Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Runciman (Chair), Craghill, Cuthbertson, Looker.

Dr Nigel Wells (Vice Chair) – Chair, NHS Vale of York Clinical Commissioning Group

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

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

Lisa Winward – Chief Constable, North Yorkshire Police
Alison Semmence – Chief Executive, York CVS

Sian Balsom – Manager, Healthwatch York
Shaun Jones – Deputy Locality Director, NHS England and Improvement

Naomi Lonergan – Director of Operations, North Yorkshire & York – Tees, Esk & Wear Valleys NHS Foundation Trust

Simon Morritt – Chief Executive, York Teaching Hospitals NHS Foundation Trust

Stephanie Porter – Director for Primary Care, NHS Vale of York Clinical Commissioning Group

Mike Padgham – Chair, Independent Care Group

Date: Wednesday, 17 November 2021

Time: 4.30 pm

Venue: Remote meeting

A G E N D A

In the event that the Health and Wellbeing Board are required to make decisions, physical attendance meetings will be arranged.

1. Declarations of Interest

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

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

which they may have in respect of business on this agenda.

2. Minutes (Pages 1 - 14)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 15 September 2021.

3. Public Participation

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

Please note that our registration deadlines have changed to 2 working days before the meeting, in order to facilitate the management of public participation at remote meetings. The deadline for registering at this meeting is at **5.00pm on Monday 15 November 2021.**

To register to speak please visit http://www.york.gov.uk/AttendCouncilMeetings to fill out an online registration form. If you have any questions about the registration

form or the meeting please contact the Democracy Officer for the meeting whose details can be found at the foot of the agenda.
Webcasting of Remote Public Meetings

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

The remote public meeting can be viewed live and on demand at www.york.gov.uk/webcasts. During coronavirus, we've made some changes to how we're running council meetings. See our coronavirus updates (www.york.gov.uk/COVIDDemocracy) for more information on meetings and decisions.

4. Development of a Dementia Strategy: Progress Report (Pages 15 - 28)

This report presents the Health and Wellbeing Board with an update on the development of a dementia strategy for York.

5. Health Protection Annual Report (Pages 29 - 66)

This report provides an update on health protection responsibilities within City of York Council and builds on the report from July 2018.

6. York Multiple Complex Needs Network: Cultural Values (Pages 67 - 94)

This report provides information on the Cultural Values Survey, undertaken by the York Multiple Complex Needs (MCN) Network in August 2020, supported by Barrett Values Centre. This was done as a part of our desire to build relationships and consensus about 'what good support looks like', and to identify what enables 'system stakeholders' to act collectively in order to better support people.

7. Current Situation re: Covid-19 and Covid Recovery

The Director of Public Health will give a presentation on the current situation in relation to Covid-19 including recovery plans. This item will be in presentation format to ensure that the most up to date information can be presented to the Health and Wellbeing Board.

8. Update from the York Health and Care Alliance (Pages 95 - 102)
This report is to provide an update on the progress of the York Health and Care Alliance.

9. Healthwatch York Report: What people are telling us: Experiences of York GP Services. A snapshot report (Pages 103 - 130)
This report is for information, sharing a report from Healthwatch York which looks at what people told us about GP services during the pandemic.

10. Report of the Chair of The York Health and Care Collaborative (Pages 131 - 138)
The Health and Wellbeing Board is asked to consider a report on the work of the York Health and Care Collaborative which is attached at Annex A.

11. Better Care Fund Update (Pages 139 - 162)
This report is to provide an update on:

- the national BCF reporting process
- 2020-21 Performance return for sign off
- the planning arrangements for 2022-23
- review of BCF Performance and Delivery Group Terms of Reference.

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

Democracy Officer:

Joseph Kennally
Telephone No – 01904 551573
Email – joseph.kennally@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**

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

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

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Agenda Item 2

City of York Council | Committee Minutes

Meeting	Health and Wellbeing Board
Date	15 September 2021
Present	Councillors Runciman (Chair), Craghill, Cuthbertson, Looker. Dr Nigel Wells (Vice Chair) – Chair, NHS Vale of York Clinical Commissioning Group Dr Emma Broughton – Chair of the York Health and Care Collaborative & a PCN Clinical Director Sharon Sholtz – Director of Public Health, City of York Council Amanda Hatton – Corporate Director of People, City of York Council Lisa Winward – Chief Constable, North Yorkshire Police Alison Semmence – Chief Executive, York CVS Sian Balsom – Manager, Healthwatch York Shaun Jones – Deputy Locality Director, NHS England and Improvement Naomi Lonergan – Director of Operations, North Yorkshire & York – Tees, Esk & Wear Valleys NHS Foundation Trust Stephanie Porter – Director for Primary Care, NHS Vale of York Clinical Commissioning Group Lucy Brown, Director of Communications, York Teaching Hospitals NHS Foundation Trust (Substitute)

Apologies	Mike Padgham – Chair, Independent Care Group Simon Morritt – Chief Executive, York Teaching Hospitals NHS Foundation Trust

52. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests, that they had in relation to the business on the agenda. None were declared.

53. Minutes

The Chair gave several updates:

- The 20 year strategy for health inequalities was still in progress under the Director for Public Health, and could be an addition to the Joint Health and Wellbeing Strategy, although this had not been decided.
- There was a move to establish a new children's partnership focused around the Health and Wellbeing Board's aspirations. This was being worked on by the Health and Wellbeing Partnerships Coordinator and the Executive Member for Children, Young People and Education.
- A meeting on co-production and listening was held between the Health and Wellbeing Partnerships Coordinator and the Manager, Healthwatch York, which will feed into the York Health and Care Alliance and Integrated Care System with the involvement of the Project Manager & Lead for Patient Equality & Diversity at York and Scarborough Teaching Hospitals NHS Foundation Trust.
- A report on the Better Care Fund was to come to the Health and Wellbeing Board in November.

Resolved: That the minutes of the last meeting of the Health and Wellbeing Board held on 21 July 2021 be approved and signed by the Chair.

54. Public Participation

It was reported that there were no registrations to speak under the Council's Public Participation Scheme.

55. The Future Direction of York Early Years Partnership's Collaboration with Nesta

York's early years partnership, the Early Years Improvement Board, was entering into a 3 – 5 year innovation collaboration with Nesta, led by City of York Council. The aim of this partnership was to work across the early years system to find ways in which to address the inequalities that exist in our communities and start from the earliest years of children's lives.

In order to maximise this opportunity the Board received a paper which asked them to consider how they can best support the partnership with a particular focus on governance arrangements in relation to the Early Years Improvement Board. The Head of Education Support Services and the Social Mobility Project Manager were in attendance to present the report and respond to questions.

Key points raised during the presentation of the report included:

- Headline outcomes in York for early years aged children (those aged 0-5) were broadly positive, however the inequality gap between children was large in the first years of their lives.
- Lifelong consequences of poor outcomes in early years were well documented, e.g. the Good Level of Development gap between disadvantaged and non-disadvantaged children in York was the largest in the country in 2017, and had remained persistently large. It was thought likely that the Coivd-19 pandemic would exacerbate this.
- Nesta were an innovation organisation set up by a National Lottery endowment, with a focus on improving outcomes for early years children from disadvantaged backgrounds. Nesta provided significant additional capacity and some funding to the partnership.
- A trial partnership with Nesta had been undertaken over 4 months to test compatibility and deliver a small project together.

- There were 4 options listed in the report which officers recommended the Board accept in order to maximise the effectiveness of the partnership opportunity. These were:
  i. Strengthening governance of early years partnership arrangements.
  ii. Clarifying the early years outcomes that sit underneath the strategic ambitions of the Health and Wellbeing Board strategy around starting and growing well.
  iii. Championing the importance of early years as a shared priority for all.
  iv. Commissioning an early years specific Joint Strategic Needs Assessment (JSNA).

- The first option was recommended by the Early Years Peer Review, which was carried out in October 2020. The proposal was for a clear line of accountability from the Early Years Improvement Board to the Health and Wellbeing Board, with the suggestion that the reports would be received at least twice yearly.
- The second option on outcomes referred to the period after the expiration of the current Health and Wellbeing Board strategy in 2022. Nutrition, immunisation, maternal mental health and speech and language were suggested as key priorities relating to early years for the next stage of the strategy.
- As a priority for the Health and Wellbeing Board, the third option was about how to translate the championing of the importance of early year's into partner's organisational priorities. It was also about challenging the perception that early years was only the responsibility of education or health services and encouraging a broad view of early child development and the wider determinants which affect it.
- The fourth option was to collate data from various early years partners in order to encourage development of integrated working, identify what the Local Partnership's priorities ought to be and to understand the impact of their work. Finally there was to be a shift from reporting on service delivery to specifically on outcomes.

Key points raised by Board members included:

- Officers had gained a great amount of insight on how best to help people to access the support they need for early years from the workshops undertaken.

- The way of working outlined in the report was transferrable to other areas, e.g. barriers to access to the Healthy Start scheme, childhood immunisation and screening programmes.
- There was scope to include NHS partners, including primary care, as having a key role in this issue.
- The JSNA process had been delayed by the Covid-19 pandemic, but the Population Hub had re-started work on it, with the work programme and timescale due to come to the Health and Wellbeing Board in future meetings.
- Links between the Early Years Improvement Board, the Health and Wellbeing Board and the new children's partnership needed to be developed further, since the new partnership's agenda, membership etc. had not yet been finalised.
- The project addressed a need for an organised system of family learning where parents are given help in learning how to transmit language, information and concepts to their children, especially to help those children at a lower Good Level of Development. However, it was unlikely that there would be recognisable results in 3-5 years.
- There were large issues of affordability of childcare nationally and in York, and there needed to be more work to investigate what the main barriers to accessing child care were, and how this could be addressed.
- Parents of young children (particularly mothers) were more likely to experience mental ill-health due to living conditions throughout the Covid-19 pandemic.
- The alignment of children's welfare with the JSNA was one of the key priorities of the York Healthcare Collaborative this year. It was important to improve the channels of communication to prevent duplication of work in this field.
- The biggest challenge G.P.s had been facing during the lockdowns had been the impact on maternal and children's mental health, with a large increase in behavioural problems reported in primary care.
- Affordability was particularly difficult as it had been exacerbated by Covid-19 with providers of childcare struggling to remain viable. Providers had been reliant on statutory funding for places for 2, 3 and 4 year-olds and they had not been able to charge for additional services/consumables. Providers also faced an issue in that wages were rising fast in other sectors, making it

more difficult to recruit and retain staff without raising wages and passing on the cost to parents.

- There was a free, fully funded early education entitlement for eligible 2 year-olds, of which uptake was around 90% in York, compared to 65% nationally. The work with Nesta provided an opportunity to discuss the positive of the scheme with those parents who had not enrolled their children.

Resolved:

i. That the Health and Wellbeing Board agree to adopt all four options presented.

Reason: The recommendations are low risk with potential for significant gain on outcomes for children and their families. To not do so presents risks to the potential impact of the opportunity.

56. Healthwatch York Report: Dentistry

The Board considered a report for information from Healthwatch York about the availability of NHS Dentistry in the city. The Manager, Healthwatch York was in attendance to present the report and respond to questions.

Key points raised during the presentation of the report included:

- People seeking NHS Dentistry services are the most common calls Healthwatch York received.
- Healthwatch York undertook a 2 month consultation with local dentists, from which they determined that it was not possible for people to find an NHS dentist in the city.
- It was believed that the creation of integrated care systems provided an opportunity for creating a strong voice of healthcare professionals to lobby for change of dental contract commissioning at national level.
- Oral health should be linked to other key issues through the integrated care systems, such as weight management, smoking cessation, cancer awareness/detection, mental wellbeing and self-confidence.
- The four areas for action detailed in the report:
  a. Rapid and radical reform of the way dentistry is commissioned and provided.

b. Tackling the twin crises of access and affordability, with particular emphasis on addressing health inequalities
c. Improving the clarity of information about NHS dentistry
d. Consideration of the role of dentistry to support people's overall health, harnessing opportunities such as the integration of health and care through Integrated Care Systems arrangements, to link oral health to other key issues such as weight management, smoking cessation, cancer awareness and detection, and mental wellbeing.

Key points raised by Board members included:

- That it was especially worrying that children were unable to access dentistry.
- Dentistry has been a priority of City of York Council for a number of years, for example the creation of an Oral Health Improvement Group to work on an Oral Health Improvement Strategy which was led by Public Health and chaired by a local dentist. This work was put on hold as a result of the pandemic but was being relaunched.
- City of York Council's Health and Adult Social Care Policy and Scrutiny Committee had been examining dental care as an area of concern for some years, and had decided to look at the issue in more detail at the January 2022 meeting, with the dental commissioner for NHS England and Chair of the Oral Health Improvement Group were to be invited to these discussions.
- Despite attempts to improve dentistry service in the city, it was acknowledged that the issue could not be resolved locally. Lobbying the Chief Dental Officer, Government and MPs was one way of raising awareness of the issue.
- Between March and June 2020, the NHS dental service was only for urgent cases, with phased re-opening of the service thereafter; it was reported that the service was operating at 60% capacity in September 2021.
- The ability for dentistry to meet local needs was hampered by the fact that it was commissioned by national contract.
- Health inequalities, especially for those with mental health issues and learning disabilities were being exacerbated by the lack of NHS dental services.
- A consequence of the absence of dentistry was that patients would present themselves to GPs or A&E with dental problems, who should not be treating dental issues,

but have been forced to prescribe medication for them. This also added to the pressure to general health services. Exact figures of A&E attendance for dental issues were to be brought to a future meeting.

- It was also noted that a large proportion of calls to 111 were related to dentistry issues.
- Many dentists are unhappy with the way dentistry is commissioned, it was suggested that the Board should lobby for an oral health protection service delivered by dentists, instead of the current commissioning by units of dental activity.
- There was a Healthwatch England convened meeting with representatives from Healthwatches around the country and NHS England. Many of the issues York faced were experienced throughout the country. It was reported there was an appetite for a national campaign to reform dentistry.
- It was suggested that lobbying could be conducted through the Local Government Association, that a letter should be written to the Secretary of State for Health and Social Care and the Chief Dental Officer.

Resolved:

i. That Healthwatch York's report, NHS Dentistry: A Service in Decay be received and noted.

ii. That the Director of Public Health write to the Chief Dental Officer and/or the Secretary of State to express the Health and Wellbeing Board's concerns

iii. That the Director of Public Health contact the Local Government Association to see if their HWBB support function could be used to lobby on behalf of HWBBs across the country in relation to access to dental services

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

57. Current Situation re: Covid-19 and Covid Recovery

The Board received a presentation on the current situation in relation to Covid-19 including recovery plans. This item was in presentation format to ensure that the most up to date information could be present to the Board. The Director of

Public Health was in attendance to present and respond questions.

