbeing Board with:

- Comments on the following two Healthwatch reports presented to the previous meeting:
  - Who's Who in Health and Social Care
  - Consistency and Confidence in Patient Led Assessments of the Care Environment (PLACE)
- Information on two new Healthwatch reports

Background

2. Health and Wellbeing Board have agreed to receive and respond to Healthwatch York reports as appropriate. Healthwatch York reports contain extensive qualitative research carried out with the residents of York and make a number of recommendations for Health and Wellbeing Board itself and for individual partners that sit around the table.

3. Recommendations arising from the two previous reports are contained within **Annex A** to this report.

Main/Key Issues to be Considered

4. Set out below is a summary of the work and practices that are in place to address the recommendations:

5. Who's Who in Health and Social Care

- Organisations would be happy to add a link to Connected York to their websites.

Organisations would be happy to provide information for the website if Healthwatch York and/or York CVS were happy to continue to update the site.

- The NHS Accessible Information Standard becomes law from April 2016. All statutory health and social care organisations will need to provide information to clients in their preferred format.
- City of York Council must meet certain legislative requirements when preparing meeting papers and agendas. A glossary of acronyms used is provided as part of all papers for meetings held in public.
- In principle all organisations around the Health and Wellbeing Board table would be open to using Healthwatch York's readability group.
- Key partners around the table publish agendas for all their public meetings on their individual websites. Each organisation has agreed timescales for publication. For most of these there are usually two or three paper copies of the papers available in the meeting room on the day of the meeting.
- For City of York Council meetings copies of papers can be provided in a different format on request. Hard copies of Council meeting papers are also available at York Explore. Details of public meetings are also advertised on the public notice board outside the gates of West Offices. The Council's website also has details of how residents can be involved in public meetings.
- City of York Council is also currently undertaking a scrutiny review (E-Democracy Task Group) with the aim of 'identifying the potential for improving public engagement and take up of services through digital means and the Council's ability to respond'.
- York Teaching Hospital NHS Foundation Trust's Board Meetings and council of Governors meetings are held in public. The Annual General Meeting is also open to the public. Dates and papers for the Board and Council of Governors meetings are published on the Trust's website. Papers can also be requested from the Foundation Trust Secretary, and packs of papers are available in hard copy at the meetings. Papers are also available in alternative formats on request.

The AGM is also promoted via the media and in promotional materials for the Trust's open day, which coincides with the AGM.

- NHS Vale of York Clinical Commissioning Group has produced information on choosing well/is A & E for me for the Vale of York footprint. A further budget would need to be identified for something York specific and/or for something to be produced for every household in the city. Yorkshire Ambulance Service have suggested that this issues around information of this nature be discussed at the Urgent Care Working Group.

6. Consistency and Confidence in Patient Led Assessments of the Care Environment (PLACE) – the recommendations within this report are not for the Health and Wellbeing Board specifically and Health and Wellbeing Board has no direct power to influence these. However, in principle they feel they are good recommendations and would encourage Healthwatch York to work with providers to implement these where possible.

7. Further Healthwatch York Reports – in addition to the two reports already referred to Healthwatch York have also published three further reports:

   - Accident and Emergency Department and its Alternatives (Annex B refers)
   - Discharge from York Hospital (Annex C refers)

8. Responses and comments on these two reports will be presented at the January 2016 meeting of the Health and Wellbeing Board.

9. Finally the Board are asked to note the work Healthwatch York has undertaken on behalf of the Health and Adult Social Care Policy and Scrutiny Committee on Wheelchair Services.

Consultation

10. Member organisations of the Health and Wellbeing Board have contributed their views to this report.

Options

11. There are no specific options for the Board to consider however they are asked to note the updates on the recommendations emerging from the Healthwatch reports and note the new Healthwatch reports.

Analysis

12. The reports give a comprehensive view of resident views on specific topic areas and suggest positive and practical steps for improvement. A number of the recommendations could be picked up in existing or forthcoming work and planned legislation may help change some of the more negative experiences and improve access to information.

Strategic/Operational Plans

13. The work undertaken by Healthwatch York contributes towards a number of strands of the Joint Health and Wellbeing Strategy.

Implications

14. There are varied implications associated with the recommendations in the Healthwatch York reports. Predominantly these are financial and equality based.

Risk Management

15. The proposed changes to accessible information that will come via the NHS Accessible Information Standard means that failure to address some of the recommendations from Healthwatch York may lead to a failure to comply with legislation when this becomes law from April 2016.

Recommendations

16. Healthwatch York is asked to note the responses within this report.

    Reason: To follow up on the recommendations of the Healthwatch reports.

Contact Details

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Report Approved ✓ **Date** 09.10.2015

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex A – Recommendations arising from previous Healthwatch Reports
Annex B – New Healthwatch York Report – Accident and Emergency Department and its Alternatives
Annex C – Discharge from York Hospital

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Annex A

Healthwatch York Reports – Recommendations

Who's Who in Health and Social Care

	Recommendation	Recommended to
1	Make a commitment to developing and maintaining Connected York. Add a link to the Connected York website from the website of statutory organisations	• Healthwatch York • City of York Council • NHS Vale of York CCG • York Hospital
2	Develop Primary Care Services (GPs, pharmacies, dentists, opticians) as resource centres	• NHS Vale of York CCG • NHS England
3	Make all written information (leaflets, meeting papers etc) as understandable and accessible as possible. Use Healthwatch York's readability group to review leaflets and websites before they are finalised)	• All statutory and voluntary organisations
4	Make amendments to the Healthwatch York Health and Social Care Directory Issue 2 to include information about mental health services and information about how to complain	• Healthwatch York (completed January 2015)
5	Produce a directory as a guide to mental health services and support in York	• Healthwatch York (completed March 2015)
6	Review the way(s) in which information is provided about meetings which are open to the public. This should take into account people who do not have internet access. People need to know when the meeting is, what the purpose of the meeting is and how the public can be involved.	• City of York Council • NHS Vale of York CCG • York Hospital • Leeds and York Partnership NHS Foundation Trust • Yorkshire Ambulance Service • NHS England

7	Collectively promote a single 'Choose Well/is A & E for me' leaflet for York. This leaflet should contain both practical examples and contact details for services. The leaflet should be delivered to every household in the city	• NHS Vale of York CCG • Yorkshire Ambulance Service

Consistency and Confidence in Patient Led Assessments of the Care Environment (PLACE)

Recommendation	Recommended to
Consider ways of improving confidence in the process, both with volunteers undertaking PLACE visits and with the wider public. This could include considering the role of commissioners within PLACE teams, giving clear guidance on potential conflicts of interest for Governors when acting as PLACE volunteers and expanding the role of Local Healthwatch organisations to support volunteers undertaking PLACE visits, working with Healthwatch England to provide a standard training package for volunteers. This could be provided within a joint training session across all local providers to improve consistency	NHS England Department of Health Healthwatch England Local Healthwatches
Provide all PLACE assessors with copies of the action plans for places they have visited. Provide copies to local Healthwatch. This helps reassure PLACE assessors that their comments and feedback are taken on board	All providers
Use a team of staff to support PLACE assessments so that no one staff member has too great an influence over the process	All providers

Develop an annual timetable for PLACE to show what happens when. Use Local Healthwatch to book lay assessors into PLACE visit slots. Direct all local volunteers interested in taking part to their local Healthwatch organisation.	NHS England All providers
Consider ways to widen the pool of volunteers used within PLACE assessments, to increase awareness of the programme and to make sure recruitment is open, transparent and involves people from across the whole local community. This may require targeted recruitment and consideration of how to meet an access requirements	NHS England Local Healthwatch

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healthwatch York

Accident & Emergency Department and Alternatives

June 2015

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Terminology

Accident and Emergency or A&E: For the purpose of this report this refers to the following services: Emergency Department, the Urgent Care Centre and the GP Out of Hours service which can all be accessed at Accident and Emergency at York Teaching Hospital.

The A&E waiting room: is the waiting room where people wait before they access either the Emergency Department, the Urgent Care Centre or GP Out of Hours (unless they are taken straight through to the Emergency Department)

NHS 111: is a free telephone service which provides urgent medical help or advice in circumstances which are not an emergency or life-threatening situation (NHS Choices, 2015).

Walk-in Centres: NHS Walk-in Centres provide access to treatment for minor injuries and illnesses.

GP Out of Hours: The GP Out of Hours service is where you can contact a GP out of normal GP surgery working hours. At the A&E Department at York Hospital there is now a GP Out of Hours service which you can use only if you have booked an appointment beforehand.

Emergency Department: Treats life-threatening or serious injuries or illnesses at York Hospital A&E

Urgent Care Centre: The Urgent Care Centre treats urgent injuries or illnesses, but where it is not an emergency, at York Hospital A&E

Alternative Services: For the purpose of this report alternative services refer to services which can be accessed instead of attending A&E and include: NHS 111, Walk-in Centre, GP, GP out of Hours and the Pharmacy.

Background

This report looks at the reasons why more people are attending A&E at York Hospital. It explores their awareness and use of alternative services in York that can help them. It also aims to consider how we can make sure the urgent care system works for people in York.

Over a dozen hospitals in the UK declared ‘major incidents’ in late 2014 and early 2015 (York Teaching Hospital was not one of these). This was due to overwhelming demand being placed on their Accident and Emergency Departments. Major incidents are declared when local health services have potential to be or are being overwhelmed by the number of patients. It is usually reserved for large scale outbreaks of infectious disease, large scale accidents, natural disasters and acts of terrorism (Patient, 2015). However, in the winter period between late 2014 and early 2015 a number of hospitals felt it necessary to declare major incidents due to an overwhelming number of patients presenting to their A&E department (ITV, 2015).

The winter of 2014-5 was dubbed the ‘winter of crisis’ in Accident and Emergency in the UK. The number of patients seen within 4 hours at A&E departments reached its lowest in a decade, since the target of four hours was introduced (Stubbs, 2015). In the final quarter of 2014 there was an average of 92.6% of people being seen within 4 hours of arriving at A&E (BBC, 2015).

York Teaching Hospital, along with the majority of trusts in England, missed the target of 95% in every week of winter (from the week ending on the 9th of Nov until the week ending on the 8th March) with 9 of these weeks falling below 85% (Triggle, 2015).

Causes of the current crisis in Accident and Emergency departments in the UK and York

The factors leading to the crisis are complex and the following have been identified as potential factors:

- the impact of an ageing population
- the closure of Walk-in Centres
- difficulties in arranging GP appointments
- the reduction in primary and social care funding
- a cultural change with particularly younger people seeking immediate service
- NHS 111 telephone referrals
- the hospitals' inability to discharge patients
- an increase in individuals with mental health issues presenting to A&E departments[i]

(Stubbs, 2015; Campbell, 2015).

Why Healthwatch York decided to look at the issue

In Healthwatch York's work plan survey of 2015-6, out of the 64 people who responded, 75% said that the issue of Accident & Emergency services and alternatives was the issue that Healthwatch York should look at next. Their concerns and comments included:

"With the problems with A&E it seems necessary to look at alternatives. NHS 111 needs improving - had a couple of bad experiences with it, be interesting to know if others feel the same way. "

"I think access to A&E, ambulance services in particular are important. Access to these services is currently not very good. Improving NHS 111 may also help with this."

"The issues I have ticked all appear to relate to the problems being found within A&E. When people don't have access to other services i.e. GP/Dentist they go to A&E when they experience problems. The problems in mental health and dementia care are well documented and lack of provision again impacts on A&E and other hospital care."

"If you can't get into a surgery with a minor ailment - where else can you go? A&E always long wait."

"A&E/111 services: Nationally several hospitals seemed unable to cope with the demands being asked of A&E departments and these were issues which were 111 problems. Are the resources inadequate or are they being used inefficiently?"

"Access to GP services may help A&E services and reduce the pressure on staff and consultants. Our first point of call for NHS services should always be through our GP. "

What we did to find out more

1) We carried out a survey in A&E as an Enter and View. The draft of this survey was sent to Healthwatch York volunteers and from their feedback we made amendments to the survey. The final version of the survey can be found in Appendix 1. The survey consisted of open and closed questions in order to obtain both qualitative and quantitative data. The survey explored people's reasons for using A&E and their use of the GP/GP out of hours, NHS 111 and self-medication and the effect of the closure of the Walk-in Centre in York.

It was an announced Enter and View visit and it was organised through liaison with Kay Gamble, York Teaching Hospital NHS Foundation Trust's Lead for Patient Experience and Jill Wilford, the Lead Nurse in A&E. We carried out the Enter and View in the A&E waiting room at York Hospital, during a 24 hour period between 10.00 am Tuesday and 10.00 am Wednesday, based on the information that this would be a representative mid-week day, during school term-time and with no significant events taking place in York on that day (which might lead to an increase in demand placed on A&E). We formally notified the hospital in writing prior to the visit (see Appendix 1).

We arranged a rota so that 1 member of staff and 1 authorised visitor were in the A&E waiting area at each time.

All authorised representatives introduced themselves to patients, briefly explained the role of Healthwatch York and outlined the purpose of the visit. Reassurance was given that all information would be treated as confidential and no one would be identified in any report. The Enter and View visitors were instructed to use their discretion and not ask people who appeared distressed or appeared unable to be surveyed. There were also a small number of patients (approximately 15) who declined to be surveyed. Overall we spoke to a total of 108 individuals.

2) We carried out an interview with a service user with mental health issues to explore whether people with mental health issues are attending A&E or are at risk of attending A&E due to a lack of primary care services for people with mental health issues. We also explored the service user's experience of the GP, GP Out of Hours, NHS 111, the

Walk-in Centre and A&E. In addition to this we had consultations with York Together and the Crisis Team to explore whether more people with mental health issues are presenting to A&E.

3) We visited NHS 111 Headquarters (HQ) and carried out interviews with the Service Development & Relationship Manager and an Urgent Care/Emergency Care Practitioner.

4) We carried out one to one interviews with a student from the University of York and a student from York St. John's University.

What we found out

Enter and View findings

The following summary provides quantitative and qualitative data based on the findings from the Enter and View survey and environmental observations about A&E which were made during the Enter and View.

Reason for attending A&E (108 responses)

The majority of patients who were in the A&E waiting room were there for what NHS Choices (2015) define as minor injuries and illnesses. These included:

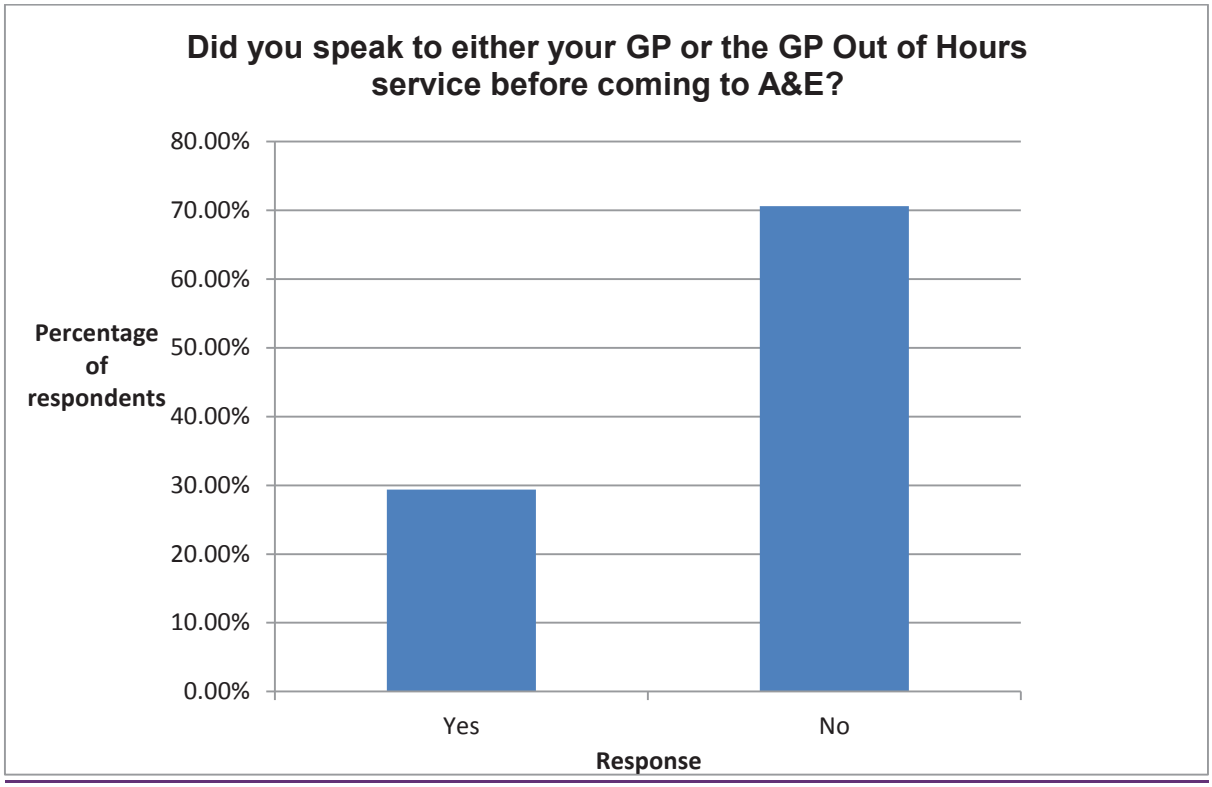
- sprains and strains
- suspected minor broken bones
- minor burns
- small cuts
- minor eye injuries
- small animal bites.

However a number of patients we spoke to were there for more serious injuries and illnesses.

Responses

Did you speak to either your GP or the GP Out of Hours service before coming to A&E? (102 responses)

Answer	Response percent	Response count
Yes	29.4%	30
No	70.6%	72



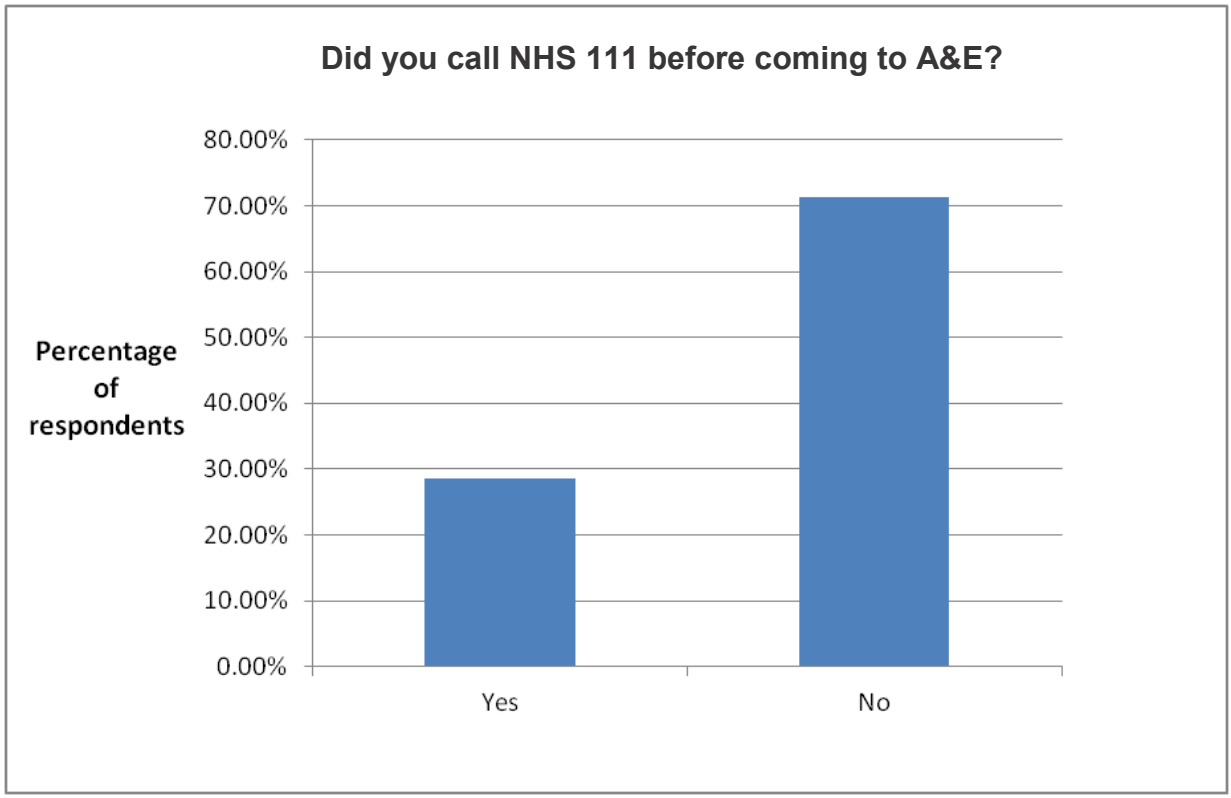
This shows that only 29.4% of respondents spoke to their GP or the GP Out of Hours service before attending A&E. Out of the 30 people who spoke to their GP or GP Out of Hours, before attending A&E, 86.6% spoke to their GP within normal surgery hours and only 13.3% spoke to the GP Out of Hours service. The vast majority of those who spoke to their GP or the GP Out of Hours service, said that they had been referred to A&E by the GP.

Common reasons for people not speaking to their GP/GP Out of Hours first included:

- Too long a wait for GP appointment
- The GP/ GP Out of Hours would only refer them to A&E anyway
- They called NHS 111 instead
- The requirement of an x-ray
- They just came straight to A&E, it was an emergency
- They did not consider using the Out of Hours service
- They were not registered with a GP
- It was an emergency

Did you call NHS 111 before coming to A&E? (98 responses)

Answer	Response percent	Response count
Yes	28.6%	28
No	71.4%	70

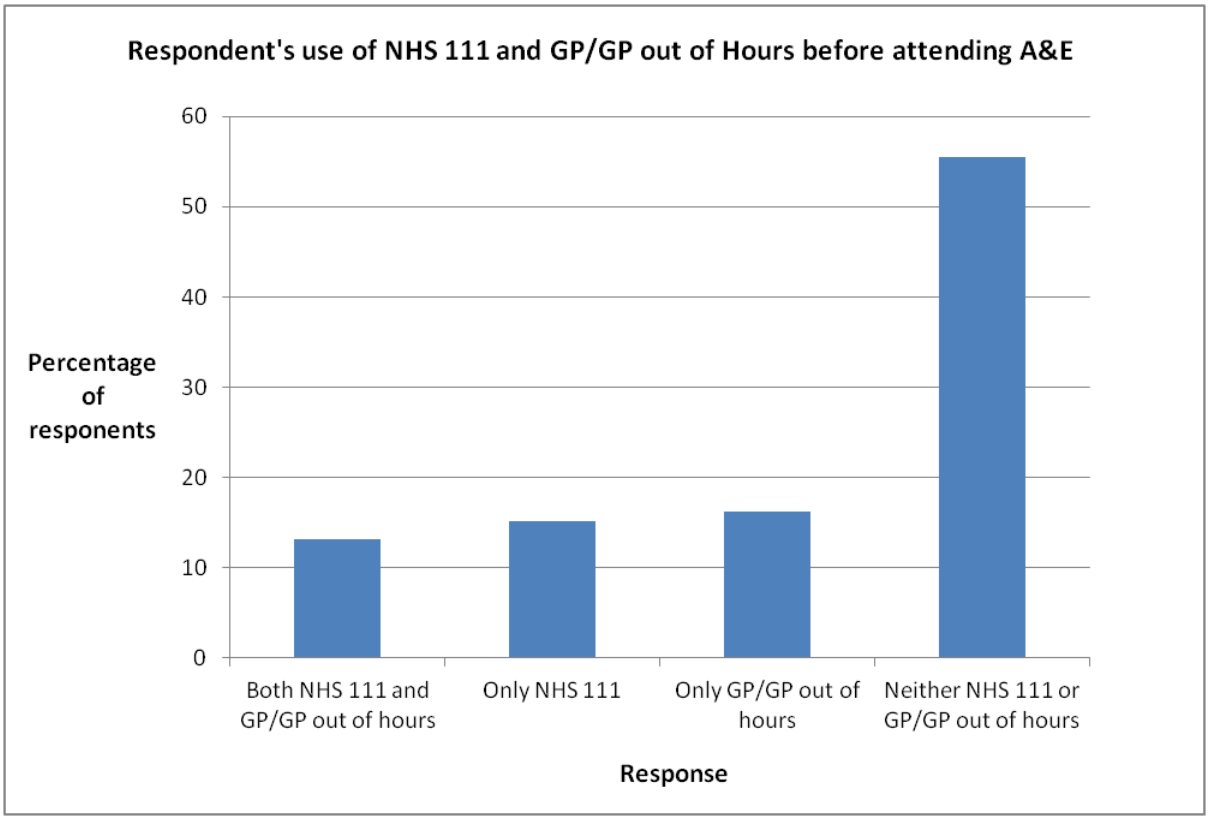


This shows that only 28.6% of respondents called NHS 111 before attending A&E. Common reasons people gave for not using NHS 111 included:

- It didn't occur to them to use NHS 111
- They did not know the service existed
- They did not "need to" use the service
- They just automatically came straight to A&E
- NHS 111 would only refer them to A&E anyway
- They spoke to their GP instead
- It was an emergency

Respondent's use of NHS 111 and GP/GP Out of Hours before attending A&E (99 responses)

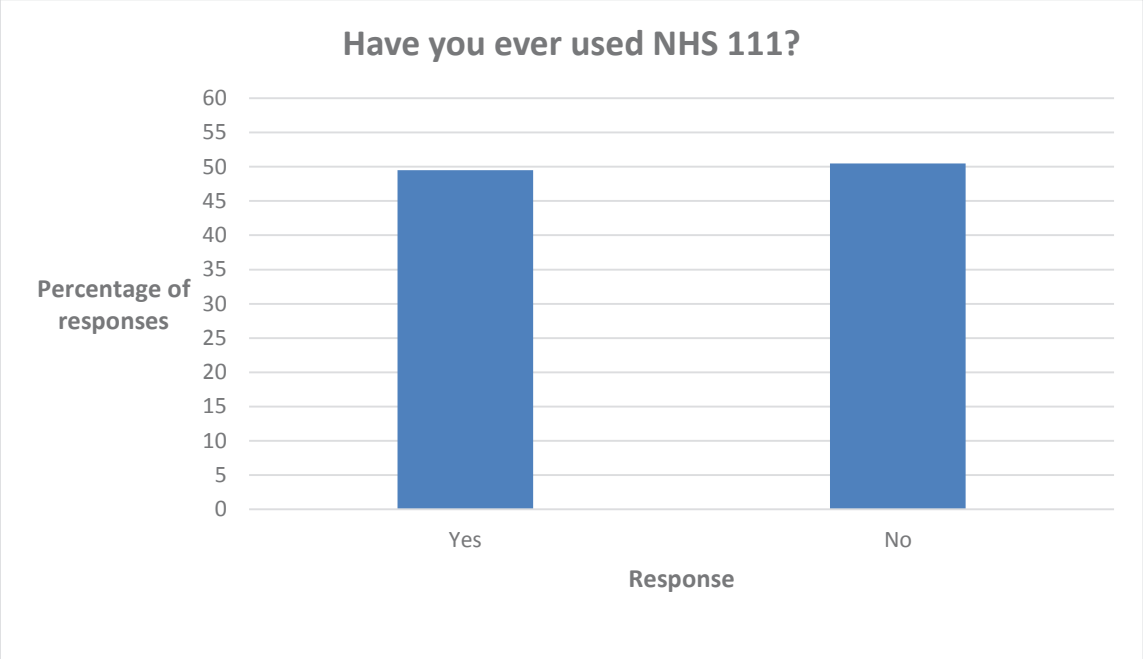
Service accessed	Response percent	Response count
Both NHS 111 and GP/GP out of hours	13.1%	13
Only NHS 111	15.2%	15
Only GP/GP out of hours	16.2%	16
Neither NHS 111 and GP/GP out of hours	55.5%	55



This shows that over half of the respondents had used neither NHS 111 nor the GP/GP Out of Hours before attending A&E.