Key points raised during the presentation included:

- York had the lowest rate of Covid-19 cases in the Yorkshire and Humber region for the period 5/9/21 to 11/9/21, and was also below the national average rate.
- However, there were consistently more than 400 new cases of Covid per week in the city, a rate which previously would have caused the imposition of a lockdown.
- It was important not to become complacent around Covid, as even though fewer people would be hospitalised, isolation was still legally mandated to isolate, having knock-on effects throughout society such as work absences and relatives having to care for those infected. A significant proportion would also develop Long Covid.
- The highest proportion of cases were in the 10-14 and 15-19 age groups, which was consistent across the whole of the UK. This was likely due to vaccinations only recently been available to 16-17 year olds and the rollout had not yet been extended to 12-15 year olds.
- There were also cases across all age groups, with relatively high rates amongst the 45-49 age group.
- As of 15/9/21 there were 40 people in York hospitals with Covid-19 and as of 10/9/21 4 people in the intensive care unit. There had been a steady increase in hospital admissions in previous months, and they were expected to increase further into winter.
- There were some deaths due to Covid, but far fewer than at earlier stages of the pandemic, which was attributable to the effects of the vaccination programme.
- As of 26/8/21, there were 6 care homes with a confirmed Covid-19 infection of at least 1 staff member or resident. 1 care home had experienced an outbreak of 2 or more cases on 8/9/21.
- In the 7 days up to 13.9.21 there were 127 children of primary or secondary school age that had tested positive across 26 schools. These cases were expected to increase as a result of these outbreaks.
- 63% of 16-17 year olds had received their first vaccination, and 7% had received their second. These figures were expected to rapidly increase.

- Since contract tracing services were taken over by local authorities, cases completed in York had consistently been above 90%.

Comments from Board members included:

- Enhanced booster doses of the vaccination, as well as co-administration with the winter flu jab were taking place.
- A total of c.150,000 individuals had received their first vaccination, which was around82.4%, with second doses at 76%. The target was 90% which had been achieved for several age brackets.
- The ward with the lowest vaccine take-up was Hull Road, at 63% for first doses.
- Pop-up clinic locations were being made more flexible to address accessibility issues. Information leaflet drops were also ongoing to those who had not yet taken up the vaccine.
- There were high vaccination figures for students returning to York, as well as first years.
- Nimbus Care and partners were running on-site vaccination centres for Fresher's Week at the universities.
- The booster vaccines were to be delivered through pharmacies and general practitioners, as well as Askham Bar through Nimbus Care.
- There was an issue of people who had received their first dose in Home Nations other than England, as well as abroad, who then were unable to prove their vaccination when seeking a second. There was to be a formal response to these issues from the NHS Vale of York CCG.

Resolved:

i. That the contents of the update be noted.

Reason: To allow the Board to remain updated on the current situation relating to Covid-19 and Covid recovery.

58. Understanding Long COVID and the Impact of Long Covid on York's Residents and on Health Inequalities

The Chair of the York Health and Care Collaborative and the Consultant in Public Health, NHS Vale of York Clinical Commissioning Group gave a presentation on the effects of Long Covid on York residents and health inequalities.

Key points raised in the presentation included:

- Long Covid had a vast array of symptoms, and affected about 10% of the population who had been infected with Covid-19.
- Vaccination reduced the risk of developing Long Covid by about 50%, and paediatric cases were likely to be lower, at around 1 in 20 cases.
- Risk factors/the relation to the acuteness of original infection and the full range of effective treatments were not known. Effective diagnostic tests had not been created but were in development.
- There were 970,000 people living with Long Covid in the UK in August 2021, which equated to around 3,000 in the City of York.
- There were three Long Covid multidisciplinary assessment services in operation across North Yorkshire and York.
- Patients were assessed by GPs and referred, with a local screening tool being developed.
- Treatment options for Long Covid included consultant led care for complex cases, occupational therapy, physiotherapy and optimising health through leading a healthy lifestyle.
- Humber, Coast and Vale's one paediatric Long Covid assessment service was based in Hull University Teaching Hospitals, reflecting the expertise there and the low prevalence of such cases.

Comments from Board Members included:

- There was a collaboration between Nimbus and York Centre for Voluntary Service to support patients with Covid, and part of their work had been to raise awareness of Long Covid symptoms and the nature of the illness.
- Increased vaccine take-up would greatly reduce the effects of Long Covid, on patients as well as family, friends and healthcare services.
- Funding for Long Covid services was only in place until March 2022 and would need to be extended to ensure that the condition can be properly understood and would be a critical factor in determining how long vaccination booster programmes would go on for.
- It was important to maintain the emphasis on wearing masks and washing hands as a means of reducing the spread of Covid.

Resolved:

i. That the contents of the update be noted.

Reason: To enable to Health and Wellbeing Board to understand the impact of Long Covid.

[Dr Broughton left the meeting at 5:48]

59. Update from the York Health and Care Alliance

The Board considered a report which provided an update on the progress of the York Health and Care Alliance, including minutes of recent Alliance meetings for Board members to note. The Joint Consultant in Public Health, NHS Vale of York CCG and City of York Council was in attendance to present the report and respond to questions.

Key points raised in the presentation of the report included:

- That the paper was similar to the one presented to the July meeting of the Board.
- There was an evolving transition in the Alliance as the Integrated Care System in Humber Coast and Vale is established in April 2022 and Clinical Commissioning Groups are disestablished.
- An integrated care board constitution had been developed, with accompanying policy documents. A Human Resources framework for transitioning staff had also been released.
- Thriving Places, a policy around place-based partnerships such as the York Health and Care Alliance, should operate was developed. There were a range of options and a certain amount of local flexibility for how place-based partnerships should operate.
- The Maturity Matrix allowed healthcare professionals to determine where the service was doing well or otherwise on integrated care, health inequalities, clinical/professional leadership and citizen engagement.

The Chair stated that this was a developing area and requested that this item be considered at each meeting of the Health and Wellbeing Board until the transition was complete.

Resolved:

i. That the update on the NHS reforms and work of the York Health and Care Alliance be noted.
ii. That the minutes of the York Health and Care Alliance be received and noted.

Reason: To allow the Health and Wellbeing Board to remain informed about the York Health and Cara Alliance and NHS reforms.

Cllr C Runciman, Chair
[The meeting started at 4.30 pm and finished at 6.16 pm].

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CITY OF YORK COUNCIL

NHS Vale of York Clinical Commissioning Group

York Health and Wellbeing Board

Health and Wellbeing Board
17 November 2021

Report of the Adult Mental Health Commissioner, NHS Vale of York Commissioning Group

Development of a Dementia Strategy: Progress report

Summary

1. This report presents the Health and Wellbeing Board with an update on the development of a dementia strategy for York. It highlights a delay in completion of the strategy to allow time for further engagement with people living with dementia and their families. A revised high-level timeline for completion by March 2022 is available at Annex A.

2. The report describes the ongoing work and commitment by partners that action is needed before the ink is dry on the strategy to bring about positive changes and improvements in dementia care and support.

3. The Board are asked to note the report and indicate their ongoing support for the direction of travel and revised timescale for completion of the York Dementia Strategy.

Background

4. A multi-agency group responsible for the delivery of the strategy was established in February 2021 with representation from City of York Council, Dementia Forward, York Minds and Voices, Vale of York CCG, TEWV, York CVS, The Alzheimer Society and York Hospital. Task and Finish groups have been established and actions are underway. These are outlined in Annex B.

5. The group is recently Chaired by Julie Hastings, Lay Member for Patient and Public Involvement, Chair of the Primary Care Commissioning Committee and of the Quality and Patient

Experience Committee, Vale of York Clinical Commissioning Group.

6. The strategy is based on the findings of the former York Dementia Action Alliance and on the experiences and insights of York Minds and Voices and their strategy for dementia. The York Dementia Collaborative has a key role in ensuring the voices of people with dementia are heard and to exchange information, knowledge, and experience so that they actively influence service development and provision. Both the Mental Health Partnership and Ageing Well Partnership are sighted on the strategy development and progress reports have been presented on a regular basis throughout the year.

Main/Key Issues to be Considered:

More time needed to listen

7. The sense of frustration at the delay in developing the strategy is acknowledged, however it is suggested that more time is needed to listen to people with dementia and draw on their experiences, so they are reflected in the strategy and the ongoing work with partners across all sectors to ensure that people can live well with dementia in York. Nevertheless, despite this delay there has been and continues to be significant service development within this area including dementia care coordinators and a specialist dementia nurse in primary care.

8. The COVID-19 pandemic has had a significant impact on people with dementia and their families and carers. Social isolation, and loss of connections to families has resulted in worsening symptoms for some people. The pandemic has also had an impact on dementia diagnosis rates as some people chose to delay their memory assessment. This has accelerated the need for a coherent strategy which addresses the current and future needs of people with dementia and their families.

Engagement carried out so far

9. Healthwatch York secured funding from the Joseph Rowntree Foundation to undertake engagement aimed at understanding people's experiences of dementia and to use these findings to inform the dementia strategy. As part of this work, Healthwatch

developed two surveys; one for people with dementia and one for carers. The timescales for the launch of the survey slipped by two weeks and it was ultimately launched on 24 June with a closing date of 7 September. The online survey is now closed however a link to the Healthwatch website which explains the reasons for the engagement is available in the background papers.

10. To reach as many people as possible and support people to have their say, Healthwatch worked with a wide range of local organisations including York Minds and Voices, Dementia Forward, Older Citizens Advocacy York, the Alzheimer's Society, and local Social Prescribing Link Workers to help complete the survey with the people they support. The survey was available online and paper copies were also distributed. Opportunities for face-to-face engagement however continued to be limited due to social distancing. In September, given there were few responses, the survey remained open online, and reminders were issued with an offer of postal packs for off-line contacts. In total over 700 surveys were distributed electronically, by post and through provider services. The following is a summary of survey responses received:

    - 83 responses in total
    - 67 from carers
    - 4 from people with dementia
    - 6 from carers with the person they support.
    - 1 carer emailed their experience.
    - 5 responses from Beetle Bank Farm

11. The limited number of returns indicates the challenges of a predominantly online approach for people with dementia. With face-to-face activities and dementia cafes now resumed, there are opportunities for genuine engagement, and it is proposed that this takes place over the next two months.

Planned Consultation

12. At the time of writing, arrangements are being made to meet with people at local dementia cafes throughout the city. This is outlined in the high-level timeline at Annex A. Opportunities to hear from people with dementia are also being made with the Dementia Care Coordinators located within primary care. A case study illustrating an example of their work is available at Annex C and demonstrates the power of listening and hearing an individual's story and experiences.

Strategy drafting event

13. A strategy drafting event took place on 7 July, attended by eight members of the multi-agency group. A series of 'We Will' statements were developed and are available at Annex D. Work is ongoing to collate information from key partners and evidence to support the aims and objectives of the strategy.

Recommendations

14. The Health and Wellbeing Board are asked to:

I. Note the report

II. Indicate their ongoing support for the direction of travel and revised timescale for completion of the York Dementia Strategy

Reason: To give the Health and Wellbeing Board oversight of the work of relation to the development of the dementia strategy.

Contact Details

Author:
Sheila Fletcher
Commissioner,
Adult Mental Health
NHS Vale of York Clinical Commissioning Group
Sheila.fletcher1@nhs.net

Chief Officer Responsible for the report:
Denise Nightingale
Director of Transformation (Mental Health and Complex Care)
NHS Vale of York Clinical Commissioning Group
d.nightingale@nhs.net

Report Approved [√] **Date** 4/11/2021

[ ]

Specialist Implications Officer(s)
None

Wards Affected: **All** [√]

For further information please contact the author of the report

Background Papers:
Web link to Healthwatch survey
https://www.healthwatchyork.co.uk/our-work/how-is-support-after-a-dementia-diagnosis-experienced-by-people-who-have-dementia-and-carers-in-york/

Annexes:
Annex A: High-level activity timeline
Annex B: Summary of ongoing work in Task and Finish Groups
Annex C: Dementia Coordinator case study
Annex D: " We Will" statements

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Annex A: High-level Activity Timeline

Activity	Timescale
Engagement: • York Minds and Voices, Lidgett Grove Methodist Church • New Earswick Folk Hall • Wellbeing Café, St Clements Hall Dean's Garden Centre, Dementia Carers Support Group	13/12/21 Date to be confirmed Fridays throughout November/ Dec 1/12/21
Meeting with CYC communication and engagement team on style and design of strategy	13/12/21
Progress reports to Ageing Well Partnership and York Mental Health Partnership	9/12/21 Date to be confirmed
Evaluation of engagement feedback	From 14/12/21
Meeting and discussion on draft with York Dementia Collaborative	January 22 Date to be confirmed
Draft 'mock-up' for partner organisation approvals	February 22 Dates to be confirmed
Deadline for final strategy and report to Health and Well Being Board	3/3/22
Health and Well Being board approval	16/3/22

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Annex B: Summary of ongoing work in Task and Finish Groups

The following is a summary of progress so far and ongoing activity in the task and finish groups.

- Referrals from primary care and self-referral to Dementia Forward for **pre-diagnostic** support to provide wrap-around support throughout the diagnostic journey and for people with concerns about their memory needing guidance and reassurance.
- Specialist dementia nurse commissioned to work with primary care to identify and support people at high risk, undertake advance care planning, work with integrated teams across the system to avoid crisis and avoidable admissions
- Dementia coordinators commissioned to undertake 'case finding', early identification and support in primary care
- Identifying and addressing bottlenecks in referral to diagnosis pathway
- Piloting a multi-disciplinary team approach for diagnosis and treatment in primary care where appropriate, with consultant support.
- Deep dive planned to highlight gaps in services for people with young onset dementia
- 'Case finding' in care homes
- Proposal for the 'Good Life' course; a peer-led, post diagnostic programme offered from the memory service. It offers an opportunity to talk about the implications of a diagnosis; about the future; about close relationships, about dying; about what’s happening and what can help – all done amongst peers.
- Roll -out of Positive Approaches to Care (PAC) training in mental health services and York Hospital Trust.
- Planned online training resource for GPs developed by the Alzheimer's Society

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ANNEX C

York Dementia Care Coordinator Case Study

Reports are run on the clinical systems by the Dementia Care Coordinator at the GP practice to identify patients at risk of dementia. A patient was identified with suspected dementia however no investigation, assessment or formal diagnosis had been undertaken. The Dementia Care Coordinator contacted the nominated family representative who agreed to a home visit.

The patient has what is considered advanced dementia and received only half an hour care visit a day. The patient's family member was also caring for his other elderly parent who was mostly bedridden. They were putting off an important operation as this would result in them being unable to walk for some months after, and as the main carer this was a huge anxiety and cause of carer strain. The Dementia Care Coordinator liaised with the GP to review the patient for primary care diagnosis and the GP requested a District Nurse to undertake the necessary blood tests. A referral was made to Dementia Forward for family support. The complex care team were unable to get the patient a bed in a specialist care home for respite as there was no formal dementia diagnosis.

A case was put forward to the GP, containing all the evidence gathered from the home visit, conversations with the patient and collateral history from the family member. Once blood results were received which ruled out any organic cause for cognitive decline, a diagnosis was made. The support package has increased to four times daily and the family member is in regular contact with the Dementia Support Advisor. They can now schedule their operation knowing their parent will receive the support and care that they require. Annual reviews will now be undertaken by the GP surgery to monitor the patient and continuous care reviews will take place to ensure the care given is fulfilling the patient’s needs.