Have you ever used NHS 111? (95 responses)

	Response percent	Response count
Yes	49.5%	47
No	50.5%	48



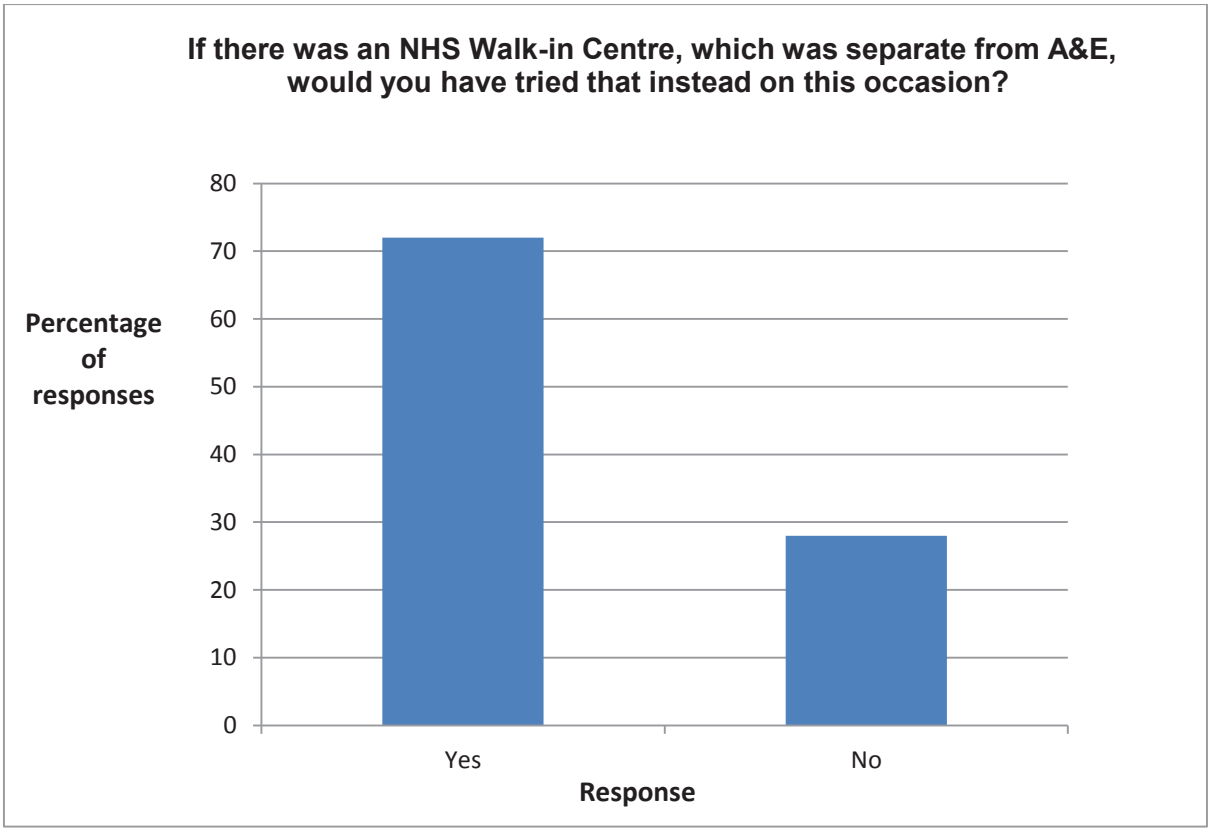
This shows that a large proportion, 50.5% of respondents, have never used the NHS 111 service.

Did you attempt to self medicate before coming to A&E e.g. with either over the counter medication or with prescribed medication? (95 responses)

43 of the 47 individuals who self-medicated before coming to A&E did so with either over-the-counter medication or basic treatments including the use of: Paracetamol, Ibuprofen, Nurofen, Calpol, eye drops, steri-strips, plasters, bandages, rinsing under cold water or 'rest, ice and elevation'. The remaining individuals had used prescription medication for either a short period before attending A&E or had just taken their usual medication for a long-term health condition.

If there was an NHS Walk-in Centre, which was separate from A&E, would you have tried that instead? (93 responses)

Answer	Response percent	Response count
Yes	72.0%	67
No	28.0 %	26



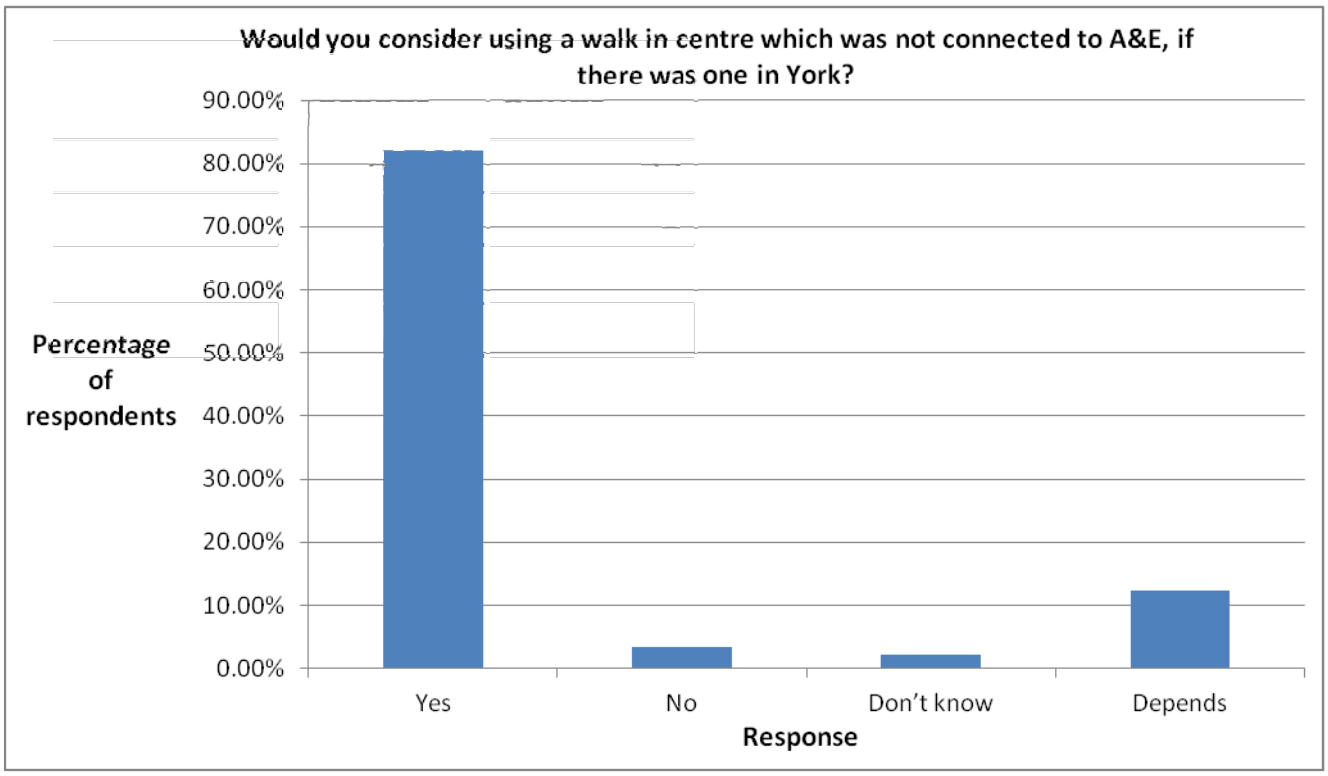
This shows that a large majority of 72.0% said that if there was an NHS Walk-in Centre in York, which was separate from A&E, they would have tried that instead.

Did you ever use the Walk-in Centre at Monkgate? (81 responses)

Answer	Response percent	Response count
Yes	43.2%	35
No	56.8%	46

This shows that although many of the respondents had used the Walk-in Centre in the past when it was located at Monkgate, this was fewer than said they would use one. 27 out of the 29 respondents did not express any concerns about the service and their reason for not using the Walk-in Centre was either because they did not have a need to, they did not live locally to the Walk-in Centre or they had not known that the Walk-in Centre existed. However, 2 out of the 29 respondents explained that their reason for not having used the Walk-in Centre at Monkgate was because of long waits.

Would you consider using a Walk-in Centre which was not connected to A&E, if there was one in York? (89 responses)



A number of respondents who answered “Yes” they would prefer to attend a Walk-in Centre which was separate from A&E, commented that they felt uncomfortable attending A&E for minor injuries and illnesses and that they would prefer to attend a Walk-in Centre. Many of those who answered “Yes” expressed that they would attend a Walk-in Centre because it would be quicker than A&E and many of those who answered “depends” said that they would attend a Walk-in Centre if it was quicker than A&E, with some suggesting that it would not necessarily be quicker and that there would also be long waits at a Walk-in Centre.

Ages of those attending A&E for treatment (90 respondents)

Age range	Response percent	Response count
0-5	10.0%	9
6-17	16.7%	15
18-25	30.0%	27
26-35	12.3%	11
36-45	8.9%	8
46-55	11.1%	10
56-65	4.4%	4
66-75	6.7%	6
75+	0%	0

This shows that out of those who were surveyed, the 18-25 age group were by far the group who attended A&E the most, through accessing A&E through the waiting room, with 30% of respondents aged 18-25. Overall children and young people (aged between 0 and 25) were over-represented, in the A&E waiting room, and made up an overall majority of 56.7% of patients.

Observations of the A&E waiting room environment

- It was not always clear to the patients in the waiting room and to Healthwatch York Enter and View visitors why the waiting time was lengthy during certain periods, when there were few people in the waiting room. Patients were not informed of how busy it was in the Emergency Department, the Urgent Care Centre or GP Out of Hours and they were not made aware of staffing numbers. The approximate waiting times did not provide sufficient information, did not provide accurate waiting times and were not updated very regularly.
- There was a lack of clarity and information provided about the distinctions between the Emergency Department and the Urgent Care Centre.
- The lighting in the waiting room is particularly bright and the seating is not very comfortable
- There was a lack of amenities in the A&E waiting room. There is a lack of magazines and books for people to read whilst sitting in the waiting room. There were vending machines for food and drinks,

but there was a lack of 'healthy' options. Although we are aware that patients cannot consume food and drink before being assessed, there were very few amenities for anyone who was assisting someone to A&E. There was also no information provided about amenities which people could access in A&E and York Hospital.

Findings on the use of A&E and alternative services by people with mental health issues

Interview with service user with mental health issues
This section presents the findings from an interview with a service user with mental health issues, who had previously accessed A&E at York Hospital and alternative health services (Appendix 3).
Mrs A attended A&E on a number of separate occasions. She had experienced negative comments from the reception at A&E saying things such as "oh it's you Mrs A again". There was another incident when the service user had slipped and had hit her head and the hospital sent her away after checking her over and did not put in place any aftercare support.

Mrs A had previously used the Walk-in Centre when it was located at Monkgate, however since the Walk-in Centre has been relocated within the A&E department she has not used it because she feels that A&E is too busy. The service user said that her experience of the Walk-in Centre had been varied and sometimes they were really good, but other times she had a similar experience as at A&E and the reception would talk down to her and she didn't like their attitude.

Mrs A expressed really positive feedback about recent use of NHS 111 and she suggested they were friendly and provided good medical advice.

Mrs A had very positive experiences with her GP who knows her. She said she is often able to get appointments on the same day if she rings in the morning because if someone cancels then she can see a GP. However, she is just given any GP who is available and if she wants to see GP that she is familiar with, she usually has to wait a couple of days

go to get an appointment. The service user said that the reception at her GP were not always welcoming.

Mrs A suggested that the problem with the GP Out of Hours service is that the GP does not know you and you don't know them. She therefore prefers to use her regular GP.

York Pathways with Together
These findings were gathered from a visit and consultations with York Pathways, who are part of Together Mental Health charity (appendix 4). The York Pathways team was set up by Together for the purpose of reducing demand placed on emergency services from people with mental health issues. This includes an increased demand placed on A&E for people presenting with attempted suicide and self-harming. It was also highlighted how individuals with mental health issues were calling 999 for support and the 101 number was set up to try and deal with this issue.

Crisis and Access service
These findings were gathered from a visit and consultations with the Crisis and Access service at Bootham Park Hospital (Appendix 4).
One of the primary purposes of the Crisis and Access service is to act as a triage service from A&E for people with mental health issues.

The service manager at the Crisis and Access service at Bootham Park Hospital has recently seen an increase in Mental Health presentations to A&E and the Crisis and Access service, an increase in the number of Section 136s (where the police remove someone from a public place, who appears to be suffering from a mental disorder, and impose compulsory detention at a 'place of safety' for up to 72 hours) and an increase in the demand on beds at hospitals and mental health hospitals in York, made by people with mental health issues.

The service manager suggested that the partnership between the A&E department and the Crisis and Access service has improved and more people with mental health issues are being triaged efficiently from A&E to the Crisis and Access service.

Findings from NHS 111 visit and interviews with the Service Development & Relationship Manager and an Urgent Care/Emergency Care Practitioner

NHS 111 visit and Service Development & Relationship Manager interview findings

This section is partly informed by a visit a member of the Healthwatch York team made to the NHS 111 Yorkshire Ambulance Service Headquarters and consultations with the Service Development & Relationship Manager and an Urgent Care/Emergency Care Practitioner (appendix 5).

NHS 111 is a free telephone service which provides urgent medical help or advice in circumstances which are not an emergency or life-threatening situation (NHS Choices, 2015). NHS 111 call advisers, including those working in Yorkshire Ambulance Service centres, use the NHS Pathways clinical assessment system in their consultations with callers, in order to assess the symptoms of the patient. They then provide medical advice or direct them to a local health service that can help them. This includes A&E, GP surgeries, GP out-of-hours, urgent care centres, Walk-in Centres, minor injuries units, a community nurse, an emergency dentist, a late-opening chemist or 999. Where possible, NHS 111 will also book an appointment for the caller or divert them directly to the service which they need. If the call adviser assesses the need for an ambulance then they will immediately arrange for one to be deployed (NHS Choices, 2015).

The Enter and View survey revealed that a number of respondents did not use NHS 111 before attending A&E because they believed that they would be referred to A&E by NHS 111 and therefore it was a waste of time. NHS 111 has been criticised for allegedly referring a large number of people to A&E. However, the number of NHS 111 calls where the recommended course of action is to attend A&E is a small minority, with only an average of 7.0% of NHS 111 Yorkshire Ambulance Service calls, in January 2015, resulting in A&E dispositions (See appendix 8).

The Service Development & Relationship Manager said that there is an issue with some patients being directed to the Emergency Department due to insufficient alternative provision, for instance a lack of emergency dentists means that patients with urgent tooth problems are often referred to the Emergency Department.

The majority of callers to NHS 111 do not speak to a trained medical clinician, unlike the NHS 111's predecessor NHS Direct which was staffed by medical clinicians. This is due to the significantly greater cost in commissioning a service where all call handlers are medical clinicians. However if the initial Pathway's assessment deems it appropriate, then callers can be diverted through to one of the medical clinicians at the NHS 111 centre, which is queued based on the level of urgency.

Emergency Care Practitioner interview findings
During the visit to the NHS 111 Yorkshire Ambulance Service Headquarters an Emergency Care Practitioner was also interviewed. Emergency Care Practitoners / Urgent Care Practitoners try and prevent unnecessary admissions to hospital and A&E and are triaged from 999 calls and ambulance crews. In the York area they are now also starting to take direct referrals from nursing homes and homeless hostels, with the scope for expanding to police custody suites and mental health care providers.

Findings from one to one interviews with University students

One to one with University of York student findings (Appendix 6)
The student had attended A&E on three separate occasions whilst a student at the University of York.
The student said that he used NHS 111 once, but not on any of the occasions relating to the times he attended A&E and he had used it once for a friend.

He explained how he self-medicated before two of the three occasions that he went to A&E. He strapped up both his knuckles and his ankle before attending A&E to try and treat the injuries. He also said he used anti-inflammatory medication on his ankle, but it was not successful.

The student stated that he registered with a GP when he first came to the university as an undergraduate as part of the induction process at the University of York. He stated that University of York students are able to access any of the Unity Health GP surgeries in York based at: the university, Hull Road and Wenlock Terrace and he had personally accessed the GP surgery at the university and Wenlock Terrace.

In terms of issues with booking appointments the student suggested that he had issues booking appointments at the GP surgery on campus and stated how on one occasion: “I remember I had an ear infection and it would have been a 3 week waiting list.”
He suggested, however, that they not were informed of any other health services, other than the GP, which they could access including: NHS 111, GP out of Hours, the Walk-in Centre and pharmacies.
He said that the GP service at the student GP surgeries could be improved by longer opening hours at the GP surgeries, particularly on Bank Holidays, and the extension of drop in sessions at the Unity Health surgeries, which is something that they have started.

The student said he had assisted one of his friends to the Walk-in Centre when it was at Monkgate. The student also said that he would prefer to use a Walk-in Centre than A&E because ‘you feel bad’ attending A&E and he said:

"I would prefer to use the Walk-in Centre than A&E. You always feel a bit bad for going to A&E. I went with my girlfriend, she had really bad stomach aches. But the A&E just said that it was just a stomach problem. But it was a chronic illness and she had to have medication for ages. If I had have known about it, I would have used the Walk-in Centre for the first occasion."

The student suggested a self-triage thought process where he considered which out of the GP, A&E, Walk-in Centre, NHS 111 or the pharmacy was the most appropriate service to access. The student said that he would attend A&E immediately if he had something which was causing him distress.

One to one with York St John's University student findings (Appendix 7)
The student had attended the A&E department at York Hospital on one occasion when she had used the GP Out of Hours service.
The student had tried to ring the university GP but was unable to book an appointment because it was about to close. She then rang NHS 111, but she had never heard of the service (and therefore had also never used the service) before her friend had mentioned it. She stated how NHS 111 were really helpful and they suggested that she should get medication from the pharmacy and then phone back if she didn't feel any better.

She then said how NHS 111 booked her an appointment with the GP Out of Hours at York Hospital A&E because she wasn't feeling any better having taken the medication and how she had not intended to go to GP Out of Hours before they suggested it and booked her in with an appointment:

"I wasn't thinking about going to A&E but 111 told me to go there. I had just wanted advice because I wasn't feeling well. 111 said to get medication and see how I felt afterwards. But I didn't feel any better, so I rang them again and they then referred me to A&E... and they booked me in with an appointment at the GP Out of Hours."

The service user said that she had a very good experience of NHS 111 when she used it on the one occasion. They gave her very good advice,

directed her to self-medicate first of all and they then booked her an appointment at GP Out of Hours because her condition did not improve.

The student stated how she had to register with a GP as part of the induction process when she first when to the University:

“It was part of the starter pack before they even gave us our keys - to register with a GP and there was a form in the starter pack”
However she stated how they didn’t provide any other information, as part of the induction, about health services which they could access in York.

She stated that there is one GP surgery on campus which is where you are registered as a student at York St John’s University and which is exclusively for students at York St John’s University.

She suggested that she had not had any issues with booking appointments at the GP. She booked an appointment and she was able to get an appointment on the same day, but she did not end up going to the appointment in the end.

The student said that she had heard of GP Out of Hours previously, but she did not know that the nearest one to her house in York was at York hospital. But NHS 111 told her that that was the nearest one and booked an appointment.

Conclusion

The Enter and View survey showed that the majority of patients did not call NHS 111 or speak to their GP/GP Out of Hours before attending A&E. A large number of people have also never used NHS 111. Any plan to improve the urgent care system must acknowledge these findings and have a clear strategy for dealing with this. People's reasons for not using these services included: that they would just be referred to A&E anyway, they automatically came to A&E, they did not know of NHS 111, it didn't occur to them to ring NHS 111, it would be too long a wait for a GP appointment, they did not consider GP out of hours, they needed an x-ray or it was an emergency.

The Enter and View survey revealed how a large number of respondents said that they did not use NHS 111 before attending A&E because they believed that the service would inevitably only refer them to A&E anyway. However this appears to be a false assumption, with Yorkshire Ambulance Service (YAS) statistics revealing that only a small minority of callers being referred to A&E.

The finding that over half of people did not self-medicate with either over-the-counter-medication or a prescription suggests more people could self-medicate before attending and not enough people are accessing medication from their pharmacy before attending A&E. The vast majority of those individuals who self-medicated also did so with either over-the-counter medication or treatments and this suggests that few people are obtaining prescriptions from their GP.

A large majority of people would have attended a Walk-in Centre before attending A&E if there was one in York. Even more people would consider using a Walk-in Centre in the future if there was one. People said that they would prefer to attend a Walk-in Centre which was separate from A&E because they felt uncomfortable attending A&E for minor injuries and illnesses and that they would prefer to attend a Walk-in centre. Many people also said that they may be seen quicker in a Walk-in Centre than they would be in A&E. Also, a large number of people used the Walk-in Centre when it was at Monkgate in York.

The closure of NHS Walk-in Centres in the UK has been occurring over the last few years and Monitor (2014) states that the following explanations have been given by commissioners for the closure of Walk-in Centres.

Firstly, a primary purpose for stakeholders' decision to open Walk-in Centres was for the purpose of reducing demand on A&E departments and commissioners have argued that Walk-in Centres have not been effective in reducing A&E attendances. This has led to commissioners focussing on improving the accessibility of urgent care services in terms of their configuration and availability with some commissioners (as was the case in York) reconfiguring Urgent Care services within A&E departments in an attempt to reduce A&E attendances.

Secondly, some commissioners have argued that people attend Walk-in Centres for the same reasons that they would see their GP and some people even attend both Walk-in Centres and their GP. Therefore, it was felt that there was the duplication of primary care services.

Thirdly, it was felt that the convenience and accessibility of Walk-in Centres meant that some commissioners argued that they created unnecessary demand and people could self-care or treat themselves with medication from the pharmacy instead. It was also argued that those individuals local to Walk-in Centres used them more and there was inequity of access.

In the current context of funding pressures and efforts made by commissioners to save costs and the previous factors which have been mentioned, commissioners came to the conclusion that Walk-in Centres were not necessary and they could not justify having them.

The NHS Walk-in Centre was reconfigured into the Urgent Care Centre at York Hospital. However, a consultant in Emergency Medicine at York Teaching Hospital NHS Foundation stated that the majority of minor illnesses and injuries can be treated by the GP or pharmacy and should not be treated at the Urgent Care Centre. He also stated that "the Urgent Care Centre staff will refer patients presenting with chronic and non-urgent conditions to a more appropriate health care provider" (Catton, 2012). Therefore, the development of the Urgent Care Centre was not supposed to act as a replacement for the Walk-in Centre.

The reconfiguration of the Walk-in Centre into the Urgent Care Centre has not been clear to patients and it is not clear when it is appropriate for them to access the Urgent Care Centre. The findings from the Enter and View visit revealed that the majority of patients were attending A&E for what can be defined as minor injuries and illnesses. However, we do not think that this should be interpreted as patients simply using the Urgent Care Centre inappropriately. This is since the closure of the Walk-in Centre has left a gap in primary care provision for minor injuries and illnesses.

There is an issue with a large number of children and young people attending A&E. 0-25 years old were over-represented in the A&E waiting room and made up the majority of A&E attendees accessing A&E through the waiting room.

Finally, there could also be more information provided in the waiting room about amenities in A&E and at York hospital and there is a lack of amenities, books and magazines in the waiting room. The lighting in A&E is also particularly bright and the seating is not very comfortable. There are also a number of improvements which could be made relating to clarity and information about waiting times and in which medical circumstances it is appropriate to access the Urgent Care Centre.

The interview with an individual with mental health issues revealed issues with how A&E, NHS 111, the GP and GP Out of Hours services work with people with mental health issues and how they are not always treated with respect by staff.

The interviews with Together with Pathways mental health charity and the Crisis and Access Service suggested that increasingly more people with mental health issues are putting pressure on York A&E department. Both of these services aim to reduce demand placed on the A&E department by people with mental health issues.

The service manager at the Crisis and Access service at Bootham Hospital stated how they, as a service, had seen an increase in mental health presentations to A&E and the Crisis and Access service, an increase in the number of Section 136s (where the police remove someone from a public place, who appears to be suffering from a mental disorder, and impose compulsory detention at a ‘place of safety’ for up to

72 hours) and an increase in the demand on beds at hospitals and mental health hospitals in York, made by people with mental health issues.

Since 2012, the government no longer publishes data on Mental Health Treatment in A&E, but Paul Burstow, previously a Liberal Democrat Health Minister, obtained 10 years of data from Ministers, which was the analysed by Incisive Health. It was estimated that, at the current trend, an all time high of more than a million people attended A&E for mental health treatment in 2014, compared with 330,000 in 2002 (The Guardian, 2015). This therefore suggests that increases in the number of people with mental health issues attending A&E at York Hospital is part of a national trend and action needs to be taken to reduce the number of people with mental health issues attending A&E.

The service manager suggested that the partnership between the A&E department and the Crisis and Access Service has improved and more people with mental health issues are being triaged efficiently from A&E to the Crisis and Access Service.

Another development in alternative services which would help to reduce the pressure on A&E departments is the expansion of Emergency Care Practitioner's (ECP). The interview with an ECP at the NHS 111 HQ revealed that in addition to ECPs being triaged from 999 calls and ambulance crews, in the York area they are now also starting to take direct referrals from nursing homes and homeless hostels, with the scope for expanding to police custody suites and mental health care providers. This is a good way of diverting people who are not in a life-threatening or people in non serious conditions away from A&E.

Finally the one to one interviews with a University of York student and a York St John's University student revealed that the students sought alternatives to A&E, including NHS 111, GP Out of Hours, the GP, the Walk-in Centre (when it was at Monkgate), the pharmacy and self-medication. The students expressed reluctance in attending A&E and they said that they would only attend if they felt it was necessary and there was no other option. However there appears to be a gap in provision for minor injuries and illnesses, since the closure of the Walk-in

Centre and students are unsure where to attend for minor injuries and illnesses in York.

The interviews revealed that at both the University of York and York St John's University students are required to register with a GP, as part of the induction process, when they first start university as an undergraduate. However, from the experience of a master's student from the University of York on their social work placement at Healthwatch York, there is not a requirement to register with a GP in York, as part of the induction process for post graduate students.

From the information provided by the students interviewed, the induction process for undergraduate students did not include any additional information about health services other than the GP, which are available in York.

It was suggested by the University of York student that the GP service at the student GP surgeries could be improved by providing longer opening hours, particularly on Bank Holidays and the extension of drop in sessions at the Unity Health surgeries, which is something that they have started in the morning at the University Unity Health GP surgery and is something which could be extended.

The York St John's University student also said how she was unable to book a GP appointment because the university GP surgery closes early.

Recommendations

Recommendations	Recommended to
Consider ways in which patients can be asked when they get to A&E whether they have accessed NHS 111 or GP/GP Out of Hours before arriving at A&E.	York Hospital NHS Foundation Trust
Consider implications of our findings for the provision of Minor injury and illness services in York	York Hospital NHS Foundation Trust
Consider targeted campaigning at 0-25 year olds about the availability of alternative services other than A&E. This may involve working with groups which work with parents, teenagers, students and children.	York Hospital NHS Foundation Trust
There should be more clarity and information provided about the distinctions between the Emergency Department and the Urgent Care Centre and particularly in which medical circumstances it is appropriate to access the Urgent Care Centre.	York Hospital NHS Foundation Trust / NHS Vale of York Clinical Commissioning Group
Patients could be provided with clearer information on how busy the Emergency Department, Urgent Care Centre and GP Out of Hours are and the staffing levels in each department during different time periods. The approximate waiting times should provide sufficient information and should be updated regularly.	York Hospital NHS Foundation Trust
The lighting could be made less bright and potentially provide more comfortable seating. There could be improvements made to the amenities provided in the A&E waiting room, in terms of food and drink, including healthier options, and the provision of more magazines and books. There could also be more information provided about amenities which patients can access in A&E and York Hospital.	York Hospital NHS Foundation Trust

Developments in the triaging of people with Mental Health issues from A&E to the Crisis and Access Service should continue.	York Hospital NHS Foundation Trust / Crisis and Access service / NHS Vale of York Clinical Commissioning Group
Consider continuing the expansion of Emergency Care Practitioner's direct referrals from a wider range of settings.	Yorkshire Ambulance Service / NHS Vale of York Clinical Commissioning Group
As part of the induction process ensure that Post-graduate students are registered with a GP in York, as well as undergraduate students	University of York, York St John's University
Include information on additional health services, other than GPs, which are available to students in York in the welcome pack or as part of the induction process.	University of York, York St John's University
Consider extending opening times at student GP surgeries and extend the provision of drop in sessions.	University of York, York St John's University

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Appendices

Appendix 1: Notification letter to York Hospital: Planned Enter and View visit to York Teaching Hospital NHS Foundation Trust

Appendix 2: Enter and View visit questionnaire

Appendix 3: Interview with service user with mental health issues

Appendix 4: York Pathways with Together and Crisis and Access service

Appendix 5: NHS 111 visit and service development & relationship manager and Emergency Care Practitioner interview findings

Appendix 6*:* One to one with University of York student findings

Appendix 7: One to one with York St John's University student findings

Appendix 1: Notification letter to York Hospital: Planned Enter and View visit to York Teaching Hospital NHS Foundation Trust

Planned Enter and View visit to York Teaching Hospital NHS Foundation Trust
Date: 21/04/15-22/04/15

Legislation in the Health and Social Care Act 2012 gives local Healthwatch organisations the power to Enter and View all publicly funded health and social care premises to gather evidence at the point of service delivery.

Accident and Emergency and alternatives is one of the topics which members of the public voted on to the Healthwatch York work plan for 2015-16. As part of our planned programme of work on this topic, we intend to carry out an Enter and View visit to the A&E department at York Hospital for a 24 hour period between 10 a.m. on the 21/04/15 to 10 a.m. on the 22/04/15.

The purpose of the visit is to speak to patients and families/carers to find out the reasons why people are attending A & E in York, their awareness of alternative places that can help them and how well the urgent care system works for people in York.

Feedback gathered during the visit will form part of a report on Accident & Emergency and alternatives, which will be published in the summer of 2015. In line with our report writing protocol, we will send you a copy of the draft report and give you the opportunity to check it for factual accuracy before it is published.

Four members of the Healthwatch York staff team will take part in the visit:

Siân Balsom (manager)

Carol Pack (information officer)

Helen Patching (Project support officer)

Nicholas Redding (student social worker on placement at Healthwatch)

Healthwatch York volunteers who have been trained and authorised as Enter and View visitors will also be taking part in the visit, working with another volunteer or a member of staff, in pre-arranged timeslots. At least one member of staff will be present at all times.

The following is a list of the Healthwatch York volunteers who will take part in the visit:

Fiona Benson, Jane Gripton, Jackie Chapman, Trish Thornton, Polly Griffith and Dorothy Murphy

All staff and volunteers will wear a photo ID badge during the visit.

If you have any questions or need further information about the visit, please don't hesitate to get in touch.

Nicholas Redding

Student Social Worker, Healthwatch York

Appendix 2: Enter and View A&E Survey

Accident and Emergency and Alternatives in York

Note: ask if the person has already answered the Healthwatch Survey.

“Hello. I am an Enter and View visitor on behalf of Healthwatch York. We are carrying out an Enter and View survey today for a report into Accident and Emergency and alternative services in York. Would you be willing to take part in the survey?” (If yes proceed). “At Healthwatch York we fully comply with data protection procedures, this means that your answers to this survey are all anonymous and confidential. No personal data you give us in this survey will be disclosed without your consent.”

Please circle whether you spoke to the actual person who needed treatment or a family member/ friend/ carer/other (please specify):

Time: Zone:

1. If you don’t mind me asking could you please tell me why you have come to A & E today?

2. Did you speak to your GP or the GP out of hours service before coming to A & E? And if so please specify which.

The GP out of hours service is where you can contact a GP out of normal GP surgery working hours.

Yes	
No	

If yes please specify whether GP or GP out of hours

2. (1). If Yes , did they tell you to come to A&E? And how was your experience of the GP or the GP out of hours service?

2. (2). If No, what was the reason that you did not speak to your GP or the GP out of hours service?

3. Have you previously ever used the GP out of hours service?

Yes	
No	

If answered No to question 3, proceed to question 4.

3. (1). If Yes, how was your experience of the service? And how long ago was it that you used it?

4. Did you call NHS 111 before coming to A & E?

NHS 111 is a medical helpline which you can ring when you need medical advice but it is not a 999 emergency.

Yes	
No	

4. (1). If No, what was your reason for not using this service?

4. (2) If Yes, did they tell you to come to A&E? And how was your experience of the service?

5. Have you previously ever used NHS 111?

Yes	
No	

If No proceed to question 6

5. (1) If Yes, what was your experience of the service? And how long ago was it that you used it?

6. Did you attempt to self medicate before coming to A&E e.g. with either over the counter medication or with prescribed medication?

Yes	
No	

6. (1). Please provide details to your answer to question 6 and whether the treatment was at all effective?

7. If there was an NHS Walk-in Centre, which was separate from A&E, would you have tried that instead?

NHS Walk-in Centres provide access to treatment for minor injuries and illnesses.

Yes	
No	

8. Did you know that there was previously a Walk-in Centre at Monkgate in York?

Yes	
No	

If answered No to question 8 please proceed to question 10.

9. Did you ever use the Walk-in Centre at Monkgate?

Yes	
No	

9. (1). If No, why not?

9. (2) If Yes, what was your experience of the Walk-in Centre at Monkgate?

10. Would you consider using a Walk-in Centre which was not connected to Accident and Emergency, if there was one in York?

Yes	
No	
Don't know	
Depends	

10. (1) Please explain your answer to question 10

11. Which service are you here to access: Urgent Care Centre, the Emergency Department or GP Out of hours?

Urgent Care Centre	
Emergency Department	
GP Out of Hours	
Don't know	

12. What do you think about the service at Accident and Emergency in York?

13. Is there anything further that you would like to say about your visit to A & E?

14. Have you ever heard of Healthwatch York?

Yes	
No	

15. If you had a bad experience involving Health or Social care services would you report it?

Yes	
No	
Maybe	

15. (1) If No, why would you not report it?

15. (2) If Yes or Maybe, who would you report your bad experience to?

NHS Clinical Commissioning Group	
Care Quality Commission	
Healthwatch York	
Patient Opinion	
The Hospital	
Don’t know	

About you

Finally, we'd just like to ask you some details about yourself. Please note that we will treat all information provided as confidential, and you can leave any questions you do not wish to answer blank.

16. For monitoring purposes please tell us the first part of your postcode, eg YO24

17. What is your gender?

18. How old is the person who is in need of treatment? (please tick as appropriate)

0-5	
6-17	
18-25	
26-35	
36-45	
46-55	
56-65	
66-75	
Over 75	

19. How would you describe your ethnic origin?

20. How would you describe your religious beliefs?

21. What is your sexual orientation?

22. Do you consider yourself to be a disabled person?

Yes	
No	

23. Are you a carer?

Yes	
No	

Appendix 3: Interview with service user with mental health issues

Interview with service user with mental health issues

A&E

She attended A&E on a number of separate occasions from overdosing a few years ago. But she had negative experiences with the reception at A&E saying things such as “oh it’s you Mrs A again”. There was another incident when the service user had slipped and had hit her head and the hospital sent her away after checking her over and did not put in place any aftercare support. She ended up putting complaints into ICAS. She has not been to A&E since then and would not feel comfortable having to attend A&E in future.

Walk in centre

The service user had previously used the Walk in Centre when it was located at Monkgate. However since the Walk in Centre has been relocated within the A&E department she has not used it because she feels that A&E is too busy and this puts her off going to the Walk in centre. The service user said that her experience of the Walk in centre was varied and sometimes they were really good, but other times she had a similar experience as at A&E and the reception staff would talk down to her and she didn’t like their attitude.

NHS 111

The service user expressed really positive feedback about recent use of NHS 111. She said how she used the service a few weeks ago and the person was friendly and helped calm her down and told her to get a cup of tea. She calmed down and had a cup of tea and felt much better. When asked if the NHS 111 person was qualified enough she said that the person was.

GP and GP out of hours

She has recently had very positive experiences with her GP who knows her and she has really helped her with some “physical problems” not related to mental health which she has been having. She said she is often able to get appointments on the same day if she rings in the morning because if someone cancels then she can see a GP. However

she is just given any GP who is available and, if she wants to see the GP that she is familiar with, she usually has to wait a couple of days to get an appointment. The service user said how she feels much more comfortable talking with the particular GP who she knows and likes because they are both familiar with one another and the service user likes that the GP listens and is nice. The service user also expressed some negative experiences with previous GPs who she did not feel listened to her and one particular GP she refused to see again due to a negative experience. The service user said that the reception staff at her GP surgery were not always welcoming.

The service user suggested that the problem with the GP Out of hours service is that the GP does not know you and you don't know them. She has used the service a few times and said it is okay if you get the right doctor who is nice, but she prefers going to see the GP that she knows.

PALS Mentioned how Patient Advice and Liaison Service always listen to her.

The support of Mainstay mental health service

Mrs A was referred to Mainstay from Mind and she said "I can't praise Mainstay enough for the support they have given me" and they have really helped me with my mental health issues and that "I wouldn't know what to do without them". She said the support of Mainstay helps prevent her from reaching crisis point and help keep her mental health and well being more stable, even though it does still fluctuate. She also mentioned how she was signposted to Mind beforehand by her GP. Mrs A said how there are not enough support services for people with mental health issues to prevent them from reaching crisis point.

Appendix 4: York Pathways with Together and Crisis and Access Service

York Pathways with Together

The York Pathways team was set up by Together for the purpose of reducing demand placed on Emergency services from people with mental health issues. This includes an increased demand placed on A&E for people presenting with attempted suicide and self-harming. It was also highlighted how individuals with mental health issues were calling 999 for support and the 101 number was set up to try and deal with this issue.
http://www.together-uk.org/together-to-support-individuals-experiencing-mental-distress-to-reduce-crisis-contact-with-emergency-services-in-york/

Crisis and Access service

The service manager at the Crisis and Access service at Bootham Hospital has seen an increase in Mental Health presentations to A&E and the Crisis and Access service, an increase in the number of section 136s and an increase in the demand on beds at hospitals and mental health hospitals in York, made by people with mental health issues.

Appendix 5: NHS 111 visit and service development & relationship manager and Emergency Care Practitioner interview findings

NHS 111

This section is partly informed by a visit a member of the Healthwatch York team made to the NHS 111 Yorkshire Ambulance Service Headquarters and consultations with the Service Development & Relationship Manager and an Urgent Care/Emergency Care Practitioner.

NHS 111 is a free telephone service which provides urgent medical help or advice in circumstances which are not an emergency or life-threatening situation (NHS Choices, 2015). NHS 111 call advisers, including those working in Yorkshire Ambulance Service centres, use the NHS Pathways clinical assessment system in their consultations with callers, in order to assess the symptoms of the patient. They then provide medical advice or direct them to a local health service that can help them, which includes A&E, GP surgeries, GP out-of-hours, urgent care centres, walk-in centres, minor injuries units, a community nurse, an emergency dentist, a late-opening chemist or 999. Where possible, NHS 111 will also book an appointment for the caller or divert them directly to the service which they need. If the call adviser assesses the need for an ambulance then they will immediately arrange for one to be deployed (NHS Choices, 2015).

The Enter and View survey revealed that a number of respondents did not use NHS 111 before attending A&E because they believed that they would be referred to A&E by NHS 111 and therefore it was a waste of time. NHS 111 has been criticised for allegedly referring a large number of people to A&E. However the number of NHS 111 calls where the recommended course of action is to attend A&E is a small minority, with only an average of 7.0% of NHS 111 Yorkshire Ambulance Service calls, in January 2015, resulting in A&E dispositions.

The Service Development & Relationship Manager it was said how there is an issue with some patients being directed to the Emergency Department due to insufficient alternative provision, for instance a lack of emergency dentists means that patients with urgent tooth problems are often referred to the Emergency Department.

The majority of callers to NHS 111 do not speak to a trained medical clinician, unlike the NHS 111's predecessor NHS Direct which was staffed by medical clinicians. This is due to the significantly greater cost in commissioning a service where all call handlers are medical clinicians. However if the initial Pathway's assessment deems it appropriate, then callers can be diverted through to one of the medical clinicians at the NHS 111 centre, which is queued based on the level of urgency.

Emergency Care practitioners

During the visit to the NHS 111 Yorkshire Ambulance Service Headquarters an Emergency Care Practitioner was also interviewed. Emergency Care Practitoners/Urgent Care Practitoners try and prevent unnecessary admissions to hospitals and are triaged from 999 calls and ambulance crews. In the Vale of York they are now also starting to take direct referrals from Nursing homes and Homeless Hostels, with the scope for expanding to police custody suites and Mental Health care providers.

Appendix 6: One to one with University of York student findings

A&E

The student had attended A&E on three separate occasions whilst being a student at the University of York:

1) "I ended up fracturing one of my knuckles. I initially didn't go because the doctor just told me to strap it up. But it got worse and I went to A&E. "
2) "I went to A&E for a suspected broken ankle and I didn't go to the doctor first. I went to A&E straight away because they would only send me to A&E and based on previous experience if the GP couldn't tell if it was broken he would just tell me to go to A&E. My ankle was about the size of my fist, so I thought it was broken. "
3) "I went to A&E for headaches. I went for an MRI and I went to the GP beforehand."

NHS 111

The student said that he used NHS 111 once, but not on any of the occasions relating to the times he attended A&E. He stated how he had used NHS 111 once for a friend who was visiting, and they therefore did not have access to the GP for her. They did not attend A&E because the next day his friend was okay. He said that the service was very good and they look at you as a whole person and they were really nice and understanding and they gave him a call back later to see how his friend was.

Self-medication

He said how he strapped up both his knuckles and his ankle before attending A&E to try and treat the injuries. He also said how he used anti-inflammatory medication on his ankle, but it was not successful.

GPs and the health induction process at the University

The student said that he registered with a GP when he first came to the university as an undergraduate as part of the induction process at the University of York. He said that University of York students are able to access any of the Unity Health GP surgeries in York based at: the

University, Hull Road and Wenlock Terrace and he had personally accessed the GP surgery at the university and Wenlock Terrace.
In terms of issues with booking appointments, the student suggested that he had issues booking appointments at the GP surgery on campus and stated how on one occasion: “I remember I had an ear infection and it would have been a 3 week waiting list.”

He suggested, however, that they not were informed of any other health services, other than the GP, which they could access including: NHS 111, GP Out of Hours, the Walk-in Centre and pharmacies.

Walk-in Centre
The student said he had assisted one of his friends to the Walk-in Centre when it was at Monkgate.

The student said that he would prefer to use a Walk-in Centre than A&E: “I would prefer to use the Walk-in Centre than A&E. You always feel a bit bad for going to A&E. I went with my girlfriend; she had really bad stomach aches. But the A&E just said that it was just a stomach problem. But it was a chronic illness and she had to have medication for ages. If I had have known about it I would have used the walk in centre for the first occasion.”

Self-triage
The student suggested a self-triage thought process where he considered which out of the GP, A&E, Walk-in centre, NHS 111 or the pharmacy was the most appropriate service to access. The student said that he would attend A&E immediately if he had something which was causing him distress.

How to reduce demand on A&E

- longer opening hours- particularly Bank Holidays.
- Have some better facilities- a lot of universities have x-rays and there are a lot of medical students who could help out.
- Now they have opened up a drop in in the morning at the University Unity Health which could be extended.
- Include more information on local health services in student induction pack

Appendix 7: One to one with York St John's University student findings

The student had attended the A&E department at York Hospital on one occasion when she used the GP Out of Hours service.

The scenario
First of all the student had tried to ring the University GP but it was just about to close when she rang. She then rang NHS 111 because one of her friends suggested for her to ring them. She had never heard of the service and had never used the service before her friend mentioned for her to use it. She stated how NHS 111 were really helpful and they suggested that she should go to the pharmacy and get some car sickness tablets and then phone back if she didn't feel any better.

She then said how NHS 111 booked her an appointment with the GP Out of Hours at York Hospital A&E because she wasn't feeling any better having taken the medication from the pharmacy and how she had not intended to go to GP Out of Hours before they suggested it and booked her in with an appointment:

"I wasn't thinking about going to A&E but 111 told me to go there. I had just wanted advice because I wasn't feeling well. 111 said to get mediction and see how I felt afterwards. But I didn't feel any better, so I rang them again and they then referred me to A&E... and they booked me in within an appointment at the GP Out of Hours."

NHS 111
The service user expressed that she had a very good experience of NHS 111 when she used it on the one occasion. They gave her very good advice, directed her to self-medicate first of all and they then booked her an appointment at GP Out of Hours because her condition did not improve.

GP and York St John's University induction process
The student stated how she had to register with a GP as part of the induction process when she first went to the University:

"It was part of the starter pack before they even gave us our keys- to register with a GP and there was a form in the starter pack"

However she stated that they didn't provide any other information, as part of the induction, about health services which they could access in York.

She stated how there is one GP surgery on campus which is where you are registered as a student at York St John's University and which is exclusively for students at York St John's University.

She suggested that she had not had any issues with booking appointments at the GP. She booked an appointment and she was able to get an appointment on the same day but she did not end up going to the appointment in the end.