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National Dementia Pathway themes	"PREVENTING WELL (Risk of people developing dementia is minimised)"	DIAGNOSING WELL (Timely accurate diagnosis, care plan and review within first year)	"SUPPORTING WELL (Access to safe high-quality health and social care for people with dementia and carers)"	"LIVING WELL (People with dementia can live normally in safe and accepting communities)"	DYING WELL (People with dementia die with dignity in the place of their choosing)	TRAINING WELL
Minds & Voices strategy	Before diagnosis promoting awareness, challenging myths, a call for transparency	At the time of diagnosis - positive language and hope through research	Post diagnosis - services to fit us rather than us having to fit services	The future - ongoing support that is not time-limited'		
DAA priorities and identified gaps	Prevention: Public Health promotion	Improve early identification and accurate diagnosis	Establish a post diagnostic pathway of support Carer's support	Have a positive campaign about living with dementia		
Series of statements here for services to populate– see BMS as an example below **WE WILL**	We will Work to improve awareness and understanding of the factors that increase the risk of dementia and how people can reduce their risk by living a healthier life Work with professionals to increase the uptake of annual NHS Health Check for people over the age of 65 and for earlier age groups there is education around risk factors and self-help "*what's good for your heart is good for your head" campaign.* Work with professionals to increase increase the uptake of health checks for people with learning disabilities. Understand local Public Health data to target interventions aimed at risk factors e.g., obesity, alcohol, deafness Increase opportunities to address social isolation and loneliness through social prescribing etc	We will: Work towards a target of everyone receiving a formal diagnosis in a timely manner (BMS) Provide a personalised approach to assessment and diagnosis with shared decision making Ensure that diagnoses are delivered in a way that recognises the impact on the person and their carer, their needs and that full follow up support is offered tailored to individual diagnosis/needs Work to ensure that the diagnosis process is clear and transparent (information beforehand) to people and involves no more professionals or appointments than necessary (BMS) Work together to explore alternative diagnostic pathways, for example using other professionals and tools such as DIADEM 'Work together to address bottlenecks in the current pathway Develop clear, accessible information to ensure people	We will Ensure people with dementia are in the driving seat of shaping and developing services, learning and research in York Promote participation in research with and alongside people with dementia rather than ON people with dementia Improve access to support and develop peer support options delivered by people living with dementia Offer more choice and control by expanding personal health budgets for people assessed as being eligible for care Build on 'discharge to assess' and Home First approaches to prevent unnecessary long stays in hospital which could lead to worse outcomes and increase someone's long-term needs Monitor and share the progress of new technology and the ways it could support people living with dementia and their carers Provide seamless holistic support that is easily	We will Develop family support (wider than just carers) and develop more support for working age adults to support them in employment' Work with employers to emphasise the importance of supporting and valuing carers of people living with dementia in employment Ensure people with dementia are not discriminated against because of their diagnosis Establish a network of peer groups of people with dementia across the area Start the dementia conversation and maintain an open dialogue with people living with dementia and their supporters throughout the life of this strategy and beyond' Challenge the disabling language, attitudes and environment that impede the lives of people living with dementia Develop dementia awareness and intergenerational projects in schools	We will Develop training and awareness around the importance of advance care planning and end of life care Improve and promote information advice and guidance to enable people to make early and informed decisions around mental capacity, planning for the future and end of life care Work to challenge the social and professional stigma and nervousness around death and dying	We will Provide a learning and development framework that meets the learning needs of health and care professionals regardless of role, position, or experience Review the training and development offer to independent sector care staff and work with providers to assess training and development needs Ensure that people with dementia are involved in leading and developing all dementia learning and development across the York area. We will provide opportunities for everyone with dementia to answer questions about the impact of their diagnosis amongst peers.

ANNEX D

		receive timely, appropriate support Ensure a 'safe travel' from the point of diagnosis and throughout Ensure that people affected by dementia design and participate in post-diagnostic support 'Provide proactive, personalised support with a named coordinator	accessible with no thresholds or time-limit Refine data on people with dementia to inform planning and commissioning of high-quality services Ensure that people with dementia have a single digital health and care record that is accessible to all professionals involved in their care. This must include advance care planning			
Principles	Hearing patient voice, co-design, and person-centred approaches to improvement Our we will statement include both people with dementia and carers….					

ANNEX D

York Health and Wellbeing Board

Health and Wellbeing Board 17 November 2021
Report of the Director of Public Health

Health Protection Assurance report

1. Summary

This report provides an update on health protection responsibilities within City of York Council and builds on the report from July 2018.

Health and Wellbeing Boards are required to be informed and assured that the health protection arrangements meet the needs of the local population.

2. Background

The scope of health protection is wide ranging. The system responsibilities for Health Protection changed on 1 October 2021 and these are outlined in Annex 1.

The scale of work undertaken by local government to prevent and manage threats to health will be driven by the health risks in the Local Authority area and includes:

- National programmes for vaccination and immunisation
- National programmes for screening, including those for antenatal and newborn; cancer (bowel, breast and cervical); diabetic eye screening and abdominal aortic aneurism screening
- Management of environmental hazards including those relating to air pollution and food
- Health emergency preparedness and response, including management of incidents relating to communicable disease (e.g. COVID-19) and chemical, biological, radiological and nuclear hazards
- Infection prevention and control in health and social care community settings

- Other measures for the prevention, treatment and control of the management of communicable disease as appropriate and in response to specific incidents.

Main/Key Issues to be considered

3. Sexual Health.

The two PHOF (Public Health Outcomes Framework) indicators for sexual health are Chlamydia detection rate and late diagnosis of HIV. For both these indicators York is worse than the England average. HIV England 43.1%, Yorkshire and Humber 51.3%, York 57.9% of HIV cases which are diagnosed late. Chlamydia rate per 100,000 population; England average 1420, Yorkshire & Humber 1498, York 1107.

The commissioned sexual health service continues to try to reverse this trend taking lessons learned and examples of good practice from national and local services.

In the last year the Chlamydia Care Pathway tool has been implemented in line with Public Health England guidance (PHE) to support comprehensive case management. This has 4 main areas of Increasing testing uptake, detecting infections, treatment and partner notification and management.

This year PHE (as was) has undertaken an evidence review of the National Chlamydia Screening Programme (NCSP) and has recommended some changes to the programme based on input from national and international experts and consultation with stakeholders and service users. Our commissioned providers – YorSexualHealth- will support these changes locally.

Comparing data from January to June 2019 and the same period in 2020 there was a 30% reduction in tests for chlamydia, gonorrhoea and syphilis and a 35% reduction in HIV at SHSs.

Between January and April 2020, the reduction in chlamydia testing was greater among specialist SHSs (85%) than in non-specialist SHSs (56%), largely due to the higher proportion of internet-delivered tests offered

Data taken from[1]PHE report.

4. Late HIV diagnosis.

It is worth noting that the data is over a 3 year period for the late HIV diagnosis. Due to the low number of cases, data swings hugely year on year.

Sexually Transmitted Infections (STI) detection rates in York (excluding Chlamydia 15-24 year olds) have improved and are better in York than the England and Regional average (Eng. 619, Y&H 419 and York 378 /100,000 population in 2020). Although late diagnosis of HIV remains a concern in York, this is reflected across the region.

There are fewer HIV diagnosis in Men who have Sex with Men (MSM), possibly due to the take up of Pre-Exposure Prophylaxis treatment (PrEP), as more MSM are using PrEP there are fewer cases in those that see themselves at risk and test regularly.

Late diagnosis of HIV is now mainly seen in individuals who would not be in a clinically higher risk population although recent PreP Impact Trials show that some groups share vulnerabilities which increases their risk of HIV and amplifies their need for, and access to, PrEP. Societal experience or complex environments may make it difficult to negotiate sex (such as housing insecurity, poverty, gender-based violence) or access services due to stigma or transphobia. The trial also recognised that there is an inequity in PrEP uptake in women, trans, non-binary, BAME and heterosexual men. Regional work is planned to look at how these inequalities can be addressed

5. The COVID effect.

There is strong evidence that the COVID-19 pandemic response, including social and physical distancing measures, led to a re-prioritisation and disruption in provision of, and patient access to, sexual health services. Several studies have that indicated during the pandemic there was a significant disruption to services and re-deployment of staff. There have also been reports of disruption to supplies of laboratory consumables due to increased demand which have impacted on testing service capacity.

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943657/Impact_of_COVID-19_Report_2020.pdf

It is likely there has been some reduction in infections and service need following compliance with social distancing measures, resulting in fewer opportunities for travelling and meeting sexual partners and reduced risk of exposure suggests there was a decline in risky behaviours during this period that may have contributed to the fall in diagnoses.

6. Immunisations and Vaccinations.

The table below shows the PHOF immunisation and Vaccination data where York is not in line with England or Y&H rates.

PHOF Indicator	England	Yorkshire and the Humber	York
MMR 2 doses (5 years). Target >95% (2019/20)	86.8	89.8	89.5
Flu primary school aged vaccination (2019)	60.4	60.8	55.0
HPV Vaccinations – 2 doses (13/14 years) female. Target >90% (2019/20)	64.7	71.9	53.0
Flu vaccinations for at risk individuals. Target >75% (2019/20)	44.9	45.0	44.3
Shingles Vaccination (71 years). Target >60% (2018/19)	49.1	51.4	47.7

- MMR2 – By five years of age York is above the regional and national average for MMR1 with an uptake of 96%. However MMR2 still remains stubbornly below the national target, this may be due to a number of factors including parents not seeing the value of two vaccinations and delay in MMR1 uptake.

- Primary age flu – Provisional monthly data for Primary age Flu (September 2020 to 31 January 2021) indicated that this has risen to 74.9 in York whilst remaining fairly static for both the regional and England average.

- HPV – Human Papilloma Virus. Covid impact on school closures, pupils not being in school when the team attended, together with schools reluctance to have visiting teams in school have all had an impact on uptake. Work continues to mitigate against the low up take with a programme of catch up clinics and this has been further supported by a more favourable response from schools.

- Flu vaccination for at risk individuals. All local authorities across the Yorkshire and Humber Region and the England average were below the national target for this cohort. These again were the individual who were shielding as part of the COVID outbreak measures and this may have had an impact on this cohort.

- Shingles. The Shingles vaccination programme was affected severely due to the target group also being those who were shielding during the COVID-19 pandemic and not wanting to attend GP surgery.

7. Influenza.

The 2020/2021 influenza vaccination was the biggest vaccination programme ever, aiming to offer protection to as many eligible people as possible during the coronavirus (COVID-19) pandemic.

As a result of non-pharmaceutical interventions in place for COVID-19 (such as mask-wearing, physical and social distancing, and restricted international travel) influenza activity levels were extremely low globally in 2020 to 2021. A lower level of population immunity against influenza is expected in 2021 to 2022. In the situation where social mixing and social contact return towards pre-pandemic norms, it is expected that winter 2021 to 2022 will be the first winter in the UK when seasonal influenza virus (and other respiratory viruses) will co-circulate alongside COVID-19.

Seasonal influenza and COVID-19 viruses have the potential to add substantially to the winter pressures usually faced by the NHS, particularly if infection waves from both viruses coincide. The timing and magnitude of potential influenza and COVID-19 infection waves for winter 2021 to 2022 are currently unknown, but mathematical modelling indicates the 2021 to 2022 influenza season in the UK could be up to 50% larger than typically seen and it is also possible that the 2021 to 2022 influenza season will begin earlier than usual.

Influenza vaccination is therefore an important priority this coming autumn to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may also be managing winter outbreaks of COVID-19.

8. Flu by group

The national influenza immunisation programme aims to provide direct protection to those who are at higher risk of influenza associated morbidity and mortality. Groups eligible for influenza vaccination are based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) and include older people, pregnant women, and those with certain underlying medical conditions.

Since 2013, influenza vaccination has been offered to children in a phased roll-out to provide both individual protection to the children themselves and reduce transmission across all age groups to protect vulnerable members of the population.

The expanded influenza vaccination programme that was introduced last year will continue in 2021 to 2022 as we are likely to see both influenza and COVID-19 in circulation. This means that the following additional cohorts will be included:

- 50 to 64 year olds will continue this year to protect this age group, as hospitalisation from COVID-19 also increases from the age of 50 years onwards.
- all those from years 7 to year 11 will be offered vaccination.

Details those eligible for NHS Influenza vaccination in 2021/2022 is outlined in Annex 2.

The table below gives the number of individuals who are eligible for a free flu vaccination, the numbers vaccinated and the percentage for Vale of York CCG in 2020.

Cohort Name	Count of Individuals	Vaccinated	% Vaccinated/Individuals
0 to 15 at risk	1,655	1,148	69.37%
16 to 17 at risk	483	257	53.21%
18 to 64 at risk	31,691	19,996	63.10%
2-3 year olds	6,531	4,563	69.87%
50 - 64 year olds	72,749	36,389	50.02%
65 + at risk	34,552	30,603	88.57%
65 + not at risk	38,172	30,764	80.59%
NHS and social care Worker	8,585	1,809	21.07%
Other - 0 to 17	691	691	100.00%
Other - 18 to 49	7,286	7,286	100.00%
Other - 50 to 64 before 1st Dec	0	0	0.00%
Pregnant women	1,516	249	16.42%
School age children reception to year 7	29,605	20,324	68.65%

9. COVID-19

In January 2019 York saw the first case of COVID-19 in the country, since then the councils statutory Public Health functions have been developed around an Outbreak Management Plan and the establishment of an Outbreak Management Advisory Board (OMAB). The membership of the board is wide ranging and includes members of staff from within CYC and associated partners from statutory, private and voluntary sectors.

OMAB ensures that the statutory bodies are able to make informed decisions throughout the pandemic by building on good practice, identifying and supporting the resolution of any barriers and making the most of any opportunities that may arise including outbreak management, Test and Trace and supporting effective communication.

10. Overview of COVID response in York.

The numbers of COVID cases per 100,000 population changes daily and is available on York Open data. This platform also shows vaccination rates:

Vaccinations for People aged 16+ (1st and 2nd dose)

• As at 20.10.21 a total of 153,290 CYC residents aged 16+ have had the first dose of the vaccine. This represents 86% of the estimated (16+) population of York (ONS 2020)

• As at 20.10.21 a total of 143,988 CYC residents aged 16+ have had both doses of the vaccine. This represents 80.8% of the estimated (16+) population of York (ONS 2020).

Vaccinations for People aged 12-15 (1st dose only)

• As at 20.10.21 a total of 873 CYC residents aged 12-15 have had the first dose of the vaccine. This represents 10.4% of the estimated (12-15) population of York (ONS 2020)

11. Health Care Acquired Infections (HCAI's)

To support the management and prevention of Health Care Acquired infections (HCAIs) a multi-disciplinary partnership group, chaired by Public Health meets regularly to:

- Through a multi-agency approach, manage Healthcare Associated Infection (HCAI) across the healthcare system aimed at the consistent reduction of all HCAI in the population of the Vale of York.
- Ensure that lessons for preventing future HCAI are learned from the review of current and previous cases.
- Ensure the lessons are shared across all sectors of healthcare
- Ensure completion of identified actions to implement the learning from these reviews.