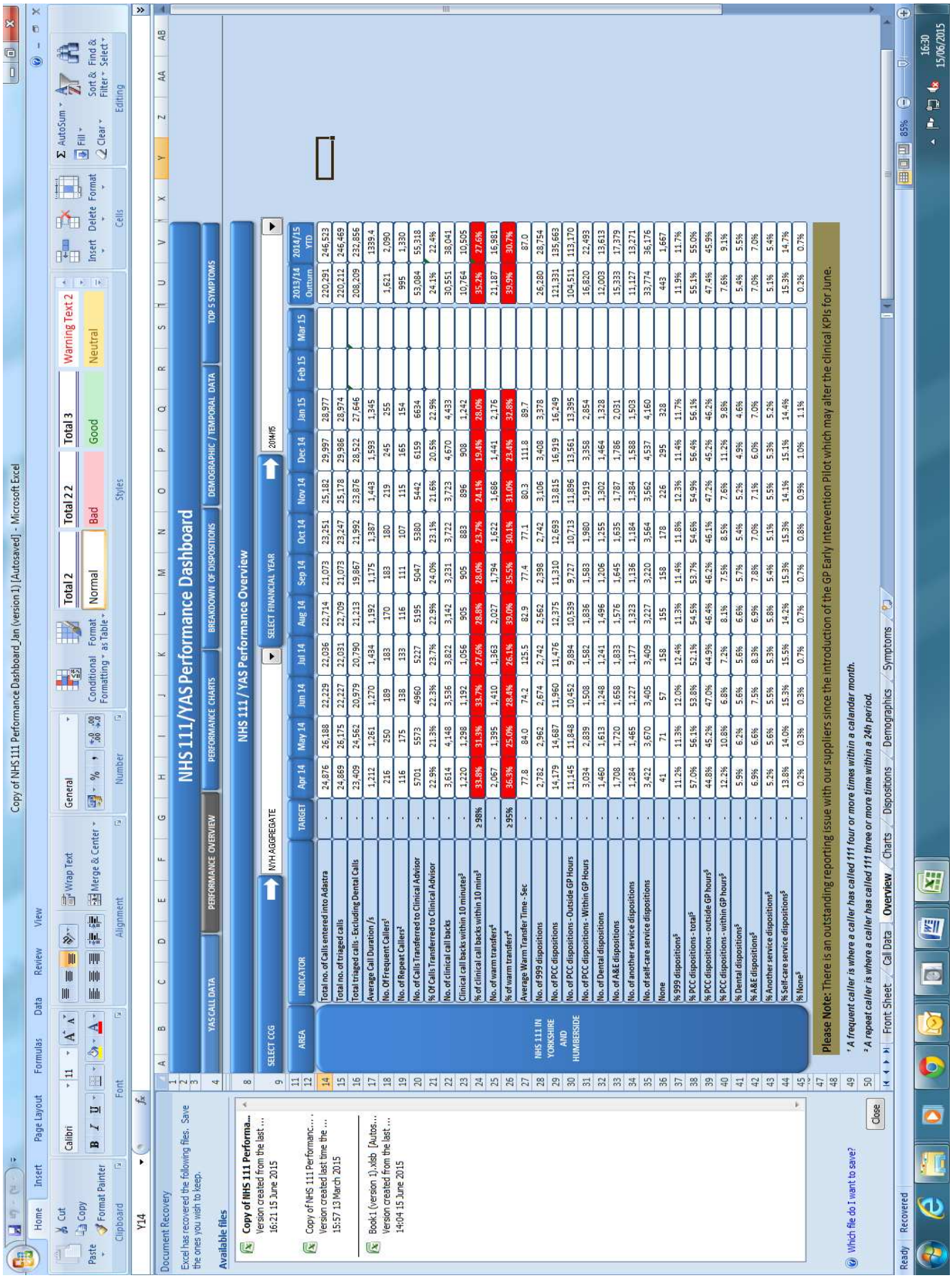
GP Out of Hours

The student said that she had heard of GP Out of Hours previously, but she did not know that the nearest one to her house in York was at York Hospital. NHS 111 told her that that was the nearest one and booked an appointment for her that evening.

Walk in Centre

The student was not aware of what Walk in Centres were and she did not live in York when the Walk in Centre was at Monkgate. The student was informed of what Walk in Centres were and was then asked "Would you consider using a walk in centre which was not connected to A&E, if there was one in York?"

To which she replied: **"**Yeah definitely if they could prescribe and then help".



Appendix 8: NHS 111 Performance database

Acknowledgements

This work has been supported by a wide range of individuals and organisations. It would not have been possible without their willingness to work with us. Particular thanks must go to;

- York Teaching Hospital, both in A&E and within the Patient Experience Team
- Leeds & York Partnership NHS Foundation Trust's Service Manager
- Everyone at Mainstay
- York Pathways with Together
- Yorkshire Ambulance Service, especially NHS 111 and the Urgent Care Practitioners

We must also thank everyone who took time to speak with us, especially those people who gave us hours not minutes to hear their story. Every single voice we hear helps us develop a richer understanding of what happens in health and social care in our city. We are nothing without your words, and we remain profoundly grateful to those who help us be more.

Last, but definitely not least, we must acknowledge Nick Redding, who spent time with us from February to June 2015. He created this report based on our brief explaining what the public had asked us to look at. He was determined to do more, reach more and hear more. I hope he learnt a lot during his time with us, and we certainly learnt a lot from him.

It was great having you with us, Nick. Thank you.

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York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York. York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This report

This report is available to download from the Healthwatch York website: www.healthwatchyork.co.uk

Paper copies are available from the Healthwatch York office

If you would like this report in any other format, please contact the Healthwatch York office

ANNEX C

Discharge from health and social care settings

October 2015

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Acknowledgements

We would like to thank:

- York Teaching Hospital NHS Foundation Trust, especially the staff at the discharge lounge
- All our volunteers who helped with the work for this report, especially Gabi Gorin for her work with people using the Age UK York Hospital transport scheme
- Everyone who shared their experiences, particularly our partner organisations who helped make sure their members experiences were heard

Discharge from health and care settings

Background

This report looks at the experiences of people in York being discharged from health and social care settings. It sets out how we identified this as an area to investigate and what we have done in response. It makes recommendations to tackle identified issues, and highlights areas of good practice.

Being discharged from hospital and other health and social care settings affects significant numbers of people each year. NHS hospitals dealt with 15.1 million admissions in 2012-13 - or about 41,500 admissions per day on average across England (HSCIC website). The majority of these people will leave hospital following admission.

When discharge goes wrong it is not only a problem for an individual, it can have a significant cost to the health and social care system. In 2012-13 there were more than one million emergency readmissions within 30 days of discharge, costing an estimated £2.4 billion. (www.nao.org.uk)

Why Healthwatch York decided to look at this issue

In our 2014 workplan survey, over 75% of people who responded felt that discharge from hospital should be part of our work plan. They told us we should look at planning for leaving hospital and getting home as soon as possible, involving patients and carers in plans and planning care for when patients get home.

Comments made by respondents to the survey included:

“Patients are being sent home far too quickly. Is there any verbal liaison between hospital and social carers?”

“I had difficulty in transferring my wife from hospital to a care home and finding suitable care for my wife.”

In addition to the comments from the workplan survey, during 2014 we received 20 individual pieces of feedback from people about their experience of hospital discharge. This feedback is included in Appendix 5. It raised issues about:

- Timing/speed of discharge
- Transport
- Personalised, co-ordinated care
- Community nursing and Social Care Support after discharge
- Involving carers in discharge planning
- Being discharged from mental health services

Feedback included:

- “The hospital did not inform my daughter that I was being discharged – it all felt very sudden when I was told to leave. Everything else was brilliant but I felt it all happened too quickly.”
- “I felt the drop off service could have stayed a bit longer – they saw me into the house but didn’t hang around. My wife is disabled and we could have done with extra support from them to settle me in.”
- A woman was discharged after 5 days on the acute stroke ward and had been told someone would be at her home to meet her and provide support. However, she was on her own from 9am on the day she was discharged until the following afternoon. There was no food in the house and she survived on coffee and water.
- “When my father was discharged from York Hospital, although staff had let his carers know he was going to be discharged, no one contacted me. If I hadn't phoned the hospital and found out he was to be discharged, he would have had no way of getting into his home (he cannot use the key box).”
- A young carer with mental health issues was referred to Limetrees. He needed to re-arrange appointments due to his caring responsibilities and was taken off treatment. He then had to go back to his GP for a new referral.

In 2014 Healthwatch England identified discharge from hospital as a national priority. We were able to share some of our initial findings with them. Their special inquiry, focussing on the experiences of older people, homeless people and people with mental health conditions, began in the summer of 2014. The resulting special inquiry report: ‘Safely home: what happens when people leave hospital and care settings?’ was published in July 2015. It is available via the Healthwatch England website: www.healthwatch.co.uk. Contact the Healthwatch York office if you need a paper copy.

Discharge of people with long term conditions back to their GP

In addition to the feedback we received about inpatients being discharged from hospital, during the period February to June 2014 we also received feedback from outpatients with long term conditions who had been discharged from their hospital consultant back to the care of their GP as part of a major system change. Patients with conditions including Myasthenia Gravis, Multiple Sclerosis and Rheumatoid Arthritis reported that GPs are not always confident dealing with their condition. (See Appendix 8)

What we did to find out more

We undertook actions 1-4 to find out more about discharge from health and care settings, and actions 5 & 6 to find out more about discharge back to GPs.

1) To support an evaluation of the Age UK York Hospital Discharge Service, we carried out a telephone survey of people who were supported by the service to leave hospital. During May 2014 we spoke to 31 people who had used the Age UK York escorted transport service following discharge from hospital between February and April 2014.
2) We carried out a survey (see Appendix 4) asking people about their experiences of being recently discharged from a hospital or care setting in York. The survey was available via the Healthwatch York website and in paper form from 1st August 2014 until 30th September 2014. There were 23 respondents in total.
3) We carried out an Enter and View visit to the Discharge Lounge of York Hospital on Friday October 24th 2014 to speak to patients as they were waiting to be discharged. Staff and trained volunteers were in the discharge lounge from 8am until 5pm. We used a specially designed questionnaire to capture peoples' experiences. During the visit we spoke to 22 patients in the discharge lounge and 2 on elderly care wards. At the end of each conversation we asked whether people would be willing for us to contact them 2 weeks later to find out how they were getting on. 15 patients gave us consent to do this. We were able to contact 8 of these patients to ask them some further questions. Our Enter and View report, which included a number of recommendations, was published in spring 2015. The full report is included at Appendix 1.
4) We gathered feedback on discharge from health and social care settings at a workshop following our Annual Meeting in July 2014. The workshop was attended by 45 people. Feedback from this workshop is included at Appendix 6.
5) We gathered feedback on discharge from hospital consultants to GPs at a workshop following our Annual Meeting in July 2014. The workshop was attended by 45 people. Feedback from this workshop is included at Appendix 7.
6) We sought feedback from people with long term conditions about their experience of being discharged from a hospital consultant to their GP. People with Rheumatoid Arthritis were identified as one group who often have issues with discharge, and specific feedback was sought at a York Rheumatoid Arthritis Support Group Meeting in May 2014. This feedback is included at Appendix 8.

What we found out

1) Findings from our telephone survey to evaluate the Age UK York Hospital Discharge Service

All 31 people we spoke to who had used the Age UK service said they were happy with the service and almost all (97%) commented that they could not say a bad word about it and had no complaints. Most commented that the physical support and the way in which they were given reassurance by the Age UK York worker when they returned home made them feel much more at ease and settled.

Some of the things which were particularly appreciated were: helping with bags, seeing people into their house/flat, making sure the heating was on, making a cup of tea or a sandwich, checking the house was safe, putting the TV on, passing efficiently over to carers, assisting people with stairs.

However, three people reported that they felt sufficient notice was not given to the patients' family members when they were being sent home from hospital, leaving them feeling as though it had been "sprung" upon them without warning.

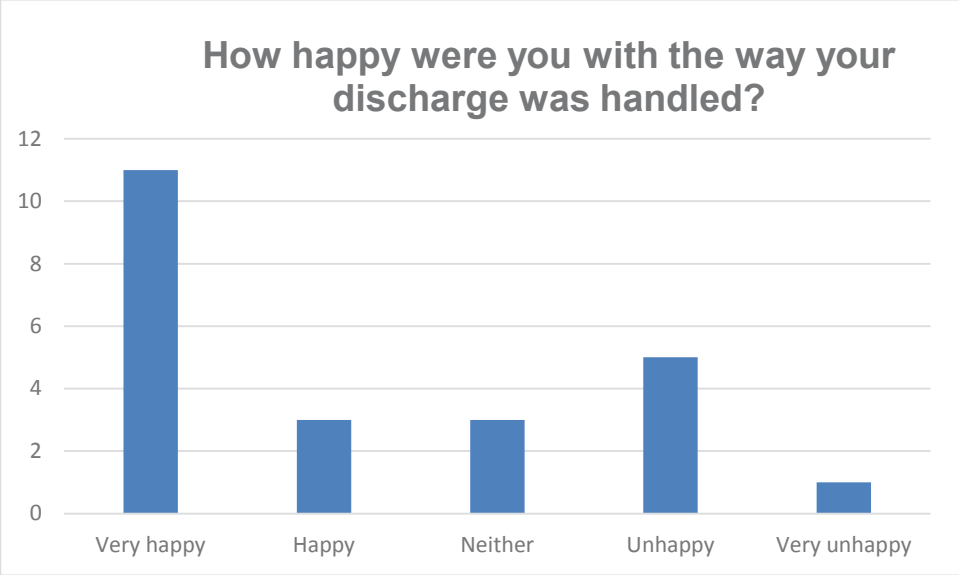
One woman speaking on behalf of her father explained that when her father was discharged from hospital they were given very little notice to prepare for his arrival home, which caused some distress to the patient's wife who has limited mobility due to a disability.

Another woman commented that her daughter was not informed of her discharge from hospital. She was concerned this may have led to issues had her daughter visited the hospital expecting her mother to be there, when she had already been discharged.

2) Findings from Healthwatch York's hospital discharge survey

The main issues identified by respondents around discharge were failings in communication. For instance one respondent felt 'un-listened to', one complained about the lack of a clear discharge time being given, one complained of their midwife not being notified of their discharge, whilst another implied that staff had not followed through on what they had said they would do.

In total 23 people responded to our survey of whom 21 had been discharged from York Hospital. 1 person had been discharged from Clifton Park Hospital and 1 from Nuffield Hospital; both of these respondents said they were 'very happy' with the way their discharge was handled. Over half of the total number of respondents were either 'very happy' (11 people) or 'happy' (3 people) with the way their discharge had been handled. 5 people were 'unhappy' and 1 person was 'very unhappy'.



One respondent, who indicated they were 'happy' with the way their discharge was handled said: "I was given a lot of paper information without very much explanation and found this quite hard to take in. I live on my own and did not feel ready to cope at home but quite understand that there are many people worse off than myself needing hospital care."

One respondent, who indicated they were 'unhappy' with the way their discharge was handled said: "It was not the right time to be discharged. I felt the reasons for discharge were primarily pressure on staffing levels."

Another respondent, who indicated they were 'neither' happy nor unhappy with the way their discharge had been handled said: "Staff were excellent but the process was slow, uncertain & I didn't know what time it (discharge) would take place as I was waiting for my medication."

3) Findings from the Enter and View visit to the discharge lounge at York Hospital

The full report of the Enter and View visit was published in early 2015. It can be downloaded from the Healthwatch York website and paper copies are available from the office. The following is a summary of the findings from the visit.

<u>Where patients were being discharged from</u>

Three of the people we spoke to were day unit patients, two had been discharged from Ward 23, two from Ward 29. The others were all being discharged from different wards.

How long patients had been in hospital

Four patients had been in hospital just for the day. Of the others:

4 patients	1 night
2 patients	2 nights
2 patients	3 nights
2 patients	4 nights
1 patient	5 nights
3 patients	1 week
2 patients	10 nights
3 patients	2 weeks

Arriving at hospital

Thirteen patients had arrived at hospital by ambulance, seven had been referred by their GP, one had been admitted via A & E, one arrived by bus and one was unsure.

How people felt about their treatment on the wards

There were a lot of very positive comments about the care and treatment patients had received during their stay in hospital. Comments included ‘Very good’, ‘excellent’, ‘I was well looked after‘, ‘absolutely excellent’, ‘no one could have been more hard working and kind’, ‘fantastic’, ‘I was treated with kindness and humanity’, ‘perfect treatment’, ‘very good – all the staff are excellent’. There were two positive comments about the food in hospital.

The only negative comments were: ‘terrible mattress’ (ward 25), ‘very noisy at night’ (ward 22), ‘not enough information is given by doctors due to time restrictions and the use of jargon in explanations’ (ward 22).

Additional health conditions

Thirteen patients had a health condition in addition to the one for which they were admitted. All these patients felt that their additional health conditions had been managed effectively.

Did patients feel ready to be discharged?

Twenty patients said they felt ready to be discharged. One said they ‘were a little bit anxious’, one felt they ‘could have done with a couple more days’ and one said they still felt a bit weak.

Did patients have everything they needed?

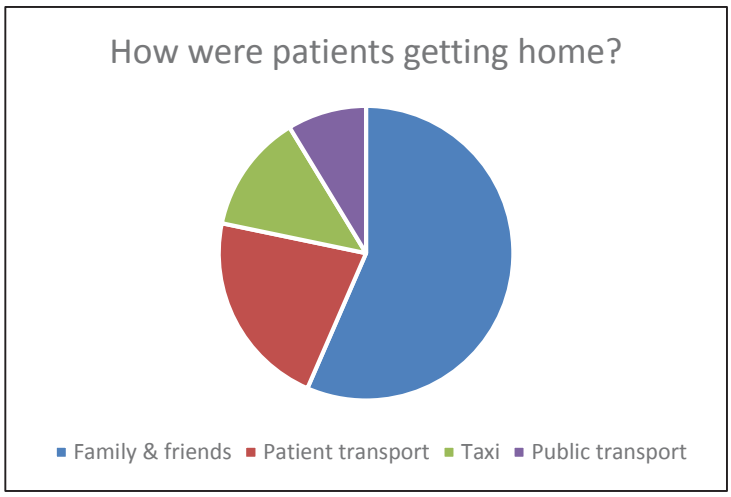
Nineteen patients said they had everything they needed. One was still waiting for their discharge letter, three were still waiting for their medication.

Where were patients being discharged to?

Eighteen patients were being discharged to their own homes, three were being discharged to care homes, one was being discharged to sheltered accommodation and one to St Helens rehabilitation hospital.

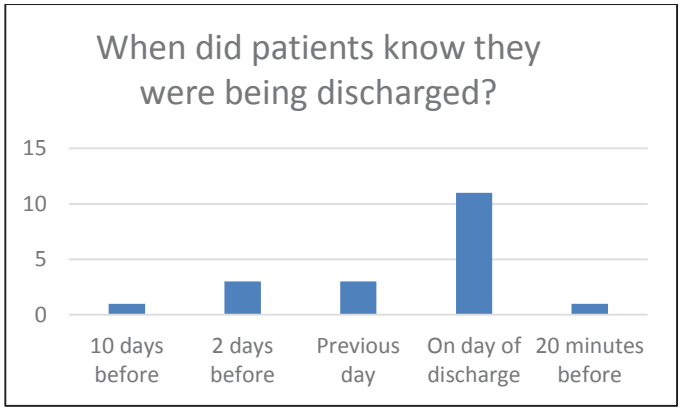
How were patients getting home

Thirteen patients were being collected by family or friends, five were using the patient transport service, three were getting taxis and two were using public transport.



When did patients know they were being discharged?

Four patients had only been admitted for day care. Of the rest, one patient said they knew when they were going to be discharged before they came into hospital, one knew ten days before. Three patients were told two days before, three were told the previous day. Eleven patients had been told on the day of their discharge. One patient who had been in hospital for two days was told they were being discharged twenty minutes earlier.



Were patients and their families involved in the discharge process?

Only one patient said that neither they nor their family had been involved in discharge planning. All the rest of the patients said that they and their families had been involved as appropriate.

Would people need help after they were discharged?

Ten patients said they would need help after they were discharged. Four of these people said they would be getting help from family members.

Were patients happy to go home in the clothes they were wearing?

All the patients we spoke to were happy to go home in what they were wearing, including the three patients in their nightwear.

What did patients think could be improved?

Three patients said that said getting their medication from the pharmacy more quickly would improve their experience. One patient said that they would have preferred to have a shower, and have more time to talk about their condition and medication. This patient was in the discharge lounge at 10.50am, and had only been told they were to be discharged that morning.

How did people feel about the discharge process two weeks later?

Two weeks after their discharge we were able to ask eight people how they felt about the discharge process. All eight people felt they had been discharged at the right time. No one identified any problems or suggested anything about the discharge process that they would change.

4) Findings from workshops following our Annual Meeting in July 2014

The notes from the workshops are in included in Appendices 6 and 7.

Feedback about discharge from health and social care settings revealed the following themes:

- Good communication between the patient, family, carers and all organisations is essential
- It is important to have the right care package in place at discharge with all relevant people being made aware of a patient's discharge. It is important that services are joined up.

Feedback about discharge from hospital consultants to GPs revealed two main themes:

- Poor communication - many people didn't know the change was happening. They were discharged from their consultant but they didn't know why, and didn't know how to get back into the system. The MS Society reported that patients had been informed by letter (which was described as 'blunt') or at the clinic and there was poor or no communication from the hospital.
- Concerns about GPs capacity to manage the extra workload and whether any extra resources, such specialist nurses, would be available.

5) Findings about discharge from hospital consultant to GP from people with long term conditions

Patients with Rheumatoid Arthritis were identified as a specific group who have issues with discharge from hospital consultants to GPs. Feedback from York Rheumatoid Arthritis Support group (YORKRA) and issues raised by other support groups and individuals is included in Appendix 8.

YORKRA expressed concerns around service users not being involved in discussions of transfer of care to GPs. There was also a feeling that the appointment system, where people are sometimes unable to change their appointment, but penalised if they miss two by being discharged, was unfair. It was also felt that GPs were not confident in dealing with the condition, but were often unable to contact specialists and unresponsive to patient's comments on treatment.

Feedback from other support groups and individuals included:

- Two patients with Myasthenia Gravis reported they were told by consultants at York Hospital that their discharge back to GPs was necessary to save money. Though their conditions were stable they were unhappy because it takes two weeks for them to get a GP appointment

and the patients feel that GPs do not know enough about Myasthenia Gravis, which is a rare condition.

- One patient reported that their consultant made it clear they were not happy discharging Myasthenia Gravis patients back to their GPs.
- An MS patient who was discharged by an MS nurse found that their condition deteriorated with no medication available from GP.
- Patients are being discharged from the Headache Clinic at York Hospital without consultation with the patient or their GP.
- One diabetes consultant told a patient that he had to remove 30% of his patient list by referring them back to GPs.
- A woman who saw a consultant at York Hospital over a wrist injury was told she could not be put on the waiting list for after care as they were not allowed to add anyone else to the list so she would be referred back to her GP.

Summary of findings

1) **Communication between hospital staff and patients, families and carers about when they will be discharged is not always good.**

People have a sense of their discharge being 'sprung on them' at the last minute. Only five of the 23 respondents interviewed during the Enter and View visit in the discharge lounge of York Hospital had been notified of their discharge more than 24 hours previously. As well as the distress this can potentially cause to the patient it can also have an impact on their family and carers who may struggle to make arrangements at short notice.

One woman described how she made the three bus journeys to meet her husband in hospital only to be told he would be not discharged. She set off for home, but shortly after arriving home she was notified that he would be discharged after all. This resulted in her making the journey again by public transport. On arrival she was told that patient transport could not take her home as well as her husband.

2) **There is not enough affordable and safe transport to take patients home**

There is a high level of reliance on family and friends to provide transport home. Thirteen of the 23 patients interviewed during the Enter and View visit said that family or friends were taking them home.
Two patients said they were using public transport and three were using taxis, neither of which provide any level of care for patients who are potentially vulnerable, particularly at night. Only five of the 23 patients were using patient transport.

> "York Hospital booked a taxi for me at 2am. I was dropped off at home and left on my own in a dark hallway feeling physically and mentally uneasy."

Patients who had used the Age UK York escorted transport service were very strongly positive of it. Of 31 respondents 97% had no complaints and 100% would recommend the service to a friend.

3) **The care and support people need after discharge is not always in place**

There was a common perception that the current follow-up care provision is not sufficient.

- One woman was told someone would be at her home to meet her after leaving the stroke ward, however no one came until the next afternoon leaving her alone in the house with no food.

- One person suggested that a follow up GP appointment should be automatic whilst another commented a ‘follow-up at home would have been great.’
- One woman reported having received only 2 minutes instruction on her 88 year old husband’s catheter bag, and not receiving a visit from a district nurse for 3 days.
- A new mother said that she and her baby went without checks for 3 days because the midwife had not been notified of their discharge.

4) Some people have experienced problems with discharge from mental health services

There seems to be confusion as to whose remit a person comes under if they have multiple conditions. One woman reported that she had been ‘bounced’ between the Community Mental Health Team, a pain clinic and a GP. She felt that none of them provided the care she needed.

There was also a report of ‘waiting list management’, where a woman was encouraged to take a course not directly applicable to her, before being subsequently discharged against her will.

We received feedback that psychiatrists provided through Community Mental Health Teams and Crisis Teams are perceived to not listen well to patients and overrule their wishes, compounding feelings of despair in patients. There also seems to be a lack of personalised care. A young carer with mental health issues was discharged from Limetrees when he re-arranged appointments because of his caring responsibilities.