Notification, outbreaks and deaths associated with Clostridium difficile (C.Diff or C.Difficile or CDI) and methicillin-resistant Staphylococcus aureus (MRSA) are all investigated in line with the CCG Serious Incident policy via a Root Cause Analysis (RCA) or Post Incident report (PIR). The group makes recommendations for improvement, disseminates and demonstrates the learning for these investigations by illustrating common root causes, themes and trends.

The group examines antibiotic prescribing across primary and secondary care and makes recommendations to improve practice in line with prescribing guidelines.

12. Oral Health

PHOF data shows that York, compared with England average has poorer access to dental services (England 94.7% successful access, York 92.5%). York has a slightly better outcome for visible dental decay in 5 year olds in comparison to the England average (England 23.4%, York 18.9%)

Oral diseases are the most prevalent non-communicable diseases (NCD) which cause mortality and disability worldwide. During the pandemic the severity of the impact of NCD is associated with the severity and positive rates of COVID-19 indicating that prevention and control of NCD are integral parts to the COVID response, NCDs are predicted to rise due to the prioritisation of COVID[2].

A global ban on elective dental procedures during the pandemic has had a strong impact on public oral health and oral health quality of life.[3] The impact of this is a deterioration of health promoting behaviours especially in the lower socio-economic groups where financial impacts of COVID has resulted in people not seeking dental treatments. Therefore public health and partners are working on oral health promotion messages to encourage good dental hygiene and care.

CYC Public Health chair the Oral Health Improvement Advisory Group (OHAIG) which is a multi agency meeting bringing together a wide range of partners and stakeholders to look at interventions and actions to promote the reduction in oral disease and dental decay.

13. Screening:

The NHS provides five national screening programmes for adults: abdominal aortic aneurysm (AAA), diabetic eye, Bowel cancer, breast cancer and cervical cancer. The COVID-19 pandemic and subsequent lock downs resulted in all programmes being significantly affected as they were temporally suspended during the early stages of the pandemic. Other factors which affected uptake was the inability or unwillingness of invitees to take part

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7323217/

[3] https://oralhealth.cochrane.org/sites/oralhealth.cochrane.org/files/public/uploads/covid19_dental_review_16_may_2020_update.pdf

due to shielding, anxiety regarding overburdening the NHS and fear of the COVID virus.

Work is taking place to encourage people to come forward for screening and to assure people that the NHS, who deliver the screening programmes, is 'open for business'. CYC public health work with partners to target communications for those screening programmes where targets are not being met.

Some comparative data for screening programmes is not available over the period of the pandemic.

- **AAA – Abdominal Aortic Aneurysm**. In England, screening for AAA is offered to men during the year they turn 65. Men aged 65 or over are most at risk of getting AAAs. For North Yorkshire and the Humber the percentage screened was 92.8% in 2020/21.

- **Breast -** Routine breast screening was paused on 24th March 2020 due to the coronavirus (Covid19) pandemic. Throughout the pandemic the service continued to see high risk women and women that had positive screen results. Routine screening in the North Yorkshire and York restarted in August 2020. Unfortunately local service data is not available due to the impact of the pandemic on screening services.

- **Bowel** - NHS bowel cancer screening programme is available to everyone aged 60 or over. In 2021 the programme expanded to include 56 year olds. The data is collected via CCG on the proportion of men and women aged 60 to 74 who when invited to participate in bowel cancer screening do so. For Vale of York CCG this is 77.1%. This is above the performance threshold of 60%.

- **Cervical –** All women and people with a cervix aged 25 to 64 are invited to screening by letter. Data is recorded by CCG area and in two cohorts with the acceptable level of those screened adequately set at 80%. In Vale of York CCG women aged 25 to 49 reached 71.4% and women aged 50 to 64, 77.1%.

- **Diabetic Eye -** Diabetic eye screening is a test to check for eye problems caused by diabetes. People aged 12 or over and have diabetes are invited via letter to have their eyes checked annually. The North Yorkshire Screening service covers York

and achieves a 78.7% attendance rate which exceeds the acceptable performance threshold of 75%.

14. Infection, Prevention and Control (IPC).

The Public Health team in CYC work with the CCG via a section 75 agreement for the provision of community and Primary care IPC. IPC for secondary care is the responsibility of York Hospitals Foundation NHS Trust and is delivered in house.

15. What we do well in York?

Health Protection encompasses a wider range of topics and agencies to ensure risks to the population are minimised, Partnership working is evident throughout with all those involved working to a common goal. This has been recognised in the recent Covid peer review attached as appendix A.

Working at regional level via the Screening and Immunisation Oversight Group (SIOG) and at a local level via Screening and Immunisation Team, working with CCG and multi-agency working for reduction of HCAI and anti-microbial stewardship.

In York there have been good levels of vaccination up take and the local covid response to care homes, school and business has been exceptional

Governance for Health Protection in York is well established, strong and robust. This was further strengthened throughout the pandemic as the Director of Public Health established the COVID Advisory Board and a multi- disciplinary Outbreak Management Group to respond to the pandemic locally, implementing government guidelines and responding to local need.

Wider governance of health protection sits with the York and North Yorkshire Health Protection Board (HPB) which is chaired by York Director of Public Health and has multi agency attendance to give assurance that measures are in place from the local authority and partner agencies to reduce the risk of harm to our population.

To complement this a York specific Health Protection Group has been established, led by the Nurse Consultant in Public Health, this group takes its strategic lead from the HPB providing practical

and operational support to ensure the health protection arrangements within the City are robust.

16. Consultation

The writing of this report has included input from Emergency Preparedness Manager, Public Protection and Business Intelligence from CYC. Data on screening and Immunisation programmes has been provided by Screening and Immunisation Co-ordinator from Yorkshire and the Humber NHS England/Improvement.

17. Options

The Health and Wellbeing Board are asked to accept this report as an accurate representation of health protection assurance in CYC, noting the risks and implications detailed within.

18. Analysis

COVID-19 continues to be a major Public Health concern as the country moves into its first winter where COVID and seasonal flu will add further pressures on to the NHS. The spread of the more transmissible Delta variant drove a rapid growth in COVID-19 cases in England and these continue to rise to a point where we now have significantly more cases than this time last year.

Without the non-pharmaceutical measures that reduced transmission in 2019/20 (e.g. face coverings, social distancing, and lockdown measures) it is likely that influenza infections will continue to increase.

Recovery plan to resume and catch up on the back log of Immunisation and Screening continues at a pace with the introduction of measures to keep staff and patients safe.

The number of organisations reporting recruitment difficulties has increased for many employers, including the NHS as the King's Fund report indicated[4]. Loss of skilled workers will have an impact on hospitals, community health provision, HCV drivers and the supplies of goods and medicines.

[4] https://www.kingsfund.org.uk/publications/articles/brexit-end-of-transition-period-impact-health-care-system

19. Strategic/Operational Plans

Good Health and Wellbeing for our population is a consistent theme that runs through all of our Strategic and Operational Plans. Public Health have been supporting communities, colleagues and partners throughout the pandemic to create resilient, well informed staff and citizens. From changing how our mandated services operated to ensure that access for our most vulnerable residents was maintained, to ensuring that testing, contact tracing and COVID vaccinations were accessible to all. The council plan acknowledges these responses to the pandemic and outlines how we will build back stronger, healthier and fairer to ensure York remains resilient to the on-going pandemic.

To support the response to the pandemic the Director of Public Health established a COVID Outbreak Management Advisory Board and a multi- disciplinary Outbreak Management Group to respond to the pandemic locally, implementing government guidelines.

20. Implications

There are no specialist implications from this report.

21. Risk Management

The immediate Health Protection priority is to continue to fight the COVID-19 pandemic. There is still a risk of new novel viruses and variants and these pose the most serious risk to global recovery. Building on the infrastructure developed for COVID there is still the need to tackle and prevent other infectious diseases and external health threats as we move into the ‘contain’ phase of the pandemic.

The pandemic exposed stark inequalities in our society and city. Understanding and influencing the wide range of factors that determine health outcomes and impacts on the most disadvantaged and tackling these remain a priority for Public Health in York.

Future funding of commissioned services remains a concern. Sexually transmitted infections (STIs) and unplanned pregnancy are amongst the most important contributors to poor health, particularly in the most deprived neighbourhoods. A recent study

indicated that in the UK the proportion of unplanned pregnancies almost doubled during the pandemic[5].

Major service transformations have taken place locally in the face of significant cuts to the budget and further innovations and efficiencies are now limited without an increase in spending. The Long Acting Reversible Contraception (LARC) contract held with are CCG partners is a particular cause for concern as the demand for LARC increases post-pandemic and lack of resource within the contract to make the service a viable commissioned service.

Staffing capacity is a concern across the health economy, and this is particularly seen in sexual health and IPC clinical staff. Qualified clinicians with these specialist skills are a valuable resource and are in short supply affecting the delivery of these services.

City of York Councils Emergency Planning Team works with the North Yorkshire Local Resilience Forum and blue light services to manage and respond to major incidents and emergencies, this includes (but not limited to): terrorist threats, flooding and pollution.

22. Recommendations

The Health and Wellbeing Board are asked to receive the report.

Contact Details

Report Authors:	**Chief Officer responsible for the report:**
Philippa Press Public Health Specialist Practitioner Advanced Philippa.press@york.gov.uk Anita Dobson Nurse Consultant in Public Health Anita.dobson@york.gov.uk	Sharon Stoltz Director of Public Health Sharon.stoltz@york.gov.uk Approved: 05.11.2021

Wards Affected: All

[5] https://srh.bmj.com/content/familyplanning/early/2021/10/17/bmjsrh-2021-201164.full.pdf?mc_cid=8fbe38bb7e&mc_eid=826051360a

Annexes*:*

Annex 1: Location of PHE functions from 1 October 2021

Annex 2: Those eligible for NHS influenza vaccination in 2021 to 2022

Appendix A: LGA Outbreak Management Peer Challenge

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Glossary for H&WBB November 2021		
Abbreviation	**In full**	**Explanation**
BAME	Black, Asian, and Minority Ethnic	Black, Asian, and minority ethnic, is an umbrella term, common in the United Kingdom, used to describe non-white ethnicities
CDI	Clostridium difficile	Also known as CDI, C. difficile or C. diff, is a bacteria that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics.
COVID or COVID-19	Coronavirus disease (COVID-19)	Coronaviruses are a large family of viruses with some causing less severe disease, such as the common cold, and others causing more severe disease, such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses. They are a different family of viruses to the Influenza viruses that cause the seasonal flu.
DHSC	Department of health and Social Care	The Department of Health and Social Care (DHSC) is the UK government department responsible for government policy on health and adult social care matters in England. The department develops policies and guidelines to improve the quality of care and to meet patient expectations.
DPH	Director of Public Health	Directors of Public Health are responsible for determining the overall vision and objectives for public health in a local area or in a defined area of public health, such as health protection. They are accountable for delivering public health objectives and reporting annually on the outcomes and future work. They may be from any background, but must be qualified specialists in public health and registered with the General Medical Council or General Dental Council or UK Public Health Register.
HCAI	Health Care Acquired Infections or Health Care Associated Infections	These are infections that occur in a healthcare setting (such as a hospital) that a patient didn't have before they came in. Factors such as illness, age and treatment being received can all make patients more vulnerable to infection.
HIV	Human Immunodeficiency Virus	HIV (human immunodeficiency virus) is a virus that attacks the body’s immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome).

HPB	Health Protection Board	The aim of the Board is to provide assurance to City of York Council and the City of York Health and Wellbeing Board about the adequacy of prevention, surveillance, planning and response with regard to health protection issues
HPV	Human papillomavirus	HPV is the name of a very common group of viruses. They do not cause any problems in most people, but some types can cause genital warts or cancer. In England, girls and boys aged 12 to 13 years are routinely offered the 1st HPV vaccination when they're in school Year 8. The 2nd dose is offered 6 to 24 months after the 1st dose.
IPC	Infection Prevention and Control	IPC prevents or stops the spread of infections in healthcare settings. IPC practices are based on a risk assessment and make use of personal protective equipment that protect healthcare providers from infection and prevent the spread of infection from patient to patient.
MMR	MMR (measles, mumps and rubella) vaccine	The MMR vaccine is a safe and effective combined vaccine. It protects against 3 serious illnesses: Measles, Mumps and Rubella (German measles). These highly infectious conditions can easily spread between unvaccinated people. Getting vaccinated is important, as these conditions can also lead to serious problems including meningitis, hearing loss and problems during pregnancy. 2 doses of the MMR vaccine provide the best protection against measles, mumps and rubella.
MRSA	Methicillin-resistant Staphylococcus aureus	MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. MRSA infections mainly affect people who are staying in hospital. They can be serious, but can usually be treated with antibiotics.
MSM	Men who have sex with men	Men, including those who do not identify themselves as homosexual or bisexual, who engage in sexual activity with other men (used in public health contexts to avoid excluding men who identify as heterosexual).

NCSP	National Chlamydia Screening Programme (NCSP)	The aim of the National Chlamydia Screening Programme (NCSP) is to reduce the harms from untreated chlamydia infection. The harmful effects of chlamydia occur predominantly in women so the opportunistic offer of asymptomatic chlamydia screening outside of sexual health services focuses on women, combined with reducing time to test results and treatment, strengthening partner notification and retesting.
NHSE/I	NHS England Improvement	From 1 April 2019, NHS England and Improvement became a new single organisation to better support the NHS to deliver improved care for patients. This new single operating model was designed to support delivery of the NHS Long Term Plan.
Non-Binary	Nonbinary	The term “nonbinary” can mean different things to different people. At its core, it’s used to describe someone whose gender identity isn’t exclusively male or female.
OHID	Office for Health Improvement and Disparities (OHID)	OHID addresses the unacceptable health disparities that exist across the country to help people live longer, healthier lives and reduce the pressure on the health and care system as work is done to reduce the backlog and put social care on a long-term sustainable footing.
OMAB	Outbreak Management Advisory Board	As part of the response to Covid-19, the Government announced the roll-out of the NHS Test and Trace programme across England in June 2020. As part of this response, each council with responsibility for statutory Public Health functions has been asked to lead the local approach, based around an outbreak management plan. A key element of local outbreak management is the engagement of democratically elected councillors/politicians and the key partnership agencies that will contribute to Test and Trace development and delivery.
PHE	Public Health England	Disbanded on 1 October 2021 and replaced by UK Health Security Agency (UKHSA) and Office for Health Improvement and Disparities (OHID).

PHOF	Public Health Outcomes Framework	PHOF sets out a vision for public health that is to improve and protect the nation's health, and improve the health of the poorest fastest. The focus is not only on how long we live – our life expectancy, but on how well we live – our healthy life expectancy and reducing differences between people and communities from different backgrounds.
PIR	Post Incident Review	A post incident review is a process to review the incident information from occurrence to closure. The output of the meeting is a report of potential findings detailing how the incident could have been handled better.
PrEP	pre-exposure prophylaxis	PrEP, or pre-exposure prophylaxis, is an HIV prevention method in which people who don't have HIV take HIV medicine to reduce their risk of getting HIV if they are exposed to the virus. PrEP can stop HIV from taking hold and spreading throughout the body.
RCA	Root Cause Analysis	Root cause analysis (RCA) is the process of discovering the root causes of problems in order to identify appropriate solutions.
SHS	Sexual Health Services	Sexual health clinics (which can also be called family planning, genitourinary medicine (GUM) or sexual and reproductive health clinics), offer support, advice and treatment on a range of sexual health issues from contraception to Sexually Transmitted Infections.
Trans	Transgender	The word "transgender" is an umbrella term that describes those who have a gender that's different from the sex assigned at birth: male, female, or intersex.
UKHSA	UK Health Security Agency (UKHSA)	The UK Health Security Agency (UKHSA), the nation's new public health body focused on health protection and security. UKHSA operates as an integral part of the public health system and the national security infrastructure. The immediate priority of UKHSA is to fight the COVID-19 pandemic. UKHSA will play a critical role in the route to developing vaccines effective against new and emerging variants. In the longer term, UKHSA will build on the infrastructure developed for COVID-19 to tackle and prevent other infectious diseases and external health threats.