5) Being discharged from hospital consultants to GPs has caused concern and anxiety.

For a number of people, particularly with long term conditions such as Rheumatoid Arthritis, Multiple Sclerosis and Myasthenia Gravis, being discharged back to their GP has caused concern and anxiety. Communication seems to have been patchy and patients have received mixed messages. Since this feedback was gathered, Healthwatch York understands that the policy has been reviewed for a number of groups of patients.

NHS Vale of York Clinical Commissioning Group has provided assurance that such patients should have access to support and encourages anyone with concerns either to get in touch with them directly or through Healthwatch York.

Recommendations

Healthwatch York has made four recommendations to York Hospital in our report on the Enter and View visit to the Discharge Lounge.

1) Consider ways in which reliance on family and friends for transport home can be reduced. For example working in partnership with voluntary organisations such as Age UK York and York Wheels to make sure patients have access to affordable and safe transport home.
2) Patients should be given at least 24 hours' notice of their discharge time, and this time should be kept to as closely as possible.
3) Consider whether patients who are ready to be discharged could be 'fast tracked' so that they receive their medication from the pharmacy as quickly as possible.
4) Review the frequency with which the IT system is updated with the expected date of discharge for patients. This would help the facilitating rapid elderly discharge (FREDA) team correctly identify patients who were ready for discharge and not spend time with patients who were not actually ready to go home.

As a result of the Enter and View report York Teaching Hospital NHS Foundation Trust has produced an action plan. Key points of the plan include finding out about patient's preferences for transport home and reviewing key communication messages between staff and patients prior to discharge.

From the feedback we have received from other sources we make the following additional recommendations:

Recommendation	Recommended to
5) Consider giving patients the option to request that a family member/carer be notified of their discharge time at the same time as the patient themselves.	York Hospital
6) Consider how to improve the consistency of approach to conversations between hospital staff and patients about what follow up care they will be receiving and the organisations they are signposted to.	York Hospital
7) In order to increase awareness and understanding of patients' pre-existing	York Hospital

conditions, consider the use of health 'passports' which can be referred to at all stages of a patients' hospital stay and discharge.	
8) Consider all the relevant feedback in this report when delivery of the new mental health contract begins in October 2015.	Tees, Esk and Wear Valley NHS Trust
9) Consider using patient participation groups at GP practices to gather feedback from patients who have been discharged back to their GP to make sure that the process is working effectively.	NHS Vale of York Clinical Commissioning Group, GP practices

Appendices

Appendix 1: Healthwatch York Enter and View report on Discharge from Hospital

Appendix 2: Enter and View visit questionnaire

Appendix 3: Healthwatch York Enter and View visit follow up questionnaire

Appendix 4: Discharge from hospital survey

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Appendix 8: - Discharge from Hospital Consultant to GP. Feedback from York Rheumatoid Arthritis Support Group Meeting 10th May 2014 plus direct feedback received at Healthwatch York

References

[1] http://www.hscic.gov.uk/article/3674/41500-patients-admitted-to-hospital-every-day-in-England---up-nearly-13-per-cent-in-five-years Taken from HSCIC website 10.12.14

Appendix 1 - Enter and View report

York Teaching Hospital NHS Foundation Trust
York Hospital **24th October 2014**

What is Enter and View?

Enter and View is the opportunity for authorised representatives to visit publicly funded health and social care services to see and hear for themselves how services are provided.

Authorised representatives collect the views of people receiving services and observe service delivery. They can also talk to families and carers.

Healthwatch York authorised representatives are members of the public who have been recruited as volunteers and have received specific training. Training includes disability awareness, safeguarding (level 1 alerter) and Enter and View training (in line with Healthwatch England's recommendations).

Why did we carry out this visit?

Discharge from hospital was voted onto Healthwatch York's work plan by members of the public in our 2014 survey. Over 75% of people who responded to our survey felt that discharge from hospital should be on our work plan. Their concerns included:

- Planning for leaving hospital and getting home as soon as possible
- Involving patients and carers in planning discharge from hospital
- Planning care for when patients get home

We carried out this visit as part of our planned programme of work on this topic, in accordance with Healthwatch England guidelines. This Enter and View report will be included in our full work plan report on discharge from hospital, which will be published in spring 2015.

Disclaimer

This Enter and View report relates to the visit which took place on October 24th 2014. It is not representative of all users of the service, only those who were consulted at the time.

About York Hospital's discharge facilities

York Hospital's discharge lounge aims to provide patients who are fit for discharge with a safe, pleasant and comfortable environment. It's a place where they can wait for their transport home or relatives to collect them, freeing up space on the hospital wards. Whilst in the discharge lounge the

patient is under the care of a staff nurse/health care assistant at all times. Patients can be provided with food and refreshments and staff can help with transport issues. Patient transport staff always refer to the discharge lounge staff before taking a patient home – this makes sure that they are collecting the right patient, and that the patient has all the necessary medication and equipment they need.

The discharge lounge is located just off the main entrance to York Hospital, near the York Wheels office. There is a dedicated collection point outside the main entrance for safe and easy use by patient transport staff, taxi drivers and relatives.

York Hospital have a team dedicated to facilitating rapid elderly discharge (FREDA). Their focus is on getting people home at the right time. Healthcare assistants co-ordinate activities to help speed up morning discharge – helping patients get washed dressed and packed up. They also support elderly patients who are not on the elderly care wards.

What was the purpose of this visit?

The purpose of this visit was to speak to patients, families/carers and staff to find out about peoples' experience of the discharge process.

Who carried out the visit?

The following Healthwatch York authorised representatives took part in the visit: Fiona Benson, Karen Hukins, Laura Branigan, Lesley Pratt, Polly Griffith, Sheila Jackson.

Two members of the Healthwatch York staff team took part in the visit: Siân Balsom (manager), Carol Pack (information officer).

What did we do?

This was an announced Enter and View visit and we liaised with Kay Gamble, York Teaching Hospital NHS Foundation Trust's Lead for Patient Experience. We were aware that nationally Friday is the busiest day for hospital discharges and chose Friday 24th October 2014 for the visit. We formally notified the hospital in writing three weeks prior to the date.

We arranged a rota so that a member of staff and 2 - 3 authorised visitors were in the discharge lounge at any one time. We attended from 8am until 5pm. We put together a questionnaire (see Appendix 2) and used this when we spoke to patients to record details of their experience of the discharge process.

All authorised representatives introduced themselves to patients, briefly explained the role of Healthwatch York and outlined the purpose of the visit. Reassurance was given that all information would be treated as confidential

and no one would be identified in any report. All the patients we approached agreed to speak to us. We spoke to 24 patients in total, 22 in the discharge lounge and two on elderly care wards. 1 patient did not want to complete the questionnaire but enjoyed a conversation with volunteers.

At the end of each conversation we asked whether people would be willing for us to contact them two weeks later, to find out how they were getting on. Fifteen patients gave us consent to do this. We were able to contact eight patients to ask them some further questions (see follow up questionnaire Appendix 3).

What did we find out?

Where patients were being discharged from

Three of the people we spoke to were day unit patients, two had been discharged from Ward 23, two from Ward 29. The others were all being discharged from different wards.

How long patients had been in hospital

Four patients had been in hospital just for the day. Of the others:

4 patients	1 night
2 patients	2 nights
2 patients	3 nights
2 patients	4 nights
1 patient	5 nights
3 patients	1 week
2 patients	10 nights
3 patients	2 weeks

Arriving at hospital

Thirteen patients had arrived at hospital by ambulance, seven had been referred by their GP, one had been admitted via A & E, one arrived by bus, one was unsure.

How people felt about their treatment on the wards

There were a lot of very positive comments about the care and treatment patients had received during their stay in hospital. Comments included ‘Very good’, ‘excellent’, ‘I was well looked after‘, ‘absolutely excellent’, ‘no one could have been more hard working and kind’, ‘fantastic’, ‘I was treated with kindness and humanity’, ‘perfect treatment’, ‘very good – all the staff are excellent’.

There were two positive comments about the food in hospital.

The only negative comments were: ‘terrible mattress’ (ward 25), ‘very noisy at night’ (ward 22), ‘not enough information is given by doctors due to time restrictions and the use of jargon in explanations’ (ward 22).

Additional health conditions

Thirteen patients had additional health conditions when they came into hospital. All these patients felt that their additional health conditions had been managed effectively.

Did patients feel ready to be discharged?

Twenty patients said they felt ready to be discharged. One said they ‘were a little bit anxious’, one felt they ‘could have done with a couple more days’ and one said they still felt a bit weak.

Did patients have everything they needed?

Nineteen patients said they had everything they needed. One was still waiting for their discharge letter, three were still waiting for their medication.

Where were patients being discharged to?

Eighteen patients were being discharged to their own homes, three were being discharged to care homes, one was being discharged to sheltered accommodation and one to St Helens rehabilitation hospital.

How were patients getting home?

Thirteen patients were being collected by family or friends, five were using the patient transport service, three were getting taxis, two were using public transport.

When did patients know they were being discharged?

Four patients had only been admitted for day care. Of the rest, one patient said they knew when they were going to be discharged before they came into hospital, one knew ten days before. Three patients were told two days before, three were told the previous day. Eleven patients had been told on the day of their discharge. One patient who had been in hospital for two days was told they were being discharged twenty minutes earlier.

Were patients and their families involved in the discharge process?

Only one patient said that neither they nor their family had been involved in discharge planning. All the rest of the patients said that they and their families had been involved as appropriate.

Would people need help after they were discharged?

Ten patients said they would need help after they were discharged. Four of these people said they would be getting help from family members.

Were patients happy to go home in the clothes they were wearing?

All the patients we spoke to were happy to go home in what they were wearing, including the three patients in their nightwear.

What did patients think could be improved?

Three patients said that said getting their medication from the pharmacy more quickly would improve their experience. One patient said that they would have preferred to have a shower, and have more time to talk about their condition and medication. This patient was in the discharge lounge at 10.50am, and had only been told they were to be discharged that morning.

How did people feel about the discharge process two weeks later?

Two weeks after their discharge we were able to ask eight people how they felt about the discharge process. All eight people felt they had been discharged at the right time. No one identified any problems or suggested anything about the discharge process that they would change.

Conclusion

We observed that the discharge lounge at York Hospital provides a comfortable environment for patients to wait for their transport home and works well. The location of the lounge is very convenient and the dedicated collection point makes it easy for patients to be picked up from the lounge.

Staff manage the discharge lounge well and this helps facilitate an organised and professional discharge process. We observed that discharge lounge nurses ask patient transport staff to always go to the nurses' desk first. This makes sure that the right patient gets the right transport. The nurses check that the patient has everything they need before they go. This service is particularly valuable for patients who are confused or who have dementia.

Discharge of elderly patients often requires additional planning and co-ordination. The FREDA team is key to supporting and facilitating the discharge of elderly patients as quickly and effectively as possible.

We observed that the FREDA team were not able to be as effective as they would wish because the IT system is frequently not up to date. Staff we spoke to reported that frequently patients who were recorded on the system as due for discharge that day were not actually ready for discharge.

56% of patients we spoke to were relying on family and friends for transport home. Many people do not qualify for patient transport, and public transport is often not suitable for people who have just left hospital. Taxis are expensive and there is no onus on drivers to make sure people get into their homes safely. Eleven of the patients we spoke to had only been told

they were being discharged on the day they were discharged. This does not give either patients or carers very much time to prepare for discharge.

Recommendations

- Consider ways in which reliance on family and friends for transport home can be reduced. For example working in partnership with voluntary organisations such as Age UK York and York Wheels to make sure patients have access to affordable and safe transport home.
- Patients should be given at least 24 hours' notice of their discharge time, and this time should be kept to as closely as possible.
- Consider whether patients who are ready to be discharged could be 'fast tracked' so that they receive their medication from the pharmacy as quickly as possible.
- Review the frequency with which the IT system is updated with the expected date of discharge for patients. This would help the FREDA team correctly identify patients who were ready for discharge and not spend time with patients who were not actually ready to go home.

Thank you!

Healthwatch York would like to thank all the York Hospital staff who were involved in our Enter and View visit, both in planning the visit and on the day. We would also like to thank all the patients who spoke to us and shared their experiences with us.

Response and actions from York Teaching Hospital NHS Foundation Trust

In response to our recommendations in our draft report York Teaching Hospital NHS Foundation Trust have produced a draft action plan (April 2015).

- We will consider further what patient preference is in relation to transport home by speaking further with patients prior to discharge as feedback from patients and their relatives has not highlighted this as a concern.
- When a patient is admitted a plan for discharge is usually commenced and discussion between staff and patient takes place around approximate discharge date. Review key communication messages between staff and patients prior to discharge.
- The expected date of discharge is reviewed at least daily by the ward clinical teams as part of each patient's review and board round. Any

updates to the discharge date or reason for delay to discharge is recorded and updated as appropriate.

Appendix 2 - Enter and View visit questionnaire

Name of interviewer:	Time of interview:
I'm a volunteer with Healthwatch York. We're a local charity that finds out what people think about health and social care in York. We are working with the hospital to find out more about people's experiences of leaving hospital. Would you mind answering a few questions? Any information you give us will be kept confidentially. No details about you will be given to anyone else without your permission.	
QUESTIONS	**OBSERVATIONS**
1 Where have you been discharged from? Name/number of Ward: Name of Department:	**Interviewed in:** Discharge lounge ☐ Specialist medicine ☐ Elderly wards ☐
2 What were you being treated for?	**This person is:** Patient ☐ Carer ☐
3 How long have you been in hospital?	
4 How did you arrive at hospital? Ambulance ☐ Referred by GP ☐ A & E ☐ 111 ☐ Don't know/not sure ☐	
5 When you were on the ward, what was your treatment like? Do you have any comments about it – positive or negative?	
6 When you came into hospital, as well as the reason you were admitted, did you have any additional health conditions? (e.g. diabetes, MS) Yes ☐ (please specify) No ☐ **If yes, were these managed effectively while you were in hospital? Yes/No**	
7 Do you feel ready to be discharged now? Yes/No **If no – why not?**	

8 Do you have everything you need with you? Your medicines ☐ Your clothes ☐ Your personal possessions e.g. glasses, walking stick, keys ☐ Is there anything you need that you haven't got with you? (please specify)	
9 Are you going to your home when you leave hospital? Yes/No **If no, where are you going?**	
10 How are you getting there? Patient transport ☐ Other (please specify) ☐ Family friends collecting ☐ Taxi ☐ Don't know ☐	
11 When did you find out you were being discharged? **11 (a) Who told you that you were being discharged?**	
12 Have you been involved in the plans for you to leave hospital? Yes/No **12 (a) Have members of your family been involved in the plans? Yes/No**	
13 Do you feel confident you can look after yourself when you get home or will you need support? I can look after myself ☐ I will need help ☐ **If you need help, do you know what support you will get after you leave? If so, please give details:**	
14 Are you comfortable going home dressed as you are? Yes/No	**What is the patient wearing?** Regular clothes ☐ Nightwear ☐

15 Do you have any suggestions to improve things for people when they are leaving hospital?	
16 We'd like to contact you in a couple of weeks to find out how you're getting on – would that be ok? Yes, by phone ☐ Yes, write to me ☐ Yes, e mail me ☐ No ☐ If yes: Name: ..... Address: ..... Phone: ..... E mail:	
17 Finally, it would help us if you could answer some questions about yourself, but you don't have to answer these questions if you'd rather not: First half of your postcode: ..... (not needed if we have their address above) Age: ..... Do you consider yourself to be a disabled person? Yes/No Do you consider yourself to have a mental health condition? Yes/No How would you describe your ethnic background? White British ☐ Asian ☐ Black ☐ Chinese ☐ Other (please specify): How would you describe your sexual orientation? Heterosexual ☐ Gay ☐ Other (please specify):	**What gender is the patient?** Male ☐ Female ☐
Thank you very much for taking the time to answer these questions. We'll be using the information to write a report to let the people who organise discharge from hospital know what is working well and what needs to improve. No personal details about you will be included in the report. Can I give you a leaflet which tells you a bit more about Healthwatch York and what we do?	

Appendix 3 - Healthwatch York Enter and View visit: Follow-up Questionnaire

Patient's name:

1. Now you are out of hospital:

Do you feel you left at the right time? Yes ☐ No ☐

Was any support put in place for you? Yes ☐ No ☐

If so, what worked well?

Were there any problems?

2. When we spoke to you in hospital, you were getting home by X

Did that work well? Yes ☐ No

Did you get settled alright? Yes ☐ No ☐

3. Have you been given any details about support groups, etc who might be able to offer you help and support in the future e.g. Yes ☐ No ☐
If no, is there any information you would like Healthwatch York to send you?

4. Thinking about the whole process of being discharged from hospital, what could have been done differently to make it better or easier? What changes would you make if you were in charge?

5. We produce a newsletter every quarter with lots of information about health and social care in York. Would you like to be added to our mailing list so you receive this? Yes ☐ No ☐

If yes would you like a paper copy Yes ☐ No ☐

Or for it to be sent by email Yes ☐ No ☐

If by email please print your address here:

Thank you for completing this questionnaire. Your name and contact details will not be used within our report on discharge from York Hospital and will remain entirely confidential to Healthwatch York.

Appendix 4 - Discharge from hospital survey

Have you been discharged (sent home) from a hospital or care facility within the past 18 months? How was it? Did you feel ready to be sent home? Did you get good follow-up care?

Healthwatch York wants to gather feedback from as many people as possible to understand what works and what doesn't in the current discharge process. By getting feedback on your experiences we can see what is working well and what needs to be improved.

Our survey is anonymous and we will not publish any information to identify you. The combined findings will be shared with people who buy and deliver health and social care services in York. Our report will also contribute to the first Healthwatch England Special Inquiry looking at discharge planning across England.

Take part in our survey

1. **Who are you answering this survey for?**

○ myself

○ on behalf of someone I care for

2. **If you are answering for someone else, who are you completing this survey on behalf of? It could be a friend, relative, or someone you care for**

3. **Have you been discharged within the last 18 months?**

○ Yes

○ No

4. **Where were you discharged from?**
Please include as much detail as possible - for example, Anywhere Hospital, Ward 101, Neurology Department

5. What were you being treated for?

6. How long were you admitted for?

7. Did you have any additional health conditions at the time in addition to the reasons you were admitted?

8. How happy were you with the way your discharge was handled?

- ○ very happy
- ○ happy
- ○ neither happy nor unhappy
- ○ unhappy
- ○ very unhappy

9. What did or didn't work for you?
How did staff treat you? Did you feel involved in the decision to be discharged? Were you offered ongoing support? Did you have a treatment plan? Do you think all your circumstances were taken into account in planning your discharge? Please tell us!

The Discharge Process

10. Did you feel that your discharge was at the right time for you? If not, what would have been better? What did you think the reasons for your discharge were? If yes, what helped you feel ready?

11. Where were you discharged to?

12. How happy were you with your support after discharge?

13. What did or didn't work for you in your follow-up support? Where did you go? Did you have to be readmitted within 28 days? Were you given the support and help you needed?

14. What do you think could be improved for someone in your position when they are being discharged?

Monitoring Questions

You do not need to answer the following questions, but it would be helpful to us if you do.

15. Please tell us the first half of your postcode

16. Age

○ 0-21 ○ 21-35 ○ 36-50 ○ 51-60 ○ 61-70

○ 71-80 ○ 80+

17. Do you consider yourself to be a disabled person?

18. Do you consider yourself to have a mental health condition?

19. How would you describe your gender?

20. How would you describe your ethnicity?

21. How would you describe your sexual orientation?

And finally

22. How did you hear about this inquiry?

23. Are you happy for us to use any of your comments within our report?

24. Would you like to be kept informed of Healthwatch York news and activities through our quarterly newsletter? If yes, please leave your preferred contact details - either an email or postal address

Appendix 5 - Discharge from health and social care settings

Issues raised direct with Healthwatch York April 2013 – June 2014

Timing / speed of discharge

- Mother in York Hospital being fed by gastro tube. Staff spoke to her about discharge arrangements while tube still in and no family members present. Daughter feels that this was inappropriate and discharge plans are being rushed for financial reasons.
- Discharge from York Hospital: hospital did not inform patient's daughter that she was being discharged, all felt very sudden when told to leave hospital. Everything else was brilliant but felt it all happened too quickly.
- Discharge from York Hospital; discharge was 'sprung on her at last minute', patient said no warning was given.
- Discharge from York Hospital; Not much warning when being discharged. Patient's wife is disabled and was distressed to be told very last minute without warning. Daughter advised, she arrived home from work luckily just as patient was dropped off.

Transport

- Patient at York Hospital ready for discharge back to care home at about midnight. Moved to lounge to wait (with wife) for patient transport back to care home. By 4.30am, no transport had arrived, no updates given. Eventually wife called son to provide a lift back to home.
- Patient felt the drop off service could have stayed a bit longer as they saw him into house but didn't hang around. Patient's wife is disabled and could have done with extra support from them to settle him in.
- Elderly patient had a bad experience with a taxi that was booked by York Hospital for 2am. Patient was then dropped off at home and left stood waiting on his own in a dark hallway. Felt the driver could have waited until the patient was let into his home as he was physically and mentally uneasy and it was the early hours of the morning.

Personalised, co-ordinated care

- Woman with Chronic Obstructive Pulmonary Diseases (COPD) and arthritis needed surgery. Number of issues including lack of communication between providers and to her (3 hospitals, 4 consultants). For example lack of understanding of pre-existing conditions, differing information on provision of follow up services. No bed on arrival at St James University Hospital, Leeds, for pre-booked surgery. Lack of personalised care to support the needs of a person

with arthritis. Lack of care post discharge, for example no district nurse visits arranged, dressings given were unsuitable so ended up buying her own as nurses would not listen.

Community Nursing and Social Care Support after discharge

- Man has been readmitted to hospital after being discharged without good information on how to take his medication - iron tablets and morphine. District nurse attended the home and stated she wasn't able to help him take it and turned her back whilst he dosed himself. Meant to be administered by syringe but he and his wife are both blind and cannot do this without some adjustments being made. So he said he would drink it. She turned her back whilst this happened. When readmitted, he was anaemic and had overdosed on morphine. Wife believes this was entirely avoidable if he had received proper information and support on discharge. Nobody has offered information in alternative formats. They are worn out by dealing with his illness and are struggling. They do have a son who does not have a visual impairment but he does not live with them and has not been engaged in any discussions about this. Wife refused to have him readmitted to ward 16 as it was dirty and he previously had bad experiences there.
- Man, aged 88, discharged from York hospital after 11 days stay. Wife (who is also in her 80s) wants to complain as he was discharged home with little warning and no care plan in place. She got two minutes instruction on sorting out his catheter. District nurses did not attend for the first three days, and at one stage left him with wrong catheter bag. Wife struggling with his care, he is now in nursing home (self-funding) but query if this should be classed as part of recovery following hospital stay and thus free.
- Man had been in hospital, unable to get out of the house on discharge but needed dressings changing. District nurses refused to visit his home as said he was not normally classed as housebound / disabled.
- Woman expressed concerned that her mother's carers were coming from Scarborough to York every day. She thought that was too far and costly for them to travel. They were not private carers, the hospital had organised it.
- Discharged from York Hospital after five days on acute stroke ward. Was told someone would be at her home to meet her and provide support. However was on own at home from 9am on day of discharge until following afternoon. No food in house and survived on coffee and water.

Involving carers in discharge planning

- Woman went to visit husband following operation. They live in Sherburn in Elmet. Took three buses to get to hospital. Was told he was not being discharged so went back using three buses. Then received call saying he was being discharged. So she returned, using three buses. They were then told patient transport could not take her home as well as him. Age UK York intervened and took them both home as part of the Tour De France extra service. She was also told she needed to arrange a community nurse visit for Monday. She knew she would not be back at home in time to call her GP, but she received no help at the hospital to do this. She used the mobile phone of an Age UK York worker to contact her GP practice in order to arrange the visit. She was told she would need to take her husband to the GP practice. She felt this was not possible given his operation, which was not keyhole. She refused, and eventually was able to arrange a home visit.
- Carer wanted to speak with a psychiatrist about the person they care for. They have been discharged, and now live in a care home, but needed to speak with someone as feels more support is needed. Community Psychiatric Nurse (CPN) completed the discharge so no route there. Wants to speak about GP so does not want to pursue that route.
- Elderly father discharged from Ward 35 on Friday 6th June. His daughter had told staff on the Wednesday that he had no medication at home. They were told on Thursday that he would be discharged on Friday - daughter travelled from Middlesbrough to take father home. They both had to wait on Ward 35 for 2.5 hours because his medication had not been sent from the pharmacy. When her father had been discharged from York Hospital on a previous occasion, although staff had let carers know he was going to be discharged, no one contacted his daughter. If daughter hadn't phoned the hospital and found out he was to be discharged, he would have had no way of getting into his home (he cannot use the key box).