ANNEX 1

Annex 1: Location of PHE functions from 1 October 2021

The table below provides an overview of where current PHE functions will be located in the new system.

Function name	Primary PHE directorate	Function destination
Emergency Preparedness and Response (EPR)	Health Protection and Medical	UKHSA
Regional and Local Health Protection	Places and Regions	UKHSA
Rare Zoonotic Infections, Gastrointestinal Infections and Associated Areas	National Infection Service	UKHSA
Radiation, Chemical and Environmental Hazards	Chief Operating Officer	UKHSA
National Specialist Surveillance and Reference Laboratories	National Infection Service	UKHSA
Local Microbiology Laboratories and Infection Specialist Services	National Infection Service	UKHSA
Infections Research and Development	National Infection Service	UKHSA
Healthcare Acquired Infections and Anti-Microbial Resistance	National Infection Service	UKHSA
National Immunisation	National Infection Service	UKHSA
Vaccines and Countermeasures	National Infection Service	UKHSA
National Poisons Information Service	Health Protection and Medical	UKHSA
Global Public Health (Health Protection)	Health Protection and Medical	UKHSA
Global Public Health (Health Improvement)	Health Protection and Medical	OHID
Medical and Public Health Professional Leadership and Practice	Health Protection and Medical	UKHSA

ANNEX 1

Nursing, Midwifery, AHP and Emergency Services Public Health Leadership	Nursing, Maternity and Early Years	OHID
Maternity and Early Years	Nursing, Maternity and Early Years	OHID
Alcohol, Drugs, Tobacco and Inclusion health	Health Improvement	OHID
Diet, Obesity and Physical Activity	Health Improvement	OHID
Health Marketing and Behavioural Change	Health Marketing	OHID
Regional and Local Health and Wellbeing Advice and Support	Places and Regions	OHID
Dental public health	Health Improvement	OHID
Health Improvement Priority Programmes (including public mental health)	Health Improvement	OHID
Health and Justice	Health Improvement	UKHSA
Blood safety, Hepatitis, Sexually Transmitted Infections Service (STIS) and HIV	National Infection Service	UKHSA
Sexual Health and HIV services	Health Improvement	OHID
National Screening Programmes	Health Improvement	OHID and NHSE/I
UK National Screening Committee	Health Improvement	OHID
Screening Quality Assurance	Health Improvement	NHSE/I
Regional and Local Screening and Immunisation Commissioning Support and Expert Advice (embedded in NHSE)	Places and Regions	NHSE/I
National Disease Registration	Health Improvement	NHSD
Science Hub Programme	Science Hub	UKHSA
Research, Translation and Innovation (Health Improvement)	Health Improvement	OHID

ANNEX 1

Research, Translation and Innovation (Health Protection)	Health Improvement	UKHSA
Health Intelligence	Health Improvement	OHID
People services	People	UKHSA
Public Health Workforce	People	OHID
Health Economics and modelling	Strategy	OHID
Strategy	Strategy	UKHSA
Corporate Functions	Corporate Affairs	UKHSA
Regional and Sub Regional Health Care Public Health (HCPH)	Places and Regions	NHSE/I
Internal and external communications	Communications	UKHSA
Business development	Finance and Commercial	UKHSA
Financial management and financial strategy and services	Finance and Commercial	UKHSA
Digital and Information Communication Technology (ICT)	Finance and Commercial	UKHSA
Procurement	Finance and Commercial	UKHSA
Estates and Facilities	Finance and Commercial	UKHSA
Data and Analytical Sciences	National Infection Service	UKHSA
National Healthcare Public Health	Health Protection and Medical	NHSE/I
Quality, Clinical Governance and Safeguarding	Nursing, Maternity and Early Years	OHID
COVID-19 response	Pandemic response unit	UKHSA
Public Health Grant Assurance	Finance and Commercial	DHSC and OHID

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Annex 2: Those eligible for NHS influenza vaccination in 2021 to 2022 are:

- all children aged 2 to 15 (but not 16 years or older) on 31 August 2021
- those aged 6 months to under 50 years in clinical risk groups
- pregnant women
- those aged 50 years and over
- those in long-stay residential care homes
- carers
- close contacts of immunocompromised individuals
- frontline health and social care staff employed by:
    - a registered residential care or nursing home
    - registered domiciliary care provider
    - a voluntary managed hospice provider
    - Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants.

All frontline health and social care workers are expected to have influenza vaccination to protect those they care for.

The influenza chapter in 'Immunisation against infectious disease' (Green Book), which is updated periodically, gives detailed descriptions of the groups outlined above and guidance for healthcare workers on administering the influenza vaccine.

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APPENDIX A

Outbreak Management Peer Challenge
City of York Council

March 2021

Feedback Report

APPENDIX A

1. Executive Summary

The City of York Council (CYC) and its partners have responded well to the Covid-19 pandemic. There is a "can-do" attitude to working together and this is reflected in numerous examples of innovation and adaptation over the last 12 months. York has much to be proud of in its response, and much to share with other councils.

The leadership of the Public Health Team (PHT) has been exemplary, and is widely recognised across both the council and its stakeholders. This applies to the Director of Public Health, as well as her broader team and more widely across the council. Partners are clear that the PHT has added significant value to how they think and respond to the pandemic. Many individuals were named during this peer challenge as having personal impact, skills and expertise which have made a difference.

The model of public health has become further embedded through the pandemic. Having key public health figures distributed across council departments has added value to the approach. When compared to pre-Covid 19, there is a much greater understanding of what public health means, to the extent that there is a widespread view that many people now "get" public health in a manner they did not previously. This is a real asset for the future, with many people feeling that this 'distributed PHT model' has continued potential for the future. A challenge, in common with other councils, will be how to further embed public health sustainably for mainstream delivery within broader council services and not lose the momentum and ground it has achieved so far.

How the council has communicated and engaged on the pandemic has been well resourced and is described by partners as exemplary when comparing their experiences with other local authorities. There is much to share with other local authorities they work with. This includes ongoing consideration of behavioural insights to understand why and how residents and other stakeholders react to messages, and how collectively the City works to reach, inform and engage with its communities.

The council is looking forward to the future with confidence and optimism. This is of course a positive approach, and York has much to be optimistic about. The council is actively exploring what next for the City and thinking about its long-term plans and there has been some focus on contingency planning which incorporates scenario planning. This could be further expanded to include the worst-case scenarios, to ensure that risk have been fully explored, particularly as the council is dealing with several unknown factors beyond its control. One of these is how to deal with York's attractiveness to visitors, with the previous release of lockdown resulting in large numbers of visitors to the City, which in turn affected a spike in positive Covid cases in January 2021. The potential remains for another influx as the national lockdown is lifted from April 2021 onwards.

In common with the challenges that all areas face, staff across the council and partners, as well as communities, are expressing weariness about the ongoing nature of restrictions and responses. Consideration of how the council will prioritise action to support everyone's recovery will be important going forwards.

There is much to be proud of from York's response to the pandemic and much good practice to disseminate for the benefit of others, particularly on its approach to communications. Like other local authorities, CYC faces challenges ahead on dealing with uncertainty, opening-up and supporting the local economy, as well as considering the future role of public health and addressing inequalities as the City moves forward.

2. Key recommendations

There are a range of suggestions and observations within the main section of the report that will inform some 'quick wins' and practical actions, in addition to the conversations onsite, many of which provided ideas and examples of practice from other organisations. The following are the peer team's key recommendations to the Council:

Resilience and capacity

- Develop a plan for addressing organisational resilience, giving people time to reflect and recharge. This should be wider than those directly working in public health and consideration should be given on how to support council staff across all services.

- Capitalise on the benefits gained from the distributed PHT model by determining where public health will be positioned in the future and the capacity required to sustain this.

Engagement and Communities

- Build on the great work with communities during pandemic to maintain focus on addressing inequalities. CYC can show many examples of great work undertaken during the pandemic to address inequalities. The council and its partners know that a joined up and strategic approach will be needed if those inequalities are to be addressed.

Partnerships

- Partnership working is a clear strength, providing the opportunity to consider next how to embed the benefits from recent closer partnership working into future ways of working across all Council priorities, over and above Covid 19 and economic recovery.

Living with Covid

- Develop contingency plans for worst case scenarios, as well as best case scenarios. For example, emergence of new vaccine resistant variants, requirement for social distancing beyond the summer, potential challenges with vaccine take-up within certain populations etc.

3. Summary of the Peer Challenge approach

The peer team

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at City of York Council were:

- Sarah Norman, Chief Executive, Barnsley Metropolitan Brough Council
- Cllr Ruth Dombey, Leader, London Borough of Sutton
- Julia Weldon, Deputy Chief Executive and Director of Public Health, Hull City Council
- Corinne Harvey, Director of Operations, Public Health England
- Ann Burrows, Covid-19 Programme Lead, Public Health England
- Jennifer Cooper, Yorkshire & Humber Regional Lead, Joint Biosecurity Centre
- Frances Marshall, Adviser, LGA
- Judith Hurcombe, Programme Manager, LGA

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Scope and focus

This peer challenge was developed with councils and stakeholders through the Yorkshire and Humber Chief Executives and the Yorkshire and Humber Co-ordination Group. It is the second peer challenge on outbreak management to be delivered in councils within the region.

The scope of this peer challenge was to explore CYC's approach to Covid 19 outbreak management. The peer team looked at:

- The overall plan and approach
- Partnership working
- Resilience and capacity
- Addressing need
- High risk areas including Care Homes & Universities
- Communications and engagement
- Data and intelligence
- Governance
- Recovery / living with Covid
- Good practice

The peer challenge process

It is important to stress that this was not an inspection. Peer challenges are improvement focussed and tailored to meet individual councils' needs. They are designed to complement and add value to a council's own performance and improvement. The process is not designed to provide an in-depth or technical assessment of plans and proposals. The peer team used their experience and knowledge of local government to reflect on the information presented to them by people they met, things they saw and material that they read.

The peer team prepared for the peer challenge by reviewing a range of documents and information to ensure they were familiar with the Council and the challenges it is facing. The team then spent 2 half days working remotely with CYC, during which they:

- Spoke to more than 40 people including a range of council staff together with councillors, external partners, and stakeholders.

- Gathered information and views from more than 16 meetings conducted remotely, and undertook additional research and reading.

- Collectively spent more than 145 hours to determine their findings – the equivalent of one person spending more than 4 weeks in CYC.

This report provides a summary of the peer team's findings. It builds on the feedback presentation provided by the peer team at the end of their peer challenge on Tuesday 9 March. In presenting feedback to you, they have done so as fellow local government officers and members, not professional consultants or inspectors. By its nature, the peer challenge is a snapshot in time. We appreciate that some of the feedback may be about things you are already addressing and progressing.

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4. Feedback

4.1 Partnership working

The pandemic has galvanised partnership working between the council and its partners, with relationships growing and maturing from an already strong base. Some of this is due to previous joint responses to the flooding which has affected the City. Several partners reflected that working together on Covid 19 has enabled a better understanding of each other's drivers and pressures, and that there is a strong and clear ethos of everyone working well together. Equally, CYC colleagues reflected that the City was working 'as a system now, not just the council'. This is a great foundation for the future.

Partners really value the direct access they have to the PHT's advice and expertise, and they value the working relationships that have developed over the last 12 months. The relationship was described by one stakeholder as CYC 'holding onto the back of the bike seat' – e.g. partners were empowered to get on with it, but the PHT were there to catch them if they wobbled. The recently appointed joint public health consultant post between the Clinical Commissioning Group (CCG) and the council is widely regarded as a catalyst of change. It is already having an impact on understanding and further joint working.

Council staff also feel that partnerships have become more embedded across the range of services and relationships that the council delivers over and above the services which would usually have contact with. For example, council staff speak with more confidence about understanding businesses better than they did pre-Covid. The council has worked extensively with businesses on hospitality when opening-up the city under the previous lifting of lockdown arrangements. (See para 4.8). The joint working between the community voluntary sector (CVS) and council has been a real success, founded on an ethos of ensuring those in need received help, irrespective of organisational boundaries and who did what. A strong push towards volunteering and mutual aid – as well as support for service delivery organisations like the Citizens Advice Bureau - resulted in 4000 volunteers being recruited. The Council is about to launch a new volunteering strategy to ensure this community resource is well embedded for the future. Covid 19 Marshalls have also been very successful in engaging with residents and businesses and dealing with localised issues.

Working across public protection in all sectors and leaning into the localised Contact Tracing model has been a real strength. Early in the response, it was agreed that colleagues across public protection including regulatory services would bring an asset-based approach to the development of the local tracing partnership model. Using the knowledge and expertise of working across business and hospitality sectors; building on existing robust processes and maximising the approach of local intelligence from across the council has enabled the York service to provide a more timely and effective service than from NHS Test and Trace. This has included providing wraparound support to assist people maintain self-isolation, working with the Police to encourage and enforce measures, and ensuring a collaborative approach for managing complexity with Health Protecting Team.

The council has lots of exciting physical regeneration plans for the City through a £300m capital programme, including York Central, which will create up to 2,500 new homes, around 6,500 new jobs and a range of public spaces, including the city's first new park in a century. There are also plans to refurbish the Guildhall at a cost of £20m. Some stakeholders expressed a desire for clearer plans for inclusion as part of building back a fairer City, with all residents being able to take advantage of many of these opportunities. (See Para 4.3.)

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4.2 Resilience and capacity

A variety of different approaches to supporting system wide resilience and capacity is evident in CYC's response to Covid 19, from partnership working to leverage in capacity, support mutual aid and create economies of scale, through to delivering differently. Examples include, though are not limited to:

- Community Hubs across the City have had a real impact, engaging with over four thousand volunteers, and catalysing a previously established model.
- The existing social prescribing service run through GP practices have been expanded and grown in both scale and GPs' understanding.
- Mutual aid approach to bring in further capacity when the hospital was experiencing a spike in admissions in January 2021.
- Wellbeing support as part of council wide messaging and offer to all staff

The responsiveness, accessibility, and impact of the PHT has been universally commended (para 4.1 refers). Capacity within the PHT however needs further consideration for the medium to long-term. This is partly due to the relatively small size of the team, as well as overall impact of the pandemic on PHTs everywhere. In addition, whilst the embedding of the public health approach across York has undoubtedly been welcomed and had a positive impact, it too has had a bearing on capacity. An overall issue to consider for the future, which is closely bound up with the long-term intentions for the public health function within York, is whether the current approach is sustainable.