Being discharged from mental health services

- Woman who has depression, self-harms and has an eating disorder, and also has a chronic pain condition. GP referred to Community Mental Health Team (CMHT) who bounced her back without seeing her as felt pain clinic more appropriate. Pain clinic felt they were not the most appropriate, so referred back to GP for referral to CMHT or eating disorder team. Now feels she cannot manage without support but has been told by GP they are not hopeful she will be seen due to waiting lists.

- Woman has been on waiting list for talking therapies for three years. Was offered a course on stress management, which she agreed to take up only on condition she wasn't removed from waiting list. Found course was not helpful. Also received letter after missing one session when unwell saying she would be discharged unless she phoned to explain - but pre course information said this would only happen if missed two. Received letter after the course saying she had been discharged. Queried this and was told that she should have completed a form at the training if she did not want to be discharged. Feels there is a clear element of waiting list management here.
- Patient in 40s, has worked all life and has full-time job although has been absent for some months recently. Has had mental health issues since childhood but this was not disclosed until went off work with severe depression and attempted suicide a couple of years ago. Saw a GP at that time which led to a CPN being allocated so thought support would be given to get her back to full health. Over the past two years has had significant difficulties with CPNs, GP, psychiatrist and social worker. Has refused to be sectioned but did spend some weeks in hospital in Sunderland (out of area care) where started to improve significantly. A bed became free in Bootham so was transferred there but the situation deteriorated rapidly; she states her “life was ruined after this”. Discharged back to the care of the original CPN she had difficulties with. Appears to have attempted suicide a number of times and is talking of it again. Job is being held open for but may be facing imminent dismissal although wants to keep job as enjoys it but needs help to get back to a level of health where can return to normality.
- Young carer with mental health issues had referral to Limetrees. Was taken off treatment due to rearranging appointments due to caring responsibilities. Both Limetrees and his school know that he is a young carer. He feels very frustrated as he now has to go back to his GP for a new referral. Not having anyone to listen to him, no emotional release is making things worse. Feels the system is not set up to support him.

Appendix 6 - Discharge from Health and Social Care Settings. Summary of information from workshop on 23rd July 2014

Table 1 feedback

No thought is given to carers. There is a duty of care to carers to provide them with training in manual handling techniques. Sixty clinicians responded to a survey run by the Carers Centre on this subject; very different responses were received from the different departments and clinics in relation to the amount of training given.

An elderly person attending hospital on a regular basis was ordered a taxi by the hospital on discharge but was left to manage on his own once he had returned home as his relatives were not informed of his discharge. A number of voluntary groups do provide transport from the hospital to home so patients do not have to rely on the ambulance service but the patients do need to know how to access these services.

An example was given of a patient being taken from the ward to the discharge room and just left there.

Discharge should be assessed and prepared for from a patient's first day in hospital so that everything is in place at the time of discharge. This process should include both the patient and the carers at home or elsewhere and also the situation at home if relevant. Patients have been known to arrive home and the paid carers have not been informed that the patient has been returned home.

Some patients, primarily elderly people, have been known to bend the truth and say they do not need help when they are returned home probably due to a sense of independence and pride.

The Human Rights Act states that everyone has a right to life, liberty and personal security so not assisting discharged patients who do need further care at home may violate this.

It is not known how social care and health care will be integrated efficiently.

People have, on occasions, remained in Archways Community Intermediate Care Inpatient Facility for six weeks i.e. longer than necessary, due to lack of care at home. Again due to a lack of care at home patients keep returning to hospital.

Liaison nurses on wards do now co-ordinate discharge from hospital and the return home to ensure appropriate care is in place.

Crossroads Care provide paid carer respite in a patient's home but as this has been limited to 20 minutes this service will end as it is considered the time is too short to provide an adequate level of care.

Improved backup is needed when patients leave hospital. Communication between the patient, family, carers and all organisations involved is necessary.

An assessment of needs should start from day one in hospital and should continue throughout the period of stay in hospital. This must include the patient, medical and nursing staff, family, carers and the requirement of any extended needs e.g. speech therapy, physiotherapy, occupational therapy, etc.

Question: Will the above be done in the future in all situations for all patients?

Table 2 feedback

An example was given related to a very good experience of endoscopy day care with the staff being clear and giving explanations at every stage of the process.

An example was given of being the last patient out of the day surgery unit at 6pm where the person felt everyone was cleaning up around them, etc. She did not feel that she was getting all the information needed and felt rushed although the staff were polite.

Pharmacy – a patient came out of hospital with a week's supply of medication. Is this normal? The GP was waiting for the discharge letter so does no know about the medication.

Joined up services are so important.

Question 1: Adult social care – how do individuals set up a personal package and do they understand them? Do people know about them?

Question 2: Who follows up when elderly people are discharged?

Question 3: What about weekend discharge and does it happen?

Table 3 feedback

One individual had a good experience of discharge from day care on two separate occasions.

Better planning and communication with a patient's relatives is needed.

Patients are sometimes waiting in hospital all day for medications from the pharmacy, sometimes into the evening when support networks are no longer available.

There needs to be much better planning in advance for discharge.

Having the right care packages in place at discharge with all relevant people being made aware of a patient's discharge are needed. Communication between different services needs to happen, ensuring all those who need to know actually do know.

It is down to the individual to ensure they get the appropriate follow-up and not everyone can do or deal with this.

The admissions process should gather all appropriate information e.g. next of kin as, if this is not done, then it will affect discharge. For pre-planned

admissions this should be done prior to the operation or treatment. This information must be correct at the beginning and be looking forwards to discharge on admission.

One size will not fit all as people have different needs on discharge.

A befriending service for those with no relatives would be beneficial as many people are very isolated.

When patients are discharged they should be given details of voluntary organisations and support groups that could help them.

People need advice on how to live with conditions whether they are long-term conditions or a temporary setback such as recovery from an operation.

Table 4 feedback

An example was given of discharge from A&E following a seizure with no advice given, no follow-up and nothing heard from the patient's GP who did not appear to know about the incident. No medication was given as the patient needed it in soluble form and it was only available as tablets. The patient was a wheelchair user and was not allowed into an ambulance so a carer had to drive him home. There is no confidence in communication between the hospital and GPs.

Prevention does not seem to be taken into account and also the difference in levels of knowledge and expertise between GPs and consultants. There also appears to be differences inexperience in different areas so the system is a postcode lottery.

There is a concern about information being lost.

Clarity is needed about who will be involved in a patient's discharge plan, how it will be carried out and who will do it. The patient should be looked at as a person not just a condition.

Having good access to and relationships with people who can put things in place e.g. someone to phone for information, would be useful so the patient feels they can contact this person and ask questions easily perhaps avoiding a future crisis.

Who is involved in this consultation; are CYC services included? CYC services and relevant voluntary organisations should be involved.

Information technology systems need to communicate with each other providing real time data that GPs can access immediately to see when discharge has been made.

Question1: With these changes there is an increased need for GP and community services but where is the funding coming from? Any savings within the hospital should be passed to the community particularly with discharge to social or rental housing.

Question 2: What measures are being taken to ensure VoYCCG savings from the hospital will be invested into community services? Presumably this cannot be done until the savings are realised.

Question 3: Can things continue to run whilst this change in budgets i.e. dual funding, takes place? Will savings actually be made?

Table 5 feedback

There is no consistency between the different York hospitals with, at present, different processes at the district hospital, Clifton and Nuffield e.g. there is no care assessment before discharge or no patient transport arrangements for follow-up.

There is no transport for a carer within patient transport.

Where a patient needs ongoing care and is self-funding, they have to sort out their own care and this can take time which delays discharge.

There is an issue with home care packages at discharge as they are not always available. People sometimes just go home without care in place as they are fed up with being in hospital.

There is a lack of transition places. Over the past year there has been a problem with the lack of step up and step down beds.

Some patients with mental health issues have to go out of the area due to the lack of beds locally which makes the discharge process more difficult.

The discharge process is not clearly explained and patients have a lack of knowledge.

The hospital has misassumptions regarding what services can be provided by, for example, sheltered housing and also about the willingness of family members to provide care.

There has to be an assumption that a patient has the mental capacity to deal with their discharge unless there are specific medical reasons otherwise. This can complicate discharge if a patient is desperate to leave hospital and says everything is alright at home.

An example of good feedback was given for York hospital where there is a practice of assessment for discharge e.g. nurses monitor how independent a patient is getting dressed, etc. Occupational Therapists are also god at making assessments. But again there is a lack of consistency as there is not the same standard of care at Clifton or Nuffield.

There is an issue where people have been supported by staffed services in the community and then this service comes to an end leading individuals to have to rely on the voluntary sector.

It is not always communicated exactly when a patient will be discharged in order to ensure that a carer or family member will be there to meet them.

There is a need for more statistics – how many people are waiting for discharge but cannot be discharged and what are the reasons. It is hard to know the scale of the problem.

Table 6 feedback

People have been seen in the discharge lounge wearing pyjamas – were they being discharged or just watching the television?

Prescriptions for long-term conditions should be free or cheaper.

One person had always received a quick follow-up after being discharged to the care of their GP.

Another person had received excellent care when discharged to the heart failure specialist nurses; they had carried out monitoring of the patient's condition and medication making adjustments to the latter as necessary, although this was only during practice hours. Experience of the specialist nurses for ovarian cancer was similarly good.

There is a dearth of community nursing with huge caseloads. There is a move from qualified nurses to carers. Also practice nurse roles are not being filled with community nurses, just assistants. Wages of care assistants are low which may lead to strike action. This would result in untrained and inexperienced volunteer provision of care i.e. a risk to safeguarding and effective continuous treatment. When relying on volunteer organisations it is important to ensure they provide feedback.

One patient, on discharge from hospital, had been told the district nurse could not visit him as he could walk to his surgery.

People living alone are facing isolation so more home visits would be appreciated. Support from local charities such as Age UK can help.

There is little or no provision for people suffering mental health problems, particularly those with borderline conditions.

Community nursing – there should be a system which allows feedback when services are not followed up.

Appendix 7 – Discharge from hospital consultant to GP. Summary of information from workshop on 23rd July 2014

At the beginning of the workshop session there was a short talk by Dr Alastair Turnbull, Medical Director for York Hospital on discharge from consultant to GP

The management of long term care patients is being moved from hospitals to the primary care services and this is a fundamental change. It is not known whether this is the right thing to do, the best model or is cost effective as there is no evidence as yet.

The disadvantages of this system are that GPs now have to see more patients than previously, requiring more clinics, including evening opening hours. The advantages are that GPs can now make consultants aware of any concerns they have regarding specific patients.

A set of conditions and associated complications will be identified that specialist consultants must see. There will be a register of chronic conditions which is very different to the situation of a year ago.

These changes will free up appointments in outpatient services although this net gain has not happened yet.

A large number of patients that were due to or were on the list to be seen by consultants have been reviewed i.e. do they need to be seen by a consultant and/or do they fit within the criteria of the register. All lists have been checked with GPs and, at the moment, all seem to be correct.

Those patients no longer seen regularly will now see a GP therefore this will increase GPs' work load substantially. Patients were informed either by letter or at their final appointment with their consultant.

The local NHS Trust is supportive of all these changes and is working closely with the Commissioners.

No patient will be discharged to a GP if the consultant thinks this would be unsafe. The safety of patients will be protected but this is not about patient choice.

Table discussions about discharge from consultants to GPs

Table 1 feedback

MS Society:

- Phone call from a female MS patient, in pain and in tears, as she can no longer see her consultant and has to see her GP
- One patient visiting the clinic once per week has now been discharged to his GP

There are too many referrals to consultants in York and this costs too much. Patients are informed by letter or at the clinic and there is poor or no communication from the hospital. Why not let the voluntary sector help in sending information out to patients? There is no consultation with patients or the relevant voluntary groups. Recommended working with other neurological groups in partnership to provide information to all people affected with neurological diseases.

It takes two weeks to get an appointment with a GP with a further two weeks for the GP to send a letter to the consultant and then it is two to three months before the patient can see the consultant.

Some patients do not need to see the consultant for six months for example, but do need a means of seeing appropriate specialists when necessary.

All of this is putting a strain on GPs who are not specialists in neurological conditions and MS is a complex disease.

All of this is to do with finances.

MY Aware (Myasthenia Gravis):

Following lobbying by the chief executive of the organisation, the decision to refer patients to GPs has been overturned so patients are now seeing their consultants. This relates to approximately 80 individuals on the organisation database. There is an open door with their consultants for some patients.

Individual: A patient with four associated conditions is now being treated by her GP. Some expensive medications are required which the GP would not prescribe. The consultant said the patient must contact him if these medications were needed. The GP monitors what is needed and this is sent quarterly to the consultant and he then makes any decisions necessary.

Other feedback:

- It's difficult for GPs taking on this extra work without specialist knowledge
- When will there be enough evidence as to whether this system is working and cost effective
- Voluntary groups must work together to get information out to patients and collate the experiences of individuals and patients
- There have been too many referrals back to consultants in some cases which has led to this situation
- Budgets must be balanced; if the Commissioners don't provide funding then work will not be done

- There are problems with lack of transparency; again this is a lack of communication with voluntary groups
- This has not been discussed at the Vale of York Clinical Commissioning Group (VoYCCG) public meetings
- There are not enough medical and nursing staff in the community to deal with this extra work
- VoYCCG does not appreciate how much care is being done in the community by carers; there will be more stress put onto carers
- There is a lack of communication and consultation between VoYCCG, the hospital, voluntary groups and patients

Question 1: What are the VoYCCG going to do about this lack of communication and when will they listen to what patients and voluntary groups have to say?

Question 2: The MS Society York Branch would like to invite Sharron Hegarty (VoYCCG) to the MS cafe to talk to their members and all those affected by all these changes.

Table 2 feedback

It takes ten days for a GP to get a prescription from a consultant; the short prescription is not working. Consultants do not check for allergies to medications and no check for allergies given in hospital.

There is no tie-up between the GP and the consultant.

Do not do reviews of drugs at GPs. GPs are now overstretched leading to long waits for appointments. Once a patient is allocated to a consultant, GPs "back off". GPs are now their own bosses.

Question**:** How will GPs manage the extra load? How will they cope having to have more knowledge of different conditions?

Table 3 feedback

It is difficult to get GP appointments now and will they be for ten minutes or more?

One patient with diabetes did not receive a letter regarding their return to GP care.

Will practices identify the GP who is the expert in a particular field and will training be provided for them? Will patients be able to see the same GP?

Will GP practices be proactive and call patients in if they are on the list? How will patients know they are on the list?

Will there be an extension of the named GP principal i.e. for the elderly, to other areas?

At the time of booking an appointment the patient will have to say to the receptionist that they need an appointment with a particular GP.

Back Pain Clinic – there is a need for clarity for the rules; are they logical? Back pain is a chronic condition therefore will be referred to GPs. If the situation alters, how does a patient get back to see the consultant?

If a patient is referred back to a GP who then has to pay for further investigation? Will what happens be affected by cost?

What is to be done about priorities, set by NHS England, as public health is now with local authorities' control?

Table 4 feedback

York Rheumatoid Arthritis (RA) support group:

Members come with issues most of which are negative. In one week alone 60 people with RA or a related condition contacted RA Support even though they were not all members.

Some people keep consultant appointments for part of their care whilst other aspects of their care are done by their GP i.e. blood tests. This is disjointed and unsafe and another cutback in services. All patients had booklets for their blood results and this no longer happens. Many GPs did not fill in the booklets so patients were not getting their results, even when the results were abnormal, whilst other patients were told by their GPs that they do not need to know their results which is shocking. There is a need for consistency and guidelines.

GPs are being asked to be more than general practitioners. They are busy and if they cannot take on the extra work then it is not good enough to continue with this new scheme.

Annual reviews are not happening for RA.

Some people with MS have been discharged and they do not know why and do not know how to get back into the system.

There is a two week wait for non-urgent appointments with GPs.

Is any extra money being provided for primary care to cope with the extra patients?

Are there enough GPs being provided or any extra training for GPs?

GPs miss diagnoses of RA and there are concerns GPs will not pick up serious issues.

It is not a good use of consultant time to see a patient once per year; it should be about access when it is needed.

No shows for appointments needs to be addressed as there are very high non-attendance figures. How many appointments would be freed up is this was to be tackled?

Presentation and identification must be a priority as the costs are less to the NHS with early identification.

GPs have less specialist expertise compared to consultants. If GPs do not have the appropriate knowledge and expertise in long-term conditions in the first place how can they manage and support patients? They need increased training.

Patients must feel confident in the person managing their long term condition.

An example was given of a GP having to phone a rheumatology nurse specialist so would an answer be to have more specialist nurses?

MS patients:

- The way the letters were sent out was blunt
- It was not made clear how to opt back into the system
- The change was done too early, before GPs really knew what was happening

Improved communication is needed between patients and the health service and between all areas of the health service internally.

GPs need improved awareness, resources and better knowledge.

Question: Is any extra money being provided for primary care to cope with the extra patients?

Table 5 feedback

Most people did not realise this change has happened including someone whose wife may be affected – no information has been received by the patients and she has not been told she has been discharged to the care of her GP.

This change started one year ago so most people affected should have been informed but a few may still be outstanding.

Would people necessarily have understood the implications of the letter they received?

Physiotherapy now allows a maximum of six appointments then there is a need to re-refer a patient. This will not change but if a patient is discharged from a specialist clinic then access to an associated clinic e.g. the dietician, also ends. If a patient with a range of conditions and attending a number of clinics is in doubt, they should contact their consultants as each consultant will make an individual decision based on their specialist knowledge.

It is not certain if this affects paediatric clinics.

GPs may know very little about specific conditions.

Question 1: Is information on the discharge changes available on the Vale of York Clinical Commissioning Group (VoYCCG) and York Hospital websites plus an explanation as to why these changes have been made?

Question 2: Is information on what patients should do if they are unsure about or they disagree with a decision also available?

Question 3: Do GP practices have easily accessible records of which consultant lists patients are still on or where patients have been discharged to?

Question 4: What follow-up will be ongoing and how can patients access it?

Table 6 feedback

Person with diabetes has an “amazing” named nurse who always replies to phone calls and knows where to refer the patient to if there are any issues.

Another person with diabetes initially had some concerns but has since had no problems and has been able to get appointments as needed.

A third person was unclear as to whether she had been discharged from her consultant. She still attends hospital for blood tests but has not been told if going to the GP instead is an option.

One issue raised was that a GP does not have a diary system for booking appointments regularly e.g. at three monthly intervals. If a patient misses an appointment no one rings to check why the appointment has been missed so if a patient does not remember after a specified time to ring and book an appointment there is no safety mechanism.

If a letter is sent from the hospital to a GP, the GP does not always read it.

There is an issue as to whether GPs have enough knowledge to monitor complex conditions; they may not have enough experience to pick up on key signs of deterioration or change in a patient’s condition. Reassurance is required.

The changes will not work if the local GP is a single-handed practice of if a GP with the required specialism is not available.

There needs to be a link between the hospital and GPs to be able to tell a patient at discharge who their named GP will be at their practice and who has the correct specialism.

Positive aspects are that if the discharge can be done safely and competently, it is much easier for people to get to their GP’s or for potential home visits.

It is not possible to book ahead for GP appointments more than two weeks. There is already an issue with getting an appointment with a GP for “normal” appointments; sometimes it is only possible on the day of phoning.

There is a need to change how GPs book appointments, moving to a proactive approach from the GP for booking follow-up appointments.

At discharge there is a clear need for information as to whose care the patient will be under i.e. a named GP who has an appropriate specialism and how this will be followed up.

Encourage the provision of patient reference groups within GP practices to encourage dialogue.

We are losing small groups in rural areas as VoYCCG only wants to engage with larger groups so smaller groups are disbanding as they do not have the resources to join with others.

Question 1: Is anyone checking that GPs can handle this extra workload and are there extra resources for GPs?

Question 2: Worries that diabetes and asthma are quite common with very good treatment at GP practices but what about specialist nurses for neurological and other chronic conditions?

Question 3: Do GPs read letters sent from the hospital? They are usually just attached to patients' records.

Table 7 feedback

Rheumatoid Arthritis clinic – a patient was initially told he would see the consultant in three months; a letter was then received to say the patient would be contacted six weeks prior to the appointment and the appointment ended up being in six months.

In some aspects these changes will be useful as there are finite resources. Outpatients often do not turn up therefore it might be more manageable at GP practices as text reminders can be used.

GPs can still refer patients back to consultants if necessary.

GPs do not have specialist knowledge.

GPs do not always have continuity that the specialists have, patients often seeing different GPs.

There is concern over problems such as headaches, etc being discharged without full diagnosis and treatment.

One person had diabetes and had never had treatment at the hospital; the GP service has been adequate.

Following discharge, a patient still had his consultant's contact details and has been able to call him.

A GP has been consulting on an alternative treatment route (elective) and this has been useful.

Rheumatoid arthritis nursing team has no cover due to illness.

It is difficult to get advance appointments, e.g. six weeks ahead, with GPs relating to RA condition and this can cause problems scheduling care. If a patient is told to come back in a month, they need to remember in two weeks to contact the GP to book the appointment.

Transport can be a problem for single individuals trying to get to GP appointments.

It is usually possible to get GP appointments at the end of the surgery for acute problems.

GPs can phone the hospital for test results.

It is easy to consult GPs on changes in physiology rather than direction of condition.

The changes in discharge all sound good but there must be a mechanism for reporting and reviewing it if it appears to not be working correctly.

Much depends on GP practice staff; receptionists can act as “gatekeepers” and it can be difficult to get past them.

Elderly people being discharged from hospital may be frightened to be left at home alone. AGE UK can help with this via their volunteers.

Patients should not be discharged at 1am.

Practice nurses can often be the best people to see.

Discharge to the care of a GP can be a good experience as the GP will probably be known, it is more personal and local whereas treatment at the hospital can be faceless.

Once a GP is familiar with a patient’s case the situation can be good but convincing a new GP of a condition can be difficult. The patient has to get past the GP and misdiagnosis does happen. A patient diagnosed in India with an urgent gall bladder condition took three months to receive any treatment via their GP when they returned to the UK.

People receiving bad treatment at the hospital can be unwilling to complain.

It is most important to have continuity of treatment and provider, particularly.

The movement of patients “off” the consultant’s list onto a GP list – is this a possibility for Mental Health issues? I think this will be more difficult but may be necessary to move the consultant costs.

Appendix 8 - Discharge from Hospital Consultant to GP

Feedback from York Rheumatoid Arthritis Support Group Meeting 10th May 2014 plus direct feedback received at Healthwatch York

- If you cancel two appointments with a consultant you are referred back to the GP. This is very distressing – have to change appointments for work, told if you do it again you will be discharged. Sounds punitive. Fails to allow for the reality of our lives
- Appointment system – hospital should send text reminders to get on top of Did Not Attends. The system currently is penalising people who are not abusing the system by not letting people change
- GPs are not confident dealing with rheumatoid arthritis. They are not able to get hold of consultants or their secretaries. They know they are out of their depth but can't get any support
- People with rheumatoid arthritis become experts in their condition, but with some GPs it goes in one ear and out the other. They just don't understand
- GPs don't understand the safety issues. They don't interpret the blood tests right. But there are times when you need to change all medication immediately if you understand what you are looking for
- Training for GPs – they only get 40 minutes on Muscular Skeletal (MSK) issues, mainly on back pain. They can't be expected to know everything about rheumatoid arthritis
- Removal of blood monitoring books. This has been stopped due to funding issues at York Teaching Hospital. Now getting more regular tests because Leeds and York hospitals don't share results but under Leeds for some things and York for others. Lots of calls to York rheumatoid arthritis support group because of this issue. These books provide an extra safety net for people on a complicated mix of drugs
- Group believes that everyone wants them (blood books) back. They are now at GPs discretion – many GPs are saying "you don't need to know your results" but it is important for people with rheumatoid arthritis as they often know more about interpreting the results than their GP does. Goes against the principle of empowering patients to self-care. There has been an article from the National Rheumatoid Arthritis Society on this, advising those in Trusts without blood books to press for them
- It also ties up GP time – have to get an appointment to discuss the results, if they are willing to share them
- Blood books are useful guides to compare how you are doing and a helpful reminder of when blood tests are due. Can also take them to places such as the dentists

- Blood books are something that works well, so why stop it? Patients have offered solutions, such as they would pay per year to keep them up to date, but these solutions have not been adopted
- Always had a very good service from the urgent referrals eye clinic. The hard bit is getting the referral needed from your GP
- Changes in provision of Methotrexate. Previously this patient had to contact YH one month before her three month prescription ran out to request a repeat, which was completed by a rheumatologist. Has been informed she can no longer get this from the hospital and her GP would now issue it. Concerns are: a) Patients and RA Support Group were not consulted. b) She received no individual warning of the change. c) She has been left without medication as she still has to give GP one month's notice and it takes two weeks to get an appointment with GP. d) She does not believe GP has been made aware of this change. e) May not be able to get drug on repeat prescription as it is cytotoxic, meaning having to arrange further appointments around work commitments. f) Would have to have duplicate blood tests as GP and York Hospital do not share details and other medication requires her to still visit rheumatologist. g) Concerned about new users in terms of training for self-inject of drug, will GPs take over administration?
- Transfer of rheumatological care to GPs. One GP practice is now saying that a patient has to attend their practice specialist arthritis clinic despite this person having to see their rheumatologist every three months. Only the rheumatologist can provide biologic drugs and the hospital perform all necessary checks, monitoring and care. Concern over unnecessary attendance of another clinic. Wider concern about service users not being involved in discussions of transfer of care to GPs. Concern over whether all GPs will be providing specialist clinics or whether a two tier system will result in some Rheumatoid Arthritis patients receiving enhanced care from GPs and others not.
- Patient was informed she can only change appointments twice and then will be discharged. Concern is that if she changes an appointment with a different department within the trust this would be included in this total. She has regular appointments in different departments. Though she changes appointments when received / with reasonable notice, the system does not take into account patient circumstances such as work commitments, dependency on an assistant, illness and family circumstances. She receives new biologics medication that can only be prescribed by consulting rheumatologist so discharge would result in her being taken off essential medication.