In common with other councils there are signs of people becoming tired, and this applies to employees across the council, its partners, and stakeholders, as well as to councillors. Although there are no easy answers, it will be important to think of the long-term strategy to support staff and maintain levels of personal and organisational resilience. Giving people time to reflect and recharge is particularly important as our response to the pandemic enters further phases in the spring and summer of 2021.

The vaccination programme will continue to be a focal point in the coming months, and whilst this is being led by the NHS, it will have an impact on CYC's resources and energies as it is in everyone's interests to promote vaccine uptake across the City. Tackling vaccine hesitancy and encouraging vaccine take-up is something that all local areas are grappling with. With a large student population, a particular challenge in York could be making inroads into the younger age cohorts, and also sections of the community where uptake may be lower than average.

4.3 Addressing need

The council and its partners are proud of their ethos of helping anyone who needs support arising from Covid-19. There is evidence of a 'do now, ask for permission later' approach across the councils' response, with Community Hubs an example of this in action to support the clinically extremely vulnerable and responding to local need (para 4.2 refers).

The daily wellbeing calls which have taken place to residents who have tested positive for Covid 19 between days 7-10 of testing have had real human impact and are of particular note. The council is clear that in some instances these calls have led to interventions which have saved individual's lives, and are rightly proud of this profound impact.

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Vulnerable children have been targeted for positive and constructive support and this has resulted in high levels of attendance in schools during lockdown. A red/amber/green assessment rating of each child was undertaken to ensure that the most vulnerable children are supported to have face to face contact. A focus on the 'voice of the child' is evident with examples including working with care leavers to support their mental health, through to joint working with parents of SEND children to understand how CYC can work together better.

York is a relatively prosperous City with many assets and advantages, including affluence. Despite this prosperity there are pockets of disadvantage, some of which can be masked by the overall data available. With the pandemic exacerbating inequalities in communities across the country, concerns were expressed that there are communities within York who are struggling to manage, or are on the cusp of becoming disadvantaged. Stakeholders are conscious of this hidden deprivation and want to do more to tackle inequality, including improving health for local people.

Many participants in this peer challenge recognise that the council has reached far and wide into its resources to support disadvantaged residents, and their health inequalities. Staff and stakeholders are rightly proud of their individual and collective responses. As the City plans for recovery there is a degree of consensus that much has been achieved and collective efforts make a significant difference the quality of life for local people. Going forward, ensuring regeneration plans (para 4.1 refer) and their delivery include broader social and community regeneration to support efforts to reduce inequalities exacerbated by the pandemic, will be important in continuing positive this legacy so that opportunities are as inclusive as they can be for everyone.

Some of the achievements in this area have been depended on individuals to champion inequalities, rather than having an overarching strategic response which takes a more overt and planned approach to tackling disadvantage, and a concern that this approach may be lost as other priorities emerge. Since this peer challenge feedback was given to the council, more evidence has been provided about the range of responses the council has provided on inequality. During the peer challenge a wide number of individuals nevertheless expressed a desire for a continued focus, and higher profile on, inequalities which will have been exacerbated by the pandemic.

4.4 High risk areas: schools, universities and care homes

The council has worked well across high risk areas and it identified 3 areas of good practice.

<u>Schools</u>
Relationships with schools are good and the already established York Schools and Academies Board (YSAB) has been a valuable platform for engaging across the City, sharing information and delivery. Schools speak highly of the support they receive from the council, particularly from Public Health, where having a named point of contact has supported consistency of approach and dialogue. Through this dialogue with YSAB schools have been able to feel they receive good updates of local issues, as well as opportunities for learning.

Schools have confidence in the City's Outbreak Management Plan and there is a good understanding that the national outbreak news and data does not always reflect the situation experienced in the City. The team also heard some reflection that when compared to some other councils, York's approach has been exemplary, and this applies across the local school family,

18 Smith Square, London, SW1P 3HZ www.local.gov.uk **Telephone** 020 7664 3000 **Email** info@local.gov.uk
Chief Executive: Mark Lloyd

including special schools. Bringing public health and education together has been welcomed and describe 'The York Way' approach as being listened to, with collegiate attitudes of schools and the council genuinely working alongside each other to tackle problems. Schools feel this is a good platform from which to now build on. Ideas for the future include building on working with the community and voluntary sector; continuing to galvanise how health, communities and schools work together in supporting a wide range of issues including cohesions and localised support to families and children.

Higher Education

Existing good relationships across higher education institutions within York and CYC were built upon during the pandemic to forge even closer joint working. This has developed a whole city response which has avoided the emergence of any narrative of divisions between students and the rest of the population.

Universities, colleges, and the council engaged well and early in response to the pandemic. The creation of a Universities Outbreak Management Advisory Board Sub-Group has been welcomed as a useful vehicle for engagement as well as manifestation of the strategic importance placed in this partnership. This has enabled nuanced messages to be delivered, which are consistent with the broader public health approach across the City, and have supported an approach of everyone in the City being affected and working together.

Universities have been a clear testing priority for the City and resources have been targeted on university halls of residence to reach students. Testing arrangements were rolled out initially with York St John University in December 2020, as part of a city-wide testing resource, which in turn has supported community wide testing capacity across the City.

Care Homes

As with many other aspects of partnership working, engagement with registered care providers has built on existing good practice, and care homes felt that the City's response has galvanised already good partnership working. Communications to care homes has included written bulletins and webinars, and is complemented by daily calls to individual care homes by Adult Social Care. Similarly, excellent working relationships and communications were reported with providers and Independent Care Group, based on mutual respect and trust. One aspect of why this worked so well has been the approach of "Team around the home." This approach built on existing strong partnership across health and social care with clinical leadership at the heart of a compassionate response to care homes. This included: use of virtual consultations; digital monitoring; enhanced support from primary and community services; training and development; and assurance visits with every care home. This work was recognised recently in the Nursing Times awards.

There have been low levels of infections in care homes, with only one significant infection outbreak. National guidance has been successfully adapted for local implementation, including local branding. This has helped to support the development of a local response. Ongoing close working between CYC, North Yorkshire County Council and the CCG has supported the development of joint policies, for example on visiting arrangements.

4.5 Communications and engagement

Another area of strong practice is how the council has managed its communications and engagement on Covid 19. The communications campaign has been based on the 3 broad strands of: prevent, respond, and manage the outbreak. The approach has been adapted according to circumstances and has included the use of Facebook Live question and answer

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sessions. These were weekly during the first national lockdown, and monthly sessions thereafter. These included interactive #AskTheLeaders sessions which are then also made available on YouTube. The insight from these sessions has been used to adapt future messages. For example, in November 2020 where the audience has shown anxiety about financial losses, the campaign has quickly picked this up as an area of focus.

A City-wide Heads of Communications network has been established which includes the main public sector partners, as well as other stakeholders across the City. This has enabled quick sharing of key messages, as well as a consistency of approach across major partners, which in turn has reduced confusion for residents and businesses. CYC has also worked effectively to translate national messages so that they resonate locally, such as advising residents to stay 'two Archbishops' apart to encourage social distancing.

Regular electronic newsletters have been provided for residents, and members and partners on a twice weekly basis, and weekly for families and businesses. The messages from these are often shared more widely through Facebook across the City, and are often adapted by those sharing to reach specific audiences. An innovative animation was also developed to explain what contact to expect from public health after a resident has tested positive.

As well as sending out information there has been emphasis on what stakeholders and communities need. Initially roundtables were held with businesses and supplemented in August with a City-wide survey. Quarterly "temperature checks" have been undertaken to gauge residents' understanding of key messages being communicated across the City. The Human Rights City group provided insight into how disadvantaged communities receive and understand communications, allowing for further adaptation.

Behaviours have been a focus from early in the pandemic. An emotional health campaign called *Feel Real York* has been driven by insight from the council's *Big Conversation* health check discussion, and a business roundtable, which provided concerns about staff mental health from employers across York. Future work is planned with Public Health England on behaviours and opening-up the City from spring 2021, including a focus on making outside space safer, to ensure that the optimum levels of intervention are put in place to support people to do the right thing. Discussions are taking place with universities and their student bodies on ensuring students can participate and benefit from the approach.

The council has also been proactive about challenging misinterpreted messages, including whether the City was heading for a lockdown in June 2020. In common with other areas, the City has found the timing of some national messages to be challenging, and the communications team's working arrangements were adapted to ensure quick responses could be made.

4.6 Data and intelligence

Good analysis of data and intelligence was in place prior to the pandemic in York and this has been further consolidated. The approach recognises the value of the established joint strategic needs assessment, as well as the use of a centralised data service to support the Community Hubs.

Early during the pandemic, a data sharing protocol was agreed between the council and its partners. This has included more detailed sharing of some GP data for the first time. The

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sharing of data and information about vulnerable people between the council, voluntary sector and GP practices has enabled targeted and direct support to be provided. Examples include shopping or prescriptions collection.

Data has been collated daily and published weekly on York Open Data since June 2020, including on: local infection rates, deaths, local R rates and vaccination rates. Data is analysed on a real time basis from national, regional and local sources, for example including the council's environmental health systems. Analysis at ward and middle layer super output area levels has enabled local hotspots of virus transmission to be identified quickly. This in turn has led to speedy action to be taken, including on information and enforcement.

A challenge for the future, which York has in common with other local authorities, is how to build on this current approach and improving awareness of the wealth of available public health data to clearly inform future decision making and prioritisation of resources.

4.7 Governance

CYC's governance arrangements for the pandemic have been clear and proportionate, with various levels of strategic meetings, including Gold and Silver levels. These have been stood up and down in accordance with the severity of local incidence and national restrictions.

The council's response has had public health at the its centre. CYC officers speak positively of the council's political and managerial leadership, citing a genuine collaborative and supportive approach across council services, and the PHT have been supported well by the leadership team.

The Outbreak Management Advisory Board, chaired by the Leader of the Council and available online, meets monthly and provides the lead for the communications activity. It is widely regarded as having been helpful in providing the mandate for activities, as well as bringing in further insight to City-wide activities.

4.8 Recovery/living with Covid

There is widespread recognition that a successful economic recovery requires York to be a safe place, and that the successful reopening of the City will depend on a safe reopening. Business representatives told us that the council has listened to their concerns and worked closely with them to address these. This included the early establishment of a contact group, and a focus on developing a good rapport with its members. A discretionary grant funding of £1m was created and which supported over 1,100 micro-businesses across the City.

For the future, the council is actively thinking about how to support the resilience of the voluntary and community sector, which has played such a strong role in supporting the council and residents over the last 12 months. There is also widespread acknowledgement that relationships with health partners have been strengthened, and consideration is being given on how to further build relationships.

There is both confidence in the council's response to date as well as optimism for the City as recovery is planned for. Some of that optimism is reflected in contingency planning for best case scenarios. This would be further enhanced by also exploring contingency planning for worst case events. Some of the latter are beyond the council's control yet could have a profound impact on the opening up of the City and should be considered. For example, if the

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Chief Executive: Mark Lloyd

national roadmap is delayed or reversed, or if there are local spikes in infection leading to further local restrictions either in the City or in neighbouring authorities.

The council worked well with the hospitality sector to innovate in enabling the opening-up of outdoor spaces during the summer of 2020. An example of this success was the use of the College Green area near York Minister to provide outdoor trading space because indoor space was too challenging due to ongoing social distancing rules. There could be an opportunity to widen York's approach to innovation to encompass testing arrangements for the hospitality sector. Liverpool City Council is looking to pilot a range of approaches in this area and its learning may be worth exploring further for York's benefit.

The PHT in CYC is relatively small, and capacity is stretched (see para 4.2). One year on since the outbreak of Covid 19 in the UK, there is much more widespread and enhanced understanding of the role of public health, not least because the council has put the function at the very heart of its Covid 19 response. A key consideration for the future should be to explore where public health will sit in relation to this recent experience. Part of that consideration should be to explore its resource base within the context of sustainability.

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York Health and Wellbeing Board

Health and Wellbeing Board 17th November 2021

Report from Catherine Scott, York MCN Programme Coordinator, York MCN Enabling Team

York MCN Cultural Values

Summary

1. In August 2020, the York Multiple Complex Needs (MCN) Network undertook a Cultural Values Survey, supported by Barrett Values Centre. This was done as a part of our desire to build relationships and consensus about 'what good support looks like', and to identify what enables 'system stakeholders' to act collectively in order to better support people.

Background

2. The York Multiple and Complex Needs (MCN) Network is an alliance of people with lived experience, frontline workers and strategic leads seeking system change in York. It provides spaces, practices and platforms to bring together people with lived experience, frontline workers and strategic leads. This allows them to think and act collectively with the aim of supporting people facing severe and multiple disadvantage who experience multiple difficulties at the same time.

3. To find out more, please watch our animation here: https://www.yorkmcn.org/

4. In 2019, the Network decided to develop a number of experiments and take these forwards as working groups. One of these experiments was set up to understand the culture and health of the systems and services currently responding to those experiencing severe and multiple disadvantage in York. The experiment is supported by Barrett Values Centre.

5. The COVID-19 crisis brought an additional, and not yet fully visible layer of opportunities and challenges to this work plan, and potentially a reworking of these pieces of work to reflect the new conditions and opportunities.

6. The Barrett Values Centre cultural values assessment is an internationally recognised model, the results of which provide insights into what is working and not working in the prevailing culture of any setting. Crucially, it highlights what is important to people, how they experience the culture and how they would like to improve it.

7. The values assessment (or survey), data interpretation and findings report were carried out by an external, independent consultant. The results give us a strong platform to work from. Armed with new knowledge about the change people want to see, we can now make sustainable adjustments to improve the culture of the system, and ultimately better support those experiencing multiple complex needs in York.

Main/Key Issues to be Considered

8. The attached report (Annex 1) provides an overview of the Cultural Values journey York MCN has been on over the last 12 months. This includes headline results and messages from the survey, a snapshot of the York Cultural Values Sense-making process that has followed, and some of the tangible and intangible benefits of undertaking the York MCN cultural values process.

9. We are taking this approach to allow listening and informed action to be at the core of our work and methodology. We hope to display a set of behaviours that all parts of the system can adopt.

10. Through relationships and participatory actions, we have nourished the soil, planted the seeds and tended to the seedlings, and we now need some other gardeners to come along and help us.

11. The Cultural Values Working Group and Facilitation Team will be sharing the journey at various meetings across York, and asking people to think about how we might want to take this work forwards together.

12. There are many opportunities for how this work could be taken forwards by system leaders, sectors, organisations, teams and individuals.

13. Some of these include:

    a. Getting involved with the 'test and learn' phase of our process – using tools and resources used and developed through the sense-making sessions to embed a values-based approach into existing or emerging initiatives. This might be exploring what it looks like to model the cultural values yourself, embed it in teams, or use a cultural values lens when reviewing or creating policies and processes.

    b. Engaging with and learning from the results and sense-making process - the results provide a snap-shot picture across one agenda area, but there will be many similarities with different areas of the system.

    c. Undertaking a cultural values process yourself, across a partnership, organisation, agenda area, or the wider health and care system.

14. If you'd like to learn more about the Cultural Values Process or how you can have input, please do get in touch with Catherine Scott, or email info@yorkmcn.org.

Consultation

15. N/A

Options

16. N/A

Analysis

17. N/A

Strategic/Operational Plans

18. This work could relate to strategic and operational plans and priorities across the city.

Implications

19. N/A.

Risk Management

20. N/A

Recommendations

21. The York Health and Wellbeing Board are asked to note the report.

22. York Health and Wellbeing Board members are asked to consider how this work could be taken forwards by within their own organisations, as well as across partnerships.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Catherine Scott *York MCN Programme Coordinator, York MCN Enabling Team* *Hosted by York CVS* *07522 229833*	*Catherine Scott* *York MCN Programme Coordinator, York MCN Enabling Team* *Hosted by York CVS* *07522 229833*
York MCN Cultural Values Facilitation Team: *Philip Marken* *Natasha Almond* *Miles Goring* *Astrid Hanlon* *Rebecca Carr*	**Report Approved** [x] **Date** *04.11.2021* *Catherine Scott* **Report Approved** [x] **Date** *04.11.2021*

Specialist Implications Officer(s): N/A

Wards Affected: **All** [X]

For further information please contact the author of the report

Background Papers:

Background Papers are linked in the main report in Annex 1, and can also be viewed here:

- An Introduction to York MCN animation: www.yorkmcn.org
- York Cultural Values – The Journey So Far animation: www.yorkmcn.org/yorkculturalvalues
- York Cultural Values Summary Report: www.yorkmcn.org/results
- York Cultural Values Full Results Report: www.yorkmcn.org/results
- York Cultural Values Results Presentation: www.yorkmcn.org/results
- Meet The Facilitation Team: www.yorkmcn.org/yorkculturalvalues
- The Journey So Far map: www.yorkmcn.org/yorkculturalvalues

Annexes

- **Annex 1:** York MCN Cultural Values

Glossary

Annex 1

York mcn

York Cultural Values

Our foundation for the future.

YORK MCN CULTURAL VALUES

NOVEMBER 2021

York MCN Cultural Values

1. Introduction

York MCN involves various projects, organisations and people coming together to create change. The goal of those involved is to improve the lives of people experiencing multiple complex needs across the city.

'Multiple Complex Needs' (or multiple disadvantage) refers to a range of issues which make life difficult, including:

housing issues
mental ill-health
contact with the criminal justice system
substance misuse
financial problems

The York MCN Network provides spaces, practices and platforms to enable those working and living in the city to act collectively and change both the culture and the system in which we live.

We are guided by the theory of **Systems Change.**

By 'system', we are referring to everyone living and working within York and the web of support and services which exists across the city. This is a broad definition encompassing people and communities, voluntary and community sector groups, formal service systems and leaders/elected members, and the way these all interact together.

The Cultural Values journey

In August 2020, the Network undertook a Cultural Values Survey, supported by Barrett Values Centre, as a part of our desire to build relationships and consensus about **what good support looks like,** and to identify **what enables 'system stakeholders'** to act collectively in order to better support people. The COVID-19 crisis brought an additional, and not yet fully visible layer of opportunities and challenges

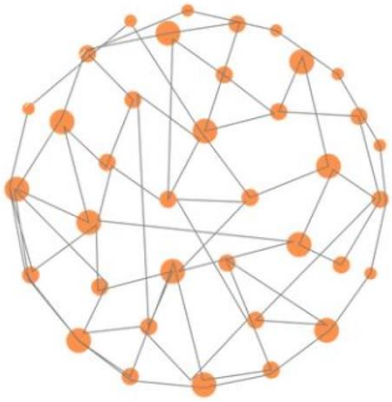
to this work plan. The recent pandemic brings a potential reworking of the survey to reflect the new conditions and opportunities.

The Barrett Values Centre cultural values assessment is an internationally recognised model, the results of which provide insights into what **is** working and **not** working in the prevailing culture of any setting.

Crucially, it highlights **what is important to people, how they experience the culture and how they would like to improve it.**

The values assessment (or survey), data interpretation and findings report were carried out by an external, independent consultant. The results give us a strong platform to work from. Armed with new knowledge about the change people want to see, we can now make sustainable adjustments to improve the culture of the system, and ultimately better support those experiencing multiple complex needs in York.

A note on Cultural Entropy



Cultural Entropy is the measure of ***negative force*** or ***resistance*** in a system that is limiting it, and consequently inhibits change or progress.

It is calculated by the ratio of positive to potentially limiting values selected by participants, and is presented as a percentage.

A **HIGHER** entropy rate means there is **MORE** resistance and dysfunction.

%

For further information about how to read and interpret the results, please see Appendix 2: How to read the results.

2. Cultural Values Results Overview

Cultural Values Assessment Survey Questions

The survey asked participants about four reference points: the personal values of each person, and their view of 3 points in time; namely the “pre-covid19” system, the current system (Aug, 2020) and the desired system in the future.

A values profile was collated from answers to four questions. Each question invited participants to choose ten values from a varied selection.

Questions that were asked:

1. **Personal Values:** please select ten values/behaviours that most reflect/represent who you are now.
2. **Pre-Covid19 Cultural Values:** please select ten values/behaviours that from your own experience, best describe how the system in York operated before the impact of COVID-19.
3. **Current (August 2020) Cultural Values:** please select ten values/behaviours that from your own experience, best describe how the system in York is operating now, in the current climate.
4. **Desired Future Values:** please select ten values/behaviours that you believe are essential for the system in York to reach its highest potential.

The survey also collected basic demographic data about participants, and invited them to qualify their value choices by answering three additional questions.

Additional questions:

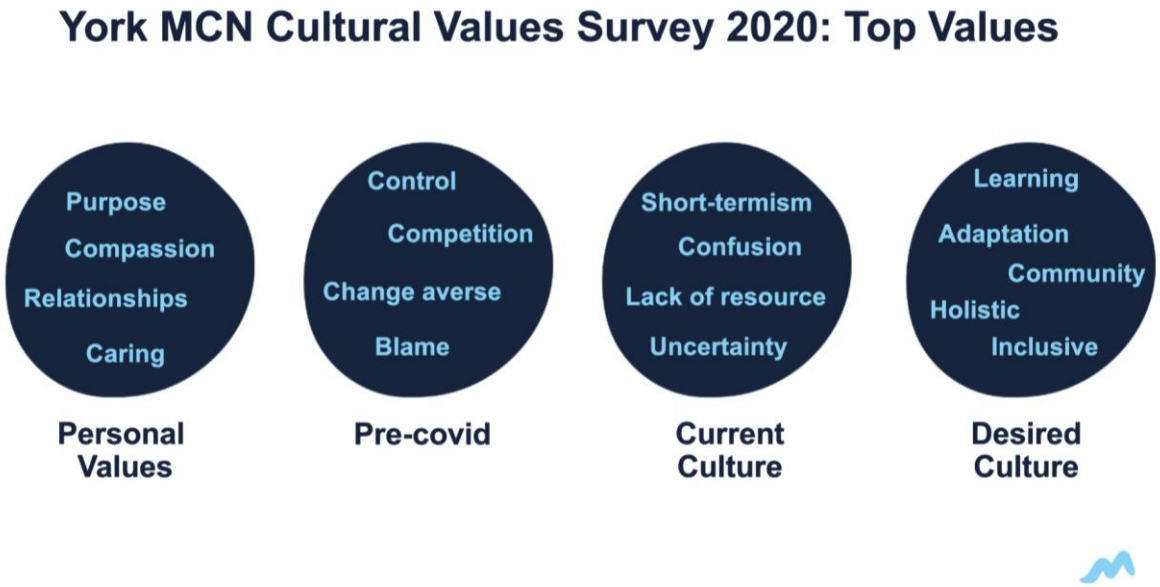
1) To what extent does your personal lived experience of complex needs influence the values selected during this survey on a scale of 1-10 (1 being no influence and 10 a huge influence.
2) What 3 things do you think would be helpful for the system to take forward following this survey?

3) Having completed the survey, is there anything else you would like to comment on about your answers?

In asking these questions, the plan was to take a snapshot picture of the current system, and feed that back to participants and other stakeholders within a series of “sense-making” groups. This, in turn, would help inform the next steps for the Network and the System development process as a whole.

For further information about the Barrett Values Centre Model and how it works, please see Appendix 1.

Headline Results



Personal values:

- People are motivated by being caring, compassionate and able to make a difference.

Pre-Covid Current culture:

- Pre-covid picture was quite heavy - more of a “control” “competition” and “blame” culture. A sense that the system was “change averse”.

Current Culture (August 2020):

- Challenges focused around lack of resources, short term focus, uncertainty about the future and confusion.
- BUT there was positive change between pre-covid and current culture: and adaptability and freedom was enabled in a time of lockdown when physical freedoms were highly limited.

Desired culture:

- Values focused on learning, adaptation and development of the community as a whole, more holistic and inclusive approach.
- Relationships were seen as integral to a good system culture.

Headline Messages

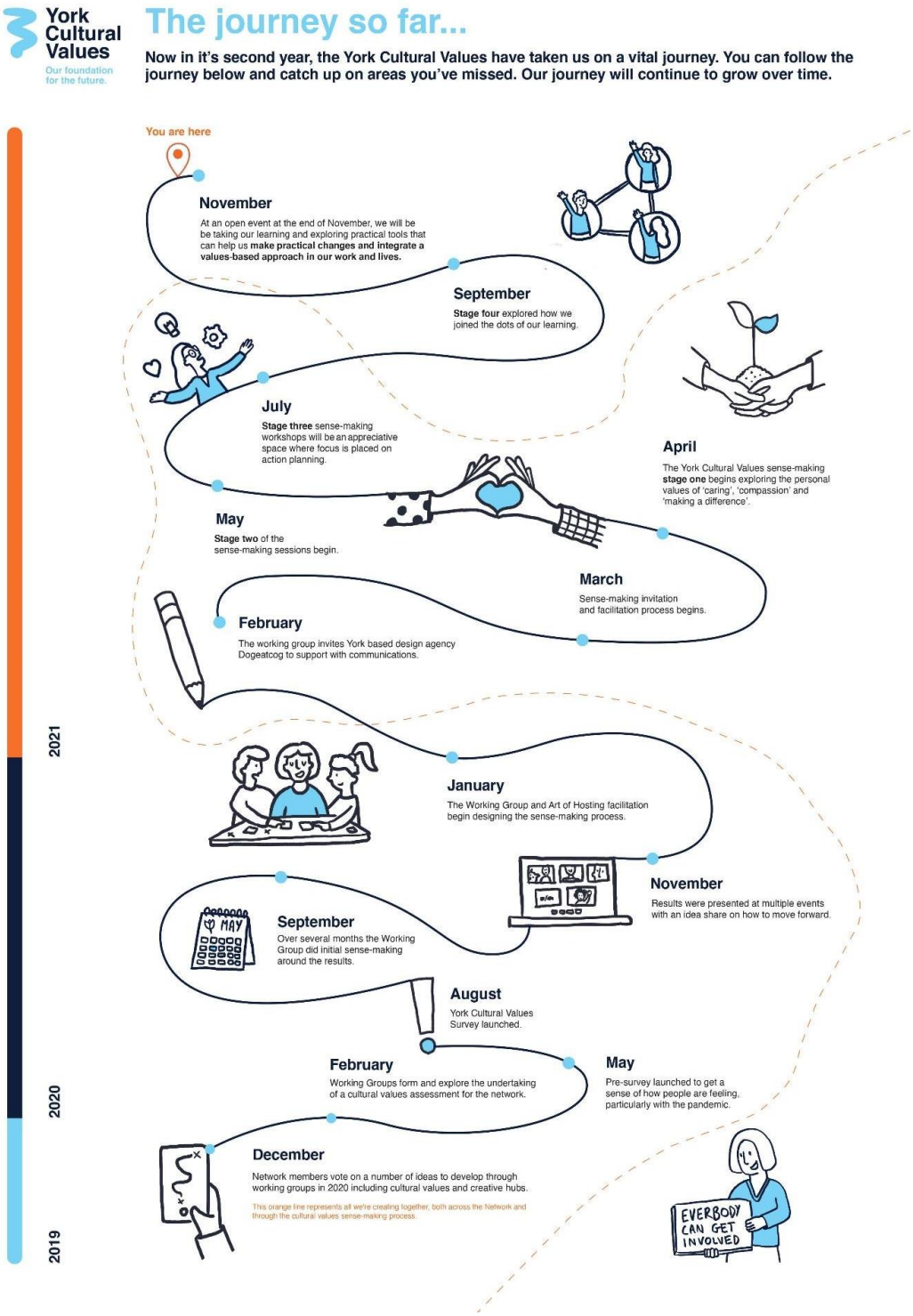
- The system currently has a **high entropy** (level of dysfunction) rate at 35%. However, this is a significant improvement of 11% on pre-covid rate of 46%.
- The shifts and adaptations generated by the pandemic have been welcome in the sense that they have generated movement and **new energy for change**.
- Energy and motivation exists within system partners. There's a **desire to learn and adapt** so they can affect further changes.
- The message from the field is to focus on those core values of c**ommunity involvement**, **cross-group collaboration** and **adaptability**.
- There is real energy for change, only inhibited by factors such as **uncertainty about the future** of lack of resources.
- There are common values across all areas, including **community involvement** and **adaptability.**

Click here to:

- watch the results being presented
- read the results slides
- read the summary and full report
- see the breakdowns of different sectors, roles, and between Network and non-Network members.

3. York Cultural Values Sense-making Process

The Journey So Far...



Watch our animation, The Journey So Far, telling you more about York MCN and the York Cultural Values process **here.**

See the full journey illustrated, here.

We began a collaborative sense-making process at the end of April 2021 to explore the results together, help us understand the health of the system, and ultimately make changes that will improve the support people can get.

You can hear members of the facilitation team and working group speaking about the York Cultural Values journey on the York MCN website.

Each video is only a few minutes long, and together they take you through the journey of how we got here, connections to other work across York, and why it's been so important to get involved in this process.

Sense-making Process

Our sense-making journey has taken place over multiple 'stages':

- **Stage one** - we made sense of our **personal values.** We asked: *'How can we create the conditions which enable these to come about?'*
- **Stage two** - we explored the **current cultural values.** We looked at how they differ from the ***desired values.*** We asked: *'How can we begin to work to overcome some of the barriers and challenges we all face together?'*
- **Stage three** - we did **action planning** around meaningful projects. We asked: *'How can we design for the inclusion of the desired values from the start?'*
- **Stage four -** we joined-up the dots of our learning, taking us into a period of 'doing'. We explored **tangible actions and tools to support us all to incorporate the desired values** into our lives, workplaces, teams and across the system in York.

Our next event will be a hybrid event online and at Friargate Quaker Meeting House, on 30th November 2021. We will be reflecting on the York Cultural Values journey so far, and spending time sharing and exploring tools that can help us incorporate a values-based approach into our projects, teams, workplaces, and across the wider system in York, leading into a six month period of 'test and learn'.

You can register to attend the event here.

4. Why is York Cultural Values so important?

“What we practice at the small scale sets the patterns for the whole system”

Emergent Strategy: Shaping Change, Changing Worlds, by Adrienne Maree Brown

We are taking this approach to allow **listening** and **informed action** to be at the core of our work and methodology. We hope to display a set of behaviours that all parts of the system can adopt.

When behaviours change, culture changes too.

Culture is the pattern of our behaviours and actions over time. If we alter our patterns of behaviour, we automatically begin to alter the world around us. This is why we've taken the approach of working to ***create conditions*** rather than creating outputs.
Better conditions will have a ripple effect, reaching individuals, teams, organisations, and ultimately the wider system.

There have been many benefits of undertaking the York MCN cultural values process, both tangible and intangible.

Tangibly, it has provided opportunities for participants to be part of a values driven approach to system-wide change. It’s allowed the chance to learn new skills, meet like-minded people with shared experiences, share learning and develop new relationships.

Intangibly, it has helped uncover and explore some of the often-invisible context and conditions that we know can influence how things are shaped, delivered and experienced in the future.

It’s supported us to align and anchor the system in a shared set of values and explore how these can be embedded throughout all our

work. It has enabled us to create meaningful, authentic and impactful action together.

What now?

We have been exploring cultural values in the 'confines' of the multiple complex needs agenda. Given that this exists within the wider context of York as a whole, we recognise we need to engage with partnerships, strategic leaders and citizens across the city for there to be genuine and long-lasting change.

Through relationships and participatory actions, we have nourished the soil, planted the seeds and tended to the seedlings, and we now need some other gardeners to come along and help us!

The Cultural Values Working Group and Facilitation Team will be sharing the journey at various meetings across York, and asking people to think about how we might want to take this work forwards together. We've already presented to the Health and Care Alliance Board and Leadership Team, with the likelihood that both will be undertaking a cultural values assessment and process themselves.

There are many opportunities for how this work could be taken forwards by system leaders, sectors, organisations, teams and individuals.

Some of these include:

- Getting involved with the '**test and learn**' **phase** of our process – using tools and resources used and developed through the sense-making sessions to embed a values-based approach into existing or emerging initiatives. This might mean exploring what it looks like to model the cultural values yourself, embed it in teams, or use a cultural values lens when reviewing or creating policies and processes.
- Engaging with and **learning from the results** and sense-making process - the results provide a snap-shot picture across one agenda area, but there will be many similarities with different areas of the system.

- **Undertaking a cultural values process** yourself, across a partnership, organisation, agenda area, or the wider health and care system.

Talk to us

Sometimes the simplest of conversations makes the biggest change. If you'd like to learn more about the Cultural Values Process or how you can have input, please contact us at: info@yorkmcn.org.

We're very open to hearing new ideas, questions and queries - and the opportunity is open for absolutely everyone to get involved.

APPENDIX

Appendix 1: About the Barrett Values Centre Cultural Values Assessment model

The Community Cultural Values Survey is an assessment and mapping tool which invites participants to choose specific values which relate most closely to their personal and system experience, and their aspirations for the future.

The values chosen by participants are then collated and ranked by preference, to give a values profile. They are also mapped onto the seven levels model (see below). The resultant profile enables system stakeholders to see themselves as well as understand what motivates people involved, how they are experiencing the current system, and where they aspire to go next. The profile also reports levels of "entropy" or resistance in the system, so it is possible to identify clearly what is inhibiting change or progress at the same time.

This tool is part of a methodology created by Richard Barrett, Founder of Barrett Values Centre (BVC)®. The fundamental basis of his approach is The Seven Levels Model. This model, adapted from Maslow's Hierarchy of (human) needs, profiles individual as well as community or system level values. It works on the basis that communities are comprised of individuals, with individual and collective motivations. When identified, collated and ranked in importance, these motivations can hold a mirror to who people are, what they collectively value, and crucially, the degree to which they can express, or find these values in the workplace or current community or system. Finally it aims to collate a values profile of what that community aspires to be and do in the future.

All of the values chosen by participants are mapped onto one of the seven levels of 'community consciousness' which enables stakeholders to see how community values are distributed, and what effect that has.

Research conducted by BVC has highlighted how communities at multiple scales have seven well-defined developmental levels of consciousness, and each of those levels focuses on a particular existential need that is common to all forms of human group structures.

The seven existential needs are the principal motivating forces in all human affairs, and communities develop and grow by learning to master the satisfaction of these needs.

The levels are grouped into three cluster areas:

1) **Lower Needs:** The “lower” needs, **levels 1 to 3**, focus on the basic requirements of communities: economic security, harmonious internal group relationships, as well as systems and processes that create order and institutional effectiveness.
2) **Transformation** point: The focus of **level 4** is transformation: the creation of the conditions that allow citizens to have a voice in the running of the community and actively embrace and manage adaptation to external conditions and continuous renewal.
3) **Higher Needs:** The “higher” needs, **levels 5 to 7,** focus on resilience building and the long-term sustainability of communities: developing a cohesive culture, building mutually beneficial alliances with neighbouring communities, and actively participating in the larger society for the common good.

The Seven Levels of Community Consciousness

Level 1: Survival

This level focuses on matters to do with the survival, maintenance, and expansion of the community and the security of its citizens. Healthy communities are financially sound and safe. This level includes values such as prosperity, financial stability, health care, employment, and emergency services.

The potentially limiting aspects of this level of consciousness include poverty, corruption, and environmental pollution.

Level 2: Relationship

This level concerns the quality of internal interpersonal relationships within the group. Healthy communities create a sense of belonging. This level includes values such as family, friendship, tradition, loyalty, neighbourliness, hospitality, and open communication.

The potentially limiting aspects of this level of consciousness include discrimination, loneliness, segregation, conformity, and intolerance.

Level 3: Self-esteem

This level addresses the community's need for efficient performance. Healthy communities are orderly, regulated, and law-abiding. This level includes values such as institutional effectiveness, quality, pride, cleanliness, and public services.

The potentially limiting aspects of this level of consciousness include bureaucracy, elitism, corruption, complacency, and arrogance.

Level 4: Transformation

This level focuses on giving members of the community, not just the leaders and managers, an opportunity to participate in decision-making. Healthy communities encourage members to be responsible and focused on their goals. There is a focus on learning opportunities and entrepreneurship.

This level includes values such as freedom of speech, equality, fairness, adaptability, accountability, self-reliance, and consensus.

Level 5: Internal Cohesion

This level concerns the creation of a collective group identity. It involves deepening the sense of internal connectedness among community members by creating a collective vision for the community and a set of shared values. Healthy communities have a positive spirit, a sense of direction and above all, optimism.

This level of consciousness includes values such as enthusiasm, integrity, fun, fairness, trust and dedication.

Level 6: Making a Difference

This level focuses on the deepening of internal connectedness within the community as well as the creation of alliances and partnerships with other communities. Healthy communities care for the disadvantaged and provide counselling services. They also develop links with neighbouring communities and participate in exchanges of information with communities that share similar issues.

This level of consciousness includes values such as community care, sustainability, environmental awareness, aesthetics, and quality of life.

Level 7: Service

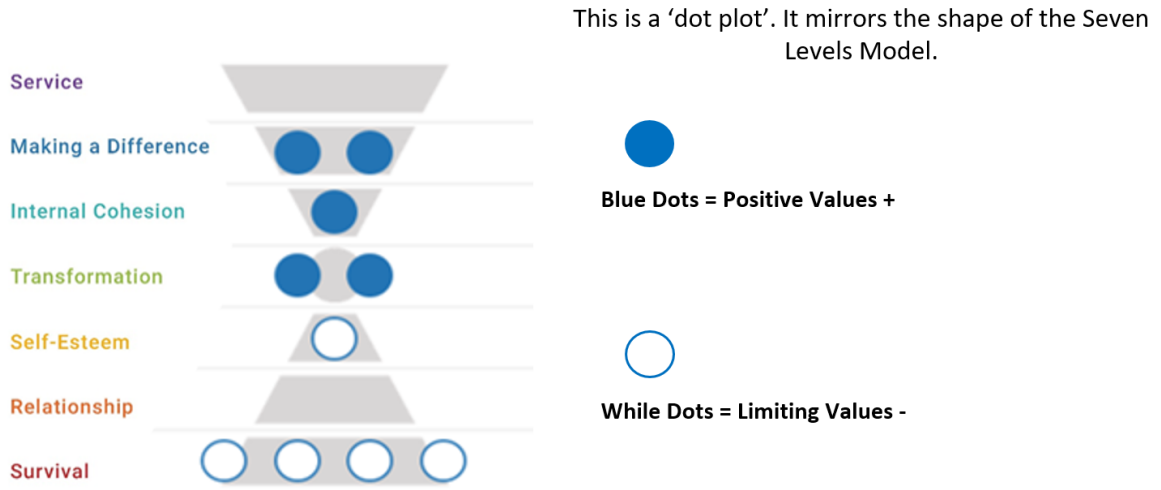
This level focuses on a further deepening of internal connectedness within the community including the expansion of external connectedness with other communities and society. Healthy communities are not only

concerned with local issues; they are also advocates for social justice and human rights at a national or global level.
They are concerned with the impact of their decisions on future generations and demonstrate wisdom and compassion.

Read more about the Barrett Values Centre and their work, **here.**

Appendix 2: How to read the results

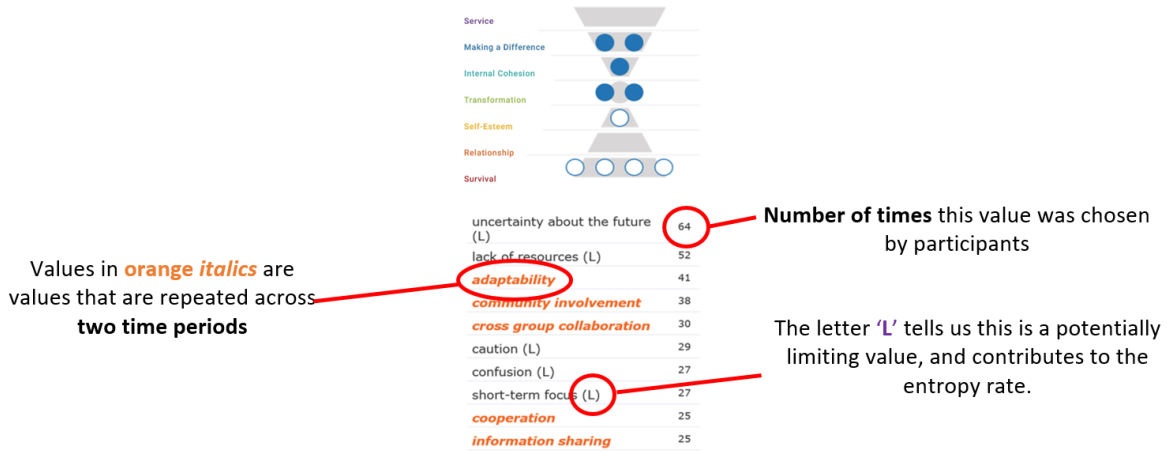
Dot Plots



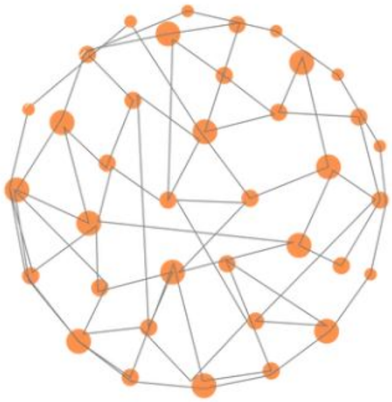
- Blue dots indicate positive values. They indicate where the energy exist that we can work with
- White dots potentially limiting values

The list beneath the dot plot indicates the top ten (highest to lowest) value preferences.

We can also break down data and see the top values chosen by participants in preference order.



Cultural Entropy



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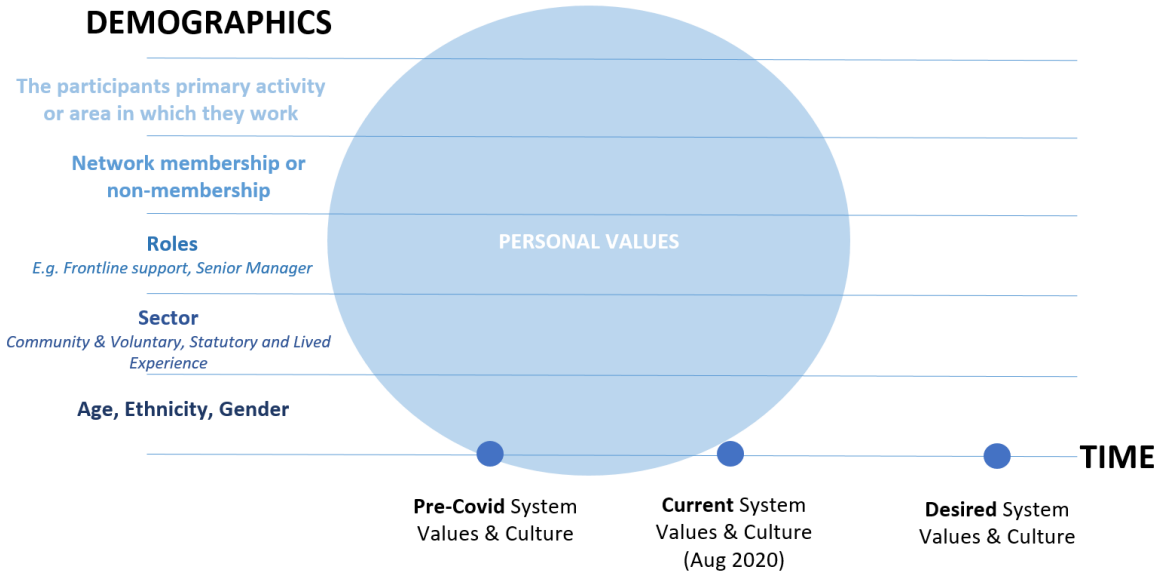
A **HIGHER** entropy rate means there is **MORE** resistance and dysfunction.

%

Mapping the results to demographics and time periods



The survey gathered certain demographics which have allowed us to break the results down in various ways. This is an overview of how these different breakdowns link together.

The survey asked people about: Age, Ethnicity and Gender; Sector; People's Primary Roles; Whether people considered themselves to be a

member of the York MCN Network or not, or if they weren't sure; People's primary activity at work.

This means that we can understand the system as a whole, as well as dig deeper into individual sectors and roles, understanding differences, and thinking about how we move forwards collectively as a community.

Health and Wellbeing Board November 17th 2021

Report of the Joint Consultant in Public Health, Vale of York CCG / City of York Council

NHS Reforms and update from the York Health and Care Alliance

Summary

1. This report is to provide an update on the progress of the York Health and Care Alliance.

Background

2. The York Health and Care Alliance was established in April 2021 as our city's response to the changes and reorganisation of the NHS proposed in the government's white paper 'Integration and Innovation'.

3. The Alliance Board was established as a sub-group of the Health and Wellbeing Board through consultation with the Health and Wellbeing Board and through Full Council in April 2021. Papers relating to the establishment of the Alliance board, including a description of its purpose and its terms of reference, can be found in Council Executive papers from their meeting on 18th March 2021.

4. As part of this arrangement, an update on the Alliance Board is presented at every Health and Wellbeing Board meeting.

Main/Key Issues