Feedback received at Healthwatch York January to June 2014

Feedback reported to Healthwatch York through Myasthenia Gravis Support Group York

- Two people with Myasthenia Gravis have been told by consultants at York Hospital that they have been discharged back to GP. They were told this is necessary to save money and they don't need to return to hospital as their condition is stable. They are worried as have to wait two weeks for a GP appointment and feel GPs don't know enough about their condition.
- A Myasthenia Gravis patient was discharged from York Hospital care after being treated for past two years. If any problems occur the patient must now consult their GP. This also appears to be the case with other Myasthenia Gravis patients.
- A Myasthenia Gravis patient was told by his consultant that he is not happy discharging Myasthenia Gravis patients back to their GPs and has not discharged any of his patients. He told the patient it was just a money saving exercise.

Issues raised by people with neurological conditions

- Patient with severe Multiple Sclerosis (MS) to lower body, wears body jacket to keep spine straight, has had neurological physiotherapy for a long time but has now been discharged into the community and has to see GP to start process over again so is very upset.
- MS patient discharged by MS Nurse in July 2013; condition is now deteriorating with no medication available. Saw their GP in October 2013 and had an appointment with Neurologist in January.
- For people moving from Disability Living Allowance (DLA) to Personal Independence Payment (PIP), will there be any negative consequences for having been discharged from the care of a neurological consultant back to a GP?

Concerns from Headache Clinic Patients

- Patients at the headache clinic at York Hospital with chronic migraine are being discharged without any consultation with patient or their GP.
- A Headache Clinic Patient wishes to ensure York Hospital is aware of the impact of changes on migraine sufferers and is very anxious about the future of the service. They are particularly aware that GPs don't have the insight that specialist consultants are able to provide.
- Changes to the headache clinic at York Hospital are 'a matter of acute concern' to patient. Specialist advice from a consultant is not available elsewhere in region. Changes will place greater burden on GPs and

neurologists who do not have time or specialist knowledge to treat headache disorders.

Other concerns raised

- A patient with diabetes is worried about the approach being taken regarding diabetes care at York Hospital. A diabetes consultant at the hospital has said they have to remove approximately 30% of patients from his list by referring them back to GPs. This patient is very concerned as GPs are already overstretched, and they have to wait several weeks to get an appointment to see the doctor.
- A woman saw consultant at York Hospital about a wrist injury. She was told she could not be put on waiting list for after care as they can no longer add people to the list, but she would have to be referred back to GP. Neither consultant nor patient were happy with this situation.
- Received letter informing them that due to long standing financial problems NHS Vale of York Clinical Commissioning Group (CCG) has told the hospital to stop a significant proportion of follow up outpatient care that it currently provides. Felt letter didn't give a very good explanation of why they were someone who could be discharged back to the GP, or what had been put in place to help GPs deal with these extra cases.
- A patient has had six monthly hearing checks at York Hospital. They have now been told that these are not being done routinely anymore. If they need a check in future they will have to ask GP for a referral.

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York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York.
York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This report

This report is available to download from the Healthwatch York website: www.healthwatchyork.co.uk

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If you would like this report in any other format, please contact the Healthwatch York office

Health and Wellbeing Board 21 October 2015

Report of the Chief Operating Officer, Vale of York CCG and of the Director of Adult Social Services, City of York Council

Update on Integration

Summary

1. This report presents an update on developing integration, which captures various elements of our joint plans to develop services that maximise the health and wellbeing of our population.

Background

2. Integration forms an essential element of local plans to develop services and of national policy, and is central to existing plans and ongoing work. The driving imperative behind our joint work through the Health and Wellbeing Board, outlined in our current and future Health and Wellbeing Strategies is to have services working together to better meet the needs of our populations and deliver improved outcomes within the resources that we have available.

   The Health and Wellbeing Board has received regular updates on progress on integration and specifically on establishing and implementing the Better Care Fund. It is important as we go forward that we consider the BCF Plan in the context of our wider work on developing the whole health and social care system to deliver efficiencies and service improvement.

Main/Key Issues to be Considered

3. Annex A updates the Health and Wellbeing Board on the main elements of integration and integrated working across health and care. It includes the following elements:

- An update on the emerging approach to **integrated commissioning** across health and care services as we look to develop these jointly in a way that supports achievement of improved health and wellbeing outcomes.

- An update on the **Provider Alliance Board** which has recently been established to support joint working between providers of community-based or “out of hospital” services across health and social care.

- An update on the **Better Care Fund**, highlighting that progress on implementation and impact is not as great as expected. This is subject to ongoing consideration between CCG and City of York Council commissioning and finance teams to understand and agree the impact of this on system and financial resources.

- An update on the newly-established **System Leaders Board**, that aims to coordinate action to deliver against existing plans and to give Chief Executive and Chief Officer direction to the approach to delivering plans.

Consultation

4. We have continued to consult with partners in the development of plans to integrate services and approaches to commissioning drawing on consultation and engagement exercises carried out with our population.

   As the work progresses it may result in proposals to change specific services that require more detailed consultation around the specific impact in relation to the service in question.

Options

5. This report is for information and there are no specific options for the Board to consider.

Analysis

6. Not applicable.

Strategic/Operational Plans

7. Developing the local health and social care system is a key priority for the Health and Wellbeing Board. One of its three principal statutory duties is to *"to promote greater partnership, including joint commissioning, integrated provision and pooled budgets."*

   The work on integration complements and is integral to the Health and Wellbeing Strategy, the NHS Vale of York CCG Integrated Operational Plan 2014-19 and the NHS Vale of York CCG refresh of this plan for 2015-16. It is consistent with the Council Plan 2011-15 and with the draft Council Plan 2015-19.

Implications

8. Not applicable.

Risk Management

9. Not applicable.

Recommendations

10. The Health and Wellbeing Board are asked to note the content of this report and continue to support the strategic direction of travel around system integration.

    Reason: To keep the Health and Wellbeing Board up to date with progress around integration

Contact Details

Author:	**Chief Officer Responsible for the report:**
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Report Approved	✓	**Date**	6.10.15

Rachel Potts
Chief Operating Officer

Report Approved	✓	**Date**	7.10.15

Martin Farran
Director of Adult Social Services

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None.

Annexes

Annex A: Update on Integration

Annex A: Update on Integration

Introduction

1. The Health and Wellbeing Board brings together the NHS, public health, adult social care and children's services, including elected representatives and Healthwatch, to plan how best to meet the needs of our local population and tackle local inequalities in health. A key component of our joint approach is to develop integrated services and integrated approaches to commissioning services. Integration is not an end in itself; it is a significant element of our strategic approach to improving health, addressing health inequalities and meeting needs within the resources that we have available.

2. We expect that by joining services up for our population, removing duplication and ensuring that the way in which services are delivered is designed around the needs of the person we will make better use of our limited resources and will have a greater impact on the health and wellbeing of the people living in our area.

3. This paper updates on a range of work taking place across the system to ensure that we are developing services in a joined up way.

Part 1
Update on integrated commissioning

4. To support the ambition to commission health and wellbeing services across the Vale of York population, a number of workshops have been held with partners over recent months. As a result of this joint working, an outline vision for integration has been produced which describes the ambition for designing, commissioning and delivering services collaboratively for our communities. Partners across health and social care have identified a number of key principles for working together in this way including a focus on:

- reducing dependency and encouraging self care through signposting, information sharing and help and advice which supports people to make informed choices and to stay independent and well;
- prioritising health and wellbeing alongside services which support people when in need;
- ensuring that information and services support and complement the development of dementia friendly communities;
- services which deliver defined outcomes designed collaboratively with service users, and partners including providers, commissioners, the voluntary sector and communities; and
- supporting the sharing of information between agencies where it helps to provide more co-ordinated support and care for those at a higher level of need.

5. An Integrated Commissioning Executive (ICE) with senior membership from City of York Council, Vale of York Clinical Commissioning Group and North Yorkshire County Council has recently been established to co-ordinate a consistent approach to commissioning services which deliver these principles. Whilst further work is ongoing to finalise the shared work programme for ICE, initial priorities have already been highlighted around the continued development of the Integrated Care pilots, rehabilitation, reablement and intermediate care services.

Part 2
Provider Alliance Board update

6. The Five Year Forward View, published in October 2014 (the "Forward View"), sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."

7. The Provider Alliance was established to enable participants to work collectively across traditional health and social care boundaries as the most efficient way of delivering safe, seamless and cost-effective out of hospital services for local people.

8. In general terms the Alliance affords the opportunity for Commissioners to move away from organising multiple contracts with many different providers, each dealing with an element of a patient pathway, towards identifying key outcomes which the Alliance can deliver by all providers working together to provide in a single, seamless pathway.

9. The membership of the Alliance includes representatives from the following organisations:

    - City of York Council
    - Vale of York CCG
    - York Foundation Trust
    - CAVA GP Confederation
    - SHIELD GP confederation
    - Nimbus GP confederation
    - North Yorkshire County Council
    - Tees, Esk and Wear Valleys NHS FT
    - York CVS
    - Selby District Association for Voluntary services

10. An independent Chair; Mr George Wood has been appointed.

11. The Alliance has worked to map services provided by each provider to the localities covered by Vale of York CCG

12. An outline work programme has been agreed and initially the Alliance will focus on how providers working together can develop the current care hubs from their existing position, and create a single, but flexible model for out of hospital care for the whole patch which encompasses all the best elements of these current ‘tests of change’.

13. In addition the Alliance will sponsor a work stream on ‘Last Year of Life’ (as opposed to ‘End of Life’) which all agree has the potential to deliver more appropriate, higher quality care to patients which may avoid unnecessary treatments and hospital admissions.

Part 3
Better Care Fund update brief

Update on current funding

14. The Better Care Fund (BCF) is a nationally agreed process to 'pool' elements of Health and Social Care Budgets to help Health and Wellbeing Board (HWB) areas integrate and improve services which support local wellbeing priorities. The mechanics of how the fund works and how budget allocations are made have been devised on a national scale using standard formulas. The performance of the fund is also measured through some nationally agreed performance metrics namely:

- To reduce Non Elective admissions to hospital by a locally agreed amount
- To reduce the permanent number of admissions to residential and nursing care homes for residents aged 65 and over, by a locally agreed amount, including maintain existing capacity in social care
- To increase the number of residents (aged 65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/reablement services by a locally agreed amount
- To reduce the numbers of delayed transfers of care from hospital, by a locally agreed amount

15. In order to fund the initiatives which will help deliver the ambitions of the BCF a pooled budget had been agreed between NHS Vale of York Clinical Commissioning Group (CCG) and City of York Council (CYC). For Financial Year 15/16 this initial pooled budget amounted to £12.127M, with the majority of the fund (£11.176M) coming from the CCG. It is important to note that the funding for the BCF is effectively not new money as it comprises of various elements of existing funding channelled via the CCG, including that previously provided under a section 256 agreement from NHS England and other existing allocations, either as a pass through of statutory funding (e.g. Disability Facilities Grant) or as a direct transfer from the CCG. Throughout the planning, design and implementation of the BCF in York it was recognised that this funding allocation could cause additional pressures across the system and had the potential to impact on financial performance throughout the year.

16. Since the submission of the BCF plan, there has not been the level of progress expected in many areas, with some elements of the plan under-performing against trajectory and other areas still not in the implementation and delivery phase. The key issues were highlighted in the report to the Health and Wellbeing Board in July. The current financial position of the CCG, coupled with a lack of tangible evidence to show a return on investment in the BCF pooled budget, has resulted in a position where the CCG and City of York Council are jointly reviewing all future funding commitments to consider and agree how the financial risks can best be mitigated. The aim is to agree an approach that is based on shared priorities and that fully considers the impact of decisions not to invest in specific services, maximising the ability of the system to prevent hospital admission and helping people to live independently in the community. We will maintain a focus on reducing dependency and ensuring sufficient future capacity across the system.

Additional National Support

17. In recognition of the challenges faced by York in mobilising the full range of the submitted BCF plan, additional resource has been funded by NHS England (at no cost to the CCG or CYC) to help move our current plan forward, with a view to identifying and realising additional benefits from our plan this financial year. This support will remain in place until March 2016 and a joint delivery plan has been agreed between CCG and CYC colleagues to make sure the impact of this resource is maximised.

18. Additional resource is also being identified to help further develop our current BCF Performance Dashboard into a wider Whole System Performance Dashboard, which will more accurately capture and monitor performance across all elements of our health and social care economy.

Part 4
System Leaders Board update

Introduction

19. An incredible amount of work has taken place over the last few years across the organisations who are leading the local health and social care system, working in partnership to tackle the collective challenges to commission and provide services that meet public expectations, that deliver high quality care and support, that represent value for money and effective use of public resources and that deliver against an ambitious national policy agenda.

20. The challenges that face us now are unprecedented; across the entire spectrum of our areas of operation our teams and communities are dealing with ever-increasing pressure, both on the way in which we provide services today and the requirements for how we need to provide them in the future. It is widely acknowledged that doing “more of the same” will not be enough to achieve recovery in the short term or to develop sustainable services in the longer term. We need to take more radical short term action that is likely to be difficult for our teams and communities in order to recover our financial and performance position. We will also need to creatively and boldly redesign the way in which services are provided in the future to ensure their sustainability and viability and to ensure that they are able to deal effectively with these pressures on an ongoing basis.

21. Key factors behind this position now and in the future include:

- Financial pressures both immediate and long term within the context of likely ongoing austerity
- Challenging performance issues across the system
- A workforce that needs to be able to meet the future demands of the population
- Cultural challenges including low historic levels of trust and the existence of silos that mitigate against joined-up working
- Increasing burden of disease including through lifestyle choices

- Demographic challenges with an ageing and growing population, including the impact of positive developments in health meaning more people with complex needs are living both into adulthood and older age
- Pressures on quality and experience of services
- Rising public expectations and messages in the media
- National policy imperatives driving closer joint working, including but not limited to the Care Act, the NHS Five Year Forward View and the Children and Families Act.

22. Various joint partnership groups have been established over the last few years to tackle specific issues across providers and commissioners, and between health and social care. These have included formal statutory partnerships such as Health and Wellbeing Boards and Children's Trusts, executive committees established in order to conduct business jointly such as Collaborative Transformation Board and Joint Commissioning Groups, smaller working groups on specific projects and a range of other approaches to partnership working.

23. While we have developed a firm basis for partnership working, the complexity of this agenda and the mounting pressures outlined above highlight a need for clear, unified leadership and collective coordination of actions for making rapid progress against our most critical issues. We have the opportunity to align the efforts of our teams and to make change happen at pace across our whole system. The chief executives and chief officers of the statutory organisations across the populations in and around York and Scarborough are now establishing collective working arrangements to tackle these issues in concert, through operating as a System Leaders Board.

Establishment of the System Leaders Board

24. The chief executives and chief officers of City of York Council, North Yorkshire County Council, NHS Scarborough and Ryedale Clinical Commissioning Group, Tees, Esk and Wear Valleys NHS Foundation Trust, NHS Vale of York Clinical Commissioning Group and York Teaching Hospital NHS Foundation Trust have established themselves as a System Leaders Board, committed to:

- working together as partners;
- setting direction for their teams to address collective priorities;
- unblocking barriers to support effective action; and
- holding each other to account for delivery.

25. This will align our teams to:

- drive rapid recovery against immediate financial and performance challenges; and
- take bold action to achieve ambitious long-term transformation of services that ensures sustainability

26. The System Leaders Board will meet for the first time in October and will agree its vision and ways of working from there. It is anticipated that the board will want to operate as a single leadership team for the health and care system, managing the priorities of the individual organisations within a wider set of ambitions for the system on behalf of local people, communities and taxpayers.

27. Subject to agreement, the System Leaders Board will support progress against the following areas of partnership working:

- achievement of short term recovery against financial and performance challenges;
- clear delivery of transformational changes to the ways in which services are delivered and configured to ensure long term sustainability;
- maintenance of financial and performance challenges in the longer term;
- development of a framework which at senior leader level endorses the whole system approach that can unblock barriers as and when identified;
- delivery of models of integration between sectors;
- development of efficient ways of working that improve outcomes and are value for money through a collective system approach;
- working together as partners and being able to hold to account and provide challenge to each other in an open and transparent way; and
- identification and communication of short and long term challenges

Governance

28. The establishment of the System Leaders Board does not alter existing governance arrangements within statutory structures. It exists to unblock and facilitate existing work, giving clear, aligned direction to system-wide activity. Reporting lines through to member Boards, Governing Bodies, Committees and the Health and Wellbeing Boards remain as established.

29. In practice this means that the formal accountabilities for the delivery of work back through to committees and boards within statutory organisations all remain in place. If it is proposed that this arrangement should be amended then this will need to be agreed through the relevant responsible committee.

30. Subject to further agreement, the Board will support progress against the priority work areas identified that are being taken forward through a number of other system-wide boards and groups including:

- Provider Alliance Board
    - *Long term focus: transforming joint delivery of integrated community services across providers*
- Integrated Commissioning Executive (ICE)
    - *Long term focus: integrating commissioning across health and social care*
- System Resilience Group (SRG)
    - *Short term focus: recovering performance against key targets*
- Financial Turnaround Board (FTB)
    - *Short and long term focus: ensuring collective system financial pressures are managed including in-year positions and the impact of longer term financial settlements including the Comprehensive Spending Review.*
- A variety of Enabling Workstream Boards
    - *To ensure the infrastructure of the sectors and the development work within them in terms of workforce development, organisational development, ICT and systems, information management, communications and legal*

31. Arrangements across the North Yorkshire area will need to coordinate with the nearest equivalent arrangements being established locally, in a way that minimises duplication. In particular it will be important to ensure good read across between the System Leaders Board and the North Yorkshire Delivery Board, and between the Integrated Commissioning Executive (York / Scarborough) and the North Yorkshire Commissioner Forum.

32. Similarly the Ambitions for Health Board in Scarborough and Ryedale provides system leadership for elements of the agenda that are specific to that locality, and is expected to coordinate its actions with the System Leaders Board across the wider geography.

Glossary

A&E	Accident and Emergency
BCF	Better Care Fund
CAVA	City and Vale Alliance (a GP Alliance)
CCG	Clinical Commissioning Group
CVS	Centre for Voluntary Services
CYC	City of York Council
FRP	Financial Recovery Plan
FTB	Financial Turnaround Board
GP	General Practitioner
HWB	Health and Wellbeing Board
ICE	Integrated Commissioning Executive
NHS	National Health Service
RTT	Referral to Treatment Time
SHIELD	Selby area Healthcare Initiative for Enhanced Local Development (a GP Alliance)

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Health and Wellbeing Board 21st October 2015

Report of the Independent Chair of City Of York Safeguarding Children Board

Annual Report of the City of York Safeguarding Children Board 2014/15

Summary

1. This report will give the Health and Wellbeing Board (HWBB) an indication of key areas of work undertaken by the Safeguarding Children Board during 2014/15. A copy of the report is at Annex A to this report.

2. At their July 2015 meeting the HWBB received a detailed update on the work of the Safeguarding Children Board. Today's report is for information and sign off.

Background

3. The Independent Chair of the Safeguarding Children Board is required by statutory guidance to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

Main/Key Issues to be Considered

4. The Annual Report is for information only but contains a comprehensive overview of work undertaken during 2014/15.

Consultation

5. Members of the Safeguarding Board have provided information for inclusion in the report. The Performance Sub group and Executive for the Board have provided input into the report which was co-ordinated by Children's Services Safeguarding Business Unit.

Options

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

Analysis

7. This section is not applicable to this report.

Strategic/Operational Plans

8. This topic relates to the theme of the CYC Council Plan "Protect vulnerable people".

Implications

9. There are no risks associated with the recommendations set out within this report, it is for information only.

Risk Management

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

Recommendations

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

Reason: To keep the Health and Wellbeing Board up to date with the work of the Safeguarding Children's Board.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Simon Westwood Independent Chair City of York Safeguarding Children Board	Jon Stonehouse Director of Children's Services City Of York Council
	Report Approved ✓ **Date** 12.10.2015

Specialist Implications Officer(s) None

Wards Affected: **All** x

For further information please contact Joe Cocker
Background Papers:
None

Annexes

Annex A - Annual Safeguarding Children Board Report 2014/15

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ANNEX A

City of York Safeguarding Children Board

Annual Report 2014/2015

Executive Summary

Working with children, families and professionals to make our children's lives safer

CITY OF YORK COUNCIL

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About this Document

This document is a short summary of the 2014-15 Annual Report for the City of York Safeguarding Children Board. The full report, with additional supporting information as appendices, will be available on the Safeguarding Children Board website at: **www.saferchildrenyork.org.uk/annual-reports-and-business-plan.htm**

Foreword

This is my second annual report as Independent Chair of the City of York Safeguarding Children Board (CYSCB) and covers the year ending on 31st March 2015.

The work of the Board is driven by its vision agreed during the year:
"For all the children of York to grow up in safety and to always feel safe"

A critical factor in safeguarding children is the skill, effectiveness and professionalism of people who work day to day with vulnerable children and their families. Their jobs are exceptionally hard; something generally not recognised in the media.

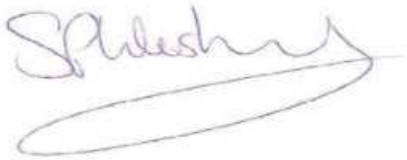
On behalf on the Board I want to thank all those people for their dedication and effort to support children and young people in York.

The Board has seen evidence that partnership working is very strong in York; in operational practice and strategic oversight. Individual agencies that contribute to the work of the Board are properly focussed on safeguarding. Within this report we have set out the achievements made this year but also identified the improvements that we must continue to address over the next few years.

The Board is confident that safeguarding arrangements in York are robust. Nevertheless, we are in no way complacent. There are always improvements to be made, both for our individual partners and as a Board. This year we implemented a new structure that is focused more on our priorities. We aim to build on this and strengthen our influence on other key partnerships supporting children in York. As a Board we are going to tackle challenges and be tenacious even in the face of continuing resource pressures.

The Board will continue to encourage the public and professionals alike to raise their concerns as early as possible. We need children and young people to know that their wellbeing is at the heart of our safeguarding systems.

The Board needs the help of the community to look out for children and young people and my message to everyone is if you have concerns about the safety of a child or young person, **"Say something if you see something."**



Simon Westwood, Independent Chair, CYSCB

Introduction

The City of York Safeguarding Children Board is a statutory body set up under the Children Act 2004, in accordance with the most recent statutory guidance Working Together (2015)[1]. Further information about our work, and our current membership, is available on our website: **www.saferchildrenyork.org.uk/**.
We work closely with York Health and Wellbeing Board and York's Children's Trust, which is known as YorOK.

York is a great place in which to grow up. Our job in the Safeguarding Children Board is to ensure that this applies to every single child and young person, whatever their circumstances. Whilst we can never eliminate entirely the risk of harm to children, the Board is satisfied that in 2014-15 the arrangements for safeguarding children were effective and appropriate.

We have reached this conclusion after a rigorous analysis of all of the evidence. We have looked at statistics, conducted formal reviews and analysis, examined each other's safeguarding arrangements, considered progress against our agreed priorities, and challenged our own performance as a Board. Most importantly of all, we have listened to what children and young people have to say.

This Executive Summary sets out brief details as to how we have reached our conclusions. It also describes our priorities for the year ahead, and the key messages we would like readers to take away. There is a great deal of further detail, and supporting evidence, in our full report, which will be made available on our website[2].

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

[2] www.saferchildrenyork.org.uk/annual-reports-and-business-plan.htm

Some facts and figures

York is a unitary authority with a population of just over 200,000, including around 44,000 children aged 0 to 19. 9.4% of schoolchildren are from a minority ethnic group.

44,000 children aged 0 to 19

The number of looked after children in the city has fallen steadily in 2014-15 from 226 at the start of the year to 195 by the end. 124 children were on a formal child protection plan at the year end.

The city is relatively prosperous, with the level people claiming of out of work benefits statistically lower than regional and national averages. However, 7% of York's population (around 14,000 people - adults and children) live in areas classified as being in the 20% most deprived areas in the country. Recent figures show that 11.4% of children under the age of 19 live in poverty. This is better than the England average and a fall for York of 1.4% since 2014.

What children a ing people have told us

As highlighted in our Annual Report for 2013-14, a joint Voice and Involvement Strategy has been agreed by the YorOK Board and the City of York Safeguarding Children Board. This strategy sets out a clear vision for our work in this area:

"Children and young people are at the heart of our strategic arrangements. We are committed to ensuring that children and young people have a voice in decision-making, planning, commissioning, design and delivery of services."

The Safeguarding Children Involvement Group has now merged with the YorOK Voice and Involvement group to provide a single multi-agency, city-wide group to take forward this agenda. A detailed report looking at work undertaken against this strategy has been produced and is available on the Children's Trust website .

Our full report sets out a range of views expressed by children and young people through a variety of means. Our Board particularly noted that in the major "Stand Up for Us" Survey, overall pupils are feeling better in school than they were in 2011. In addition, in the "UMatter" survey for Looked After Children, 87% of young people felt the council provides good quality placements for children and young people in care.

The table below shows **how safe children in care** felt in different locations.

	Not Safe - 1	Not Sure - 2	Safe - 3	Really safe - 4
At home	2%	7%	9%	82%
At school	6%	2%	30%	62%
Area they live	4%	11%	25%	60%

(Where any concerns were identified these were discussed and normal safeguarding procedures followed.) There is good evidence that issues previously raised with us and our partners by children and young people have been acted on.

Although we believe that the range of opportunities for young people to have a voice is very impressive, our Board is working with the Children's Trust to improve things further.

87% of young people felt the council provides good quality placements for children and young people in care

[3] As a reminder, "Yor-OK" is the name of York's Children's Trust.
[4] See www.yor-ok.org.uk/workforce2014/Voice/voice-and-involvement.htm

How we are doing as a Partnership

In last year's Annual Report we identified five thematic priorities for development and a number of actions. Progress has been made on all fronts, although there is still work to do in some areas:

- Our **Early Help Sub-group** concluded that high quality multi-agency early help provision is making a difference; that the number of statutory interventions is reducing or being maintained against a backdrop of effective early help provision; that early help is now at the heart of strategic multi-agency planning and prioritisation; and that our understanding about the impact of early help arrangements continues to improve.

- **Neglect** remains a serious challenge both nationally and locally. At the end of 2014-15, 46.4% of the children subject to a Child Protection Plan in York were under the category of "neglect". This percentage has risen during the year and is higher than last year, although on a par with the years preceding that. We consider that there remains a pressing need for a coordinated response which builds on the findings of the 2012 thematic review in this area. We have therefore established a new Sub-group to ensure this remains a focus for us in the year ahead.

- We have no reason to believe that there is widespread or under-reported prevalence of **Child Sexual Exploitation** in the York community. However, we are not complacent and we recognise that more needs to be done. We have therefore been working with NSPCC on preparing an awareness campaign about of sexual abuse branded 'It's Not Ok'. The campaign will be launched in early 2015-16 and will cover prevention and education, as well as ensuring that children and their families know how to seek help. A website to complement the campaign will also be created.

The 'It's Not Ok' campaign about sexual abuse, will be launched in early 2015-16

- Data provided to our Board showed that by the end of 2014-15, 94% of those children reported as **missing from education** had either been found or had their cases closed. Cases involving the remaining 6% (2 children) continued to be open and active. New systems have resulted in significant improvements; however, we recognise the need to improve further the coordination of information about children who are missing, and how we jointly consider the strategic implications.

- The information provided to the Board about the increasing number and percentage of children recorded by North Yorkshire Police as present at incidents of **domestic abuse** has raised the Board's concern to the point where we have decided to form a new Sub-group specifically to focus on domestic abuse and the impact on children. The Sub-group will interrogate the data and formulate an approach and strategy in relation to children to complement the city's overall domestic abuse strategy.

We also decided in the course of the year that we needed to initiate a York perspective in a sixth area: **female genital mutilation**. We intend to produce local multi-agency guidance in 2015 based on the national guidance.

Persistent absence and total absence has continued to fall in both primary and secondary schools

The Board has also looked at a range of evidence relating to all aspects of a child's potential "journey". Some key points include:

- Persistent **absence** and total absence has continued to fall in both primary and secondary schools;
- 81% of children aged 0-4 who live in the most deprived 10% of local areas are registered with a **Children's Centre**;
- 2014-15, York had 3,899 **contacts**, and 798 **referrals**, to Children's Social Care[5] . York has a statistically lower rate of referrals than the averages for its statistical neighbours;
- As of 31st March 2015, there were 124 children subject to **Child Protection Plans**, similar to the previous year. This equates to 34 per 10,000 below that of statistical neighbours;
- The number of **looked after children** in the city has fallen steadily in 2014-15 from 220 at the start of the year to 197 by the end. At a rate of 55 per 10,000 population, this is lower than national and regional averages;
- **Health and dental checks of looked after children** remain a challenge: although figures improved at year end, with 66% having up to date health checks and 74.1% up to date dental checks, these are below the England average and below the figures for 2013-14. Health and Social Care colleagues continue to work on ways of improving these figures;
- 62.22% of **adopted children** waited less than 20 months between entering care and moving in with a new family;
- There has been an increase in notifications of **private fostering arrangements** during the year: there were six such arrangements;
- In 2014-15, 306 families meeting the '**Troubled Families**' criteria had their lives successfully turned around by interventions supported by the Family Focus Team;

[5] A 'contact' or 'enquiry' to Children's Social Care refers to a call/email/letter/referral form to the Referral and Assessment teams. A 'referral' is defined as a contact which is accepted for assessment or investigation

- From April 2014 to March 2015, 2 young people age 16 to 25 attended **counselling** appointments. 32 clients aged 16-19 had issues relating to **self-harm**; 33 clients aged 16 to 19 experienced **suicidal thinking**. Fewer than ten young people made suicide attempts;
- The number of first time entrants to the **youth justice system** has reduced by 50% since 2011-12;
- The rate of **teenage pregnancies** has continued to reduce and is at the lowest level since monitoring began in 1998;
- In January 2015, 10% of the mainstream school population (Primary and Secondary) were identified as having **special educational needs**;

e latest 2011 census shows that 313 children and young people aged 0-15 and 997 young people aged 16-25 were identified as **young carers**. York Carers Centre provides a variety of different kinds of support and all young carers are now entitled to an assessment of their needs from the Local Authority.

Our Board examines such data on a regular basis. In 2014-15, we created a new "scorecard" to enable us to monitor trends and developments, particularly in relation to our agreed priorities. In addition the Board accesses data from a range of other sources. These will be published alongside our full report.

Formal Audits a views

Our Board also undertakes a series of more formal audits and reviews in order to provide assurance that safeguarding arrangements are in place, and to serve as a prompt for any improvements that can be made. In 2014-15 we conducted two types of formal audit.

The "Section 11" Audit

Section 11 of the Children Act 2004 places a statutory duty on key agencies and bodies to make arrangements to safeguard and promote the welfare of children. This is the Board's primary audit to examine local safeguarding arrangements and provides us with assurance that agencies are doing all they can to ensure the safety and welfare of children and young people.

In 2014-15, the City of York Safeguarding Children Board collaborated with the North Yorkshire Safeguarding Children Board on the development of a Section 11 audit tool and a joint Section 11 Peer Learning Event. All agencies reported clear improvement across all areas measured against last year's audit. There were no significant multi-agency safeguarding concerns across all agencies as a whole, although some issues and challenges have been identified for individual agencies. In addition, some general areas of development were identified, especially in relation to recognising additional vulnerabilities and barriers in relation to equality, consideration of communicating information in different languages, and the management of complaints.

Multi-agency Case File Audits

During 2014-15 our Multi-agency Case File Audit Group met on nine occasions and examined, in depth, elements of 13 case files. As a result, a range of actions have been agreed:

- 2015 was made the 'Year of Assessment', with multi-agency training delivered by the Advice Team, remodelled to meet audited need;
- The introduction of a new 'Single Assessment' to ensure a holistic approach to assessment and collaboration from all involved with the child and family;
- A strong recommendation from the Board to all partners that therapeutic support should always be sought for victims of sexual abuse;
- Child Sexual Abuse training identified as a priority by our Learning and Development Sub-group and included in the training plan;
- A comprehensive action plan developed by the Head of Safeguarding at York Hospital NHS Foundation Trust to address awareness of, and training in, Female Genital Mutilation for all midwives.

From April 2015 our Multi-agency Case File Audit Group will become the new **Partnership Practice Scrutiny & Review Sub-group** with revised terms of reference, a new chair person, and a fresh programme of thematic audits.

Other audits and reviews

We are pleased to report that no cases have merited **Serious Case Review** during 2014-15. At year end, one case for a possible **Learning Lessons Review** is under consideration by the Serious Cases Panel.

No cases have merited Serious Case Review during 2014-15

Our Board reviews the death of every child (up to the age of 18 years) in the York area via a **Child Death Overview Panel** in order to learn any lessons that may help other children and families in the future. In 2014-14 there were 9 child deaths in York. This brings the average to 11 over the last 5 years and shows a year-on- year decrease of approximately 10%.

There were a total of 45 allegations against professionals received by the **Local Authority Designated Officer** in 2014-15. This represents four fewer than in 2013-14, although the numbers are in line with previous years' figures.

Individual Partner Assessments

The Board also invited the individual agencies who make up our partnership to submit an up-to-date assessment of the state of safeguarding in their organisation. This enables us to share best practice and, where necessary, to challenge each other. These assessments will be published within our full report: they contain a wide range of innovations and improvements to local safeguarding arrangements. Any general learning points that have emerged have been taken into account in determining our priorities for the year ahead.

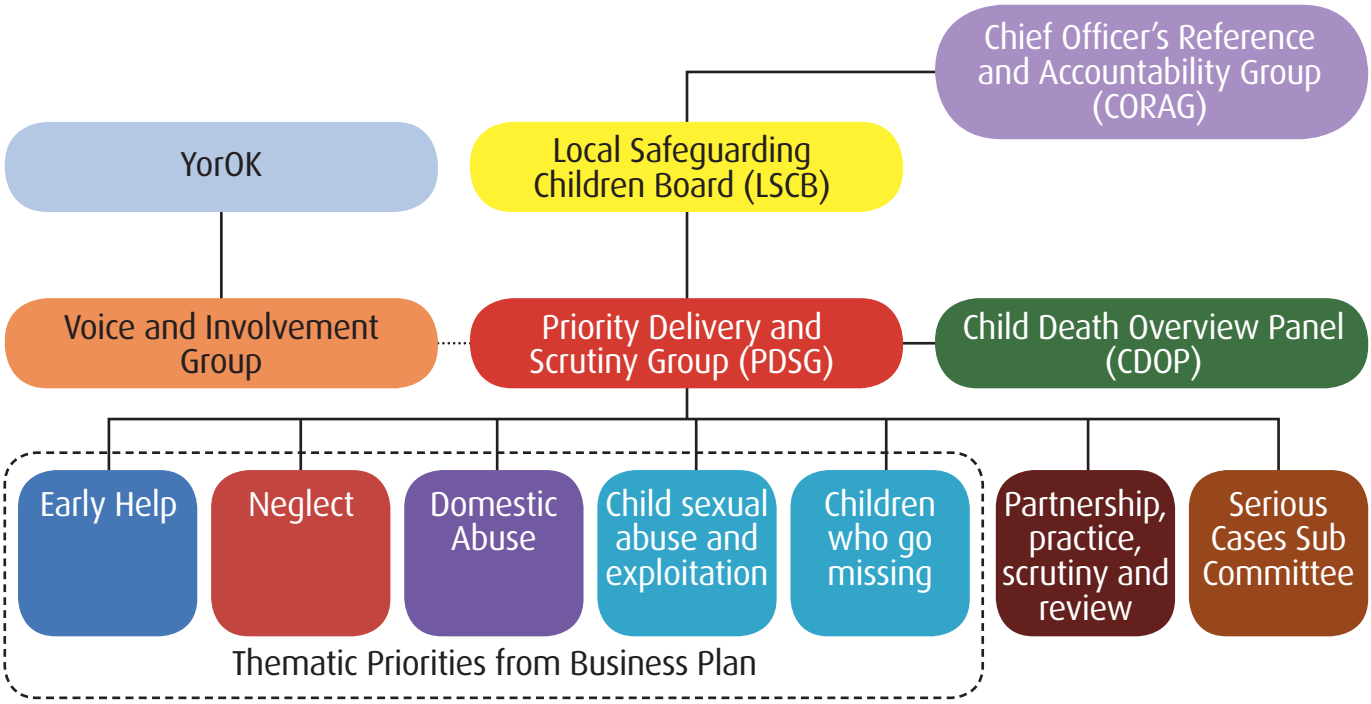
Our performance Board

City of York Safeguarding Children Board meetings, which take place quarterly, are always well attended by members, both statutory and non-statutory, and by advisors. Minutes of our meetings are available on our website. We have a key strategic relationship with York's Children's Trust (YorOK): the Chair of our Board is a Member of the Trust and reports regularly to it; equally, we review and challenge Trust information on a regular basis.

We consider that we work well as a Board, in a spirit of robust challenge and support. However, we could always improve further, and we have therefore agreed a new structure from April 2015. This will see the addition of task groups focused on domestic abuse and neglect; the co-ordination of information about, and strategies for, children and young people missing from home and care into the Child Sexual Abuse & Exploitation Sub-group; the Early Help group (formerly Integrated Working Implementation Group) as a Sub-group of our Board and the YorOK Board jointly; and performance and safeguarding training as overall themes for all groups. The Serious Case Review Sub-committee and Panel will in future be known as the Case Review Group.

This restructure will improve our Board's effectiveness so that we, and our Sub-groups, are even better able to interrogate data and information, as well as to recommend, support and challenge safeguarding activity across all partners.

The new structure is illustrated below. The latest membership is available on our website.



Training and development

The Board has continued to provide a programme of learning and development opportunities throughout 2014-15. Courses are linked to Board priorities, core knowledge requirements and emerging issues and lessons. Quality and content is overseen by our Learning and Development Sub-group. The latest Training Brochure, which conveys the richness and range of our offering, is available on our website[6].

Attendance at our multi-agency training events is usually good, with numbers at, or close to, the preferred target for each course. Courses are not run unless registration rates are viable. There are often waiting lists for some courses. A total of 628 delegates attended multi-agency training from April 2014 – March 2015.

In addition to multi-agency courses, other events, short courses, team inputs or information sessions for staff, linked to the Board's objectives, have been delivered. Around 400 learners/ participants received an input in this way during this period. Finally, a number of commissioned and/or bespoke events took place, reaching almost 200 learners.

Post-course feedback on content, presentation, venue and whether the course met expectations is sought from all delegates at the end of the event. Feedback is consistently excellent and good, with only one or two exceptions (e.g. because the delegate did not feel that the course was relevant to their role, or they expected something different).

Around 600 learners participated in training courses and events in 2014/15

Equality and diversity principles run through all the training we offer. For example, we challenge agency delegates as to whether they make their services accessible to all, including those with physical disabilities or learning difficulties who may require specific tools, aids or language. Our safeguarding training also addresses issues of cultural norms and whether practitioners understand the difference between a safeguarding matter and a cultural matter.

[6] www.saferchildrenyork.org.uk/learning-and-development.htm

The priorities and challenges for next year

Our view is that the existing five priorities identified in last year's Report remain valid – but that some of their component elements may need to change:

- Early help provision forms the foundation for prevention of the escalation of cases and the need for statutory intervention. The Board continues to see this as a priority area and has identified a number of key priorities for the year ahead:
  - further narrowing the attainment gap for pupils in receipt of free school meals, pupil premium groups, and children with special educational needs and disabilities;
  - delivering an integrated and cohesive local child and adolescent mental health services (CAMHS) offer for children and young people in York;
  - responding to increased reporting of self-harm amongst younger people;
  - continuing to improve not in employment, education or training (NEET) rates for vulnerable groups;
  - tackling child obesity, alcohol consumption and the effects of child and parental consumption on health and wellbeing outcomes for children;
  - developing a shared focus on, and response to, the needs of adult parents and how these impact on children;
  - improving our strategic commissioning to enhance provision and outcomes in areas that span children's and adults services.
- Neglect remains a priority for the Board. The overall purpose of the new Neglect Sub-group will be to improve early identification and the effectiveness of the professional response (at all tiers of need) to child neglect. During 2015-16 we will:
  - identify the barriers to translating the lessons of the thematic review into practice and identify strategies to overcome these;
  - develop the thematic review's findings into specific, measurable, achievable, realistic and timely objectives;
  - develop practice guidance and learning opportunities to further improved identification and more effective interventions;
  - identify a range of indicators to identify the prevalence of neglect in York and to measure progress in tackling this;
  - develop and implement systems and practices which improve the early identification and the effectiveness of the professional response to child neglect.
- Child sexual abuse and exploitation also remains a key issue for the Board. Via the Child Sexual Abuse and Exploitation Sub-group, the Board will continue to:
  - establish an understanding of the known prevalence and nature of child sexual abuse and exploitation in the city;

- take an overview of the range o provision, services and interventions available to children and families across all tiers of need that are contributing, or could contribute, to the prevention of abuse and/or exploitation;
- identify learning and development needs across agencies and identify or commission training to address those needs;
- prevent abuse or exploitation by identifying opportunities for raising awareness among young people, parents, carers and potential perpetrators ;
- update an action plan in line with key agreed priorities.

2015 will see the launch of a succession of workshops and seminars for frontline practitioners and for service leaders, linked to the 'It's Not Ok' campaign.

- Missing children, whether from home, from care or from education, are potentially vulnerable to harm. A new joint protocol (York and North Yorkshire) about 'Children Who Go Missing from Home or from Care' goes live in April 2015. The Board will continue to require information about the scale of the issue in York and, the action being taken to protect those most vulnerable children. Mindful of the links between missing children, vulnerabilities and exploitation, the 'missing children' priority will become incorporated into the focus of our Child Sexual Abuse and Exploitation Sub-group. The Board will need to give consideration to the national 'Prevent' agenda and guidance designed to address the issue of young people becoming involved in violent extremism of any kind. The

dern Slavery Act 2015, is designed to tackle slavery in the UK and consolidates previous offences relating to trafficking and slavery. This will also require the attention of the Board and an understanding of the implications for York.

- Domestic abuse remains a significant priority for the Board's attention. The impact on children who live with domestic abuse either as part of a household, or living elsewhere but part of the family, can be profound. Children experiencing domestic abuse may go missing from home or be vulnerable to exploitation. There is an increasing awareness of domestic abuse perpetrated within adolescent relationships. The new Sub-group will interrogate the known data and information about children and young people affected by Domestic Abuse and the effectiveness of arrangements to support them.

Above all, the Board will want assurance that safeguarding remains a priority at all stages of the child's journey, from early help through to statutory services, notwithstanding the challenge of reducing public funds and significant organisational change. Multi-agency planning, strategy and delivery will be reinforced by strong links between our Board, the Office of the Police and Crime Commissioner, the YorOK Board and the Health and Wellbeing Board.

Key messages f[illegible]lers

ANNEX A

For children and young people

- Your wellbeing is at the heart of our child protection systems. Your voices are the most important of all. This Board plans to develop better ways of listening to you.
- Tell us how we can improve services to improve your well-being, to prevent you being harmed, and to protect you.

For the community

- You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them.
- 'If you see something, say something'.
- We all share responsibility for protecting children. If you are worried about a child, contact the Children's Front Door (contact details below).

For practitioners:

- Ensure you are booked onto, and attend, all safeguarding courses and learning events required for your role.
- Be familiar with, and use when necessary, the multi-agency tools designed for you: e.g. our 'Threshold Guidance'[7] and the online safeguarding procedures[8].

For City of York Safeguarding Children Board partners and organisations

- Keep the protection of children at the forefront of your mind. Consider how any plans will affect children and young people.
- You are required to assure this Board that you are discharging your safeguarding duties effectively and ensuring that services are commissioned for the most vulnerable children.
- Ensure that the voices of all children and young people are informing service development.
- Ensure that the voices of vulnerable children are taken notice of, particularly in relation to listening and responding when children disclose abuse.
- Use your representative on our Board to make sure the voices of children and young people and front line practitioners are heard.
- Ensure your workforce is able to contribute to the provision of safeguarding training and to attend training courses and learning events.

[7] www.yor-ok.org.uk/workforce2014/Concerned%20about%20a%20child/childrens-front-door.htm

[8] www.saferchildrenyork.org.uk/child-protection-procedures.htm

If you see something, say something

City of York
Safeguarding Children Board

www.saferchildrenyork.org.uk/

Contact details for the Safeguarding Children Board
CYSCB Chair: Simon Westwood
CYSCB Manager: Joe Cocker

CYSCB, City of York Council,
West Office, Station Rise,
York,
YO1 6GA
Tel 01904 555695

www.saferchildrenyork.org.uk/contact-us.htm
How to report concerns about a child or young person

If you have a concern that a child is vulnerable or at risk of significant harm please contact the Children's Front Door:
Phone for advice: **01904 551900**
or, using a referral form:
Email: **childrensfrontdoor@york.gov.uk**

Post: The Children's Front Door, West Offices, Station Rise, York, YO1 6GA
More information and a referral form are available at:
www.saferchildrenyork.org.uk/concerned-about-a-child-or-young-person.htm

CITY OF YORK COUNCIL

Health and Wellbeing Board Forward Plan 2015-2016

Date	Item
21st October 2015	Report of Safeguarding Adults Board
	Position Statement: Bootham Park Hospital
	Update on Progress Against Renewing the Children's and Young People's Plan
	Response to Recommendations in Healthwatch Reports (PLACE and Who's Who in Health and Social Care) New Healthwatch York Report – A & E and its Alternatives New Healthwatch Report – Discharge from York Hospital
	Standing Item: Better Care Fund (BCF)/Integration
	For Information and Sign Off - Report of Children's Safeguarding Board
October 2015	**Development Session** – Joint Strategic Needs Assessment (JSNA)
November 2015	**Development Session** – **Topic 1** – Information Sharing Protocols and **Topic 2** – Impact of Poor Housing on Health
2nd December 2015	Performance Monitoring Report
	Annual Report from YorOK Board
	Update on Work Towards Implementing the Recommendations Arising from Healthwatch Reports - ("Loneliness – A Modern Epidemic and the Search for a Cure", "Access to Health and Social Care Services for Deaf People", and "Discrimination against Disabled People in York").
	Update: Joint Strategic Needs Assessment
	Update on 0-19 transfer and implementation of new service arrangements

Health and Wellbeing Board Forward Plan 2015-2016

Date	Item
20th January 2016	Update on Progress made against refreshing the Joint Health and Wellbeing Strategy
	Annual Report of the Director of Public Health
	Response to Recommendations in Healthwatch York Reports – A & E and its Alternatives and Discharge from York Hospital
	Getting Past the Barriers in Mental Health Housing/Support – Report from the Mental Health and Learning Disabilities Partnership Board
	Update on the NHS Vale of York Clinical Commissioning Group Five Year Forward Plan
	Family Focus Programme – phase 2 update
	Standing Item: Better Care Fund (BCF)/Integration
February 2016	**Development Session** – Joint Health and Wellbeing Strategy Refresh (tbc)
9th March 2016	Draft Joint Health and Wellbeing Strategy 2016-19
	First Year Report - York Together
	Annual Report of the Health and Wellbeing Board
	Mental Health and Learning Disabilities Partnership Board Annual Report
	Approval Before Submission – NHS Vale of York Clinical Commissioning Group Five Year Forward Plan
	Update on Mental Health Facilities for York
	Emotional Health and Well-being / FiM Transformation Plan
	Standing Item: Joint Strategic Needs Assessment (JSNA)
	Standing Item: Better Care Fund (BCF)
April 2016	**Development Session** – topic to be confirmed

Health and Wellbeing Board Forward Plan 2015-2016

Scheduled for 2016/17:

July 2016 – Report of Adults Safeguarding Board
June/July 2016 – Annual Report on Health Protection 2015/16
Summer 2016 – Healthwatch Report – Access to GPs
October 2016 – Report of Children's Safeguarding Board

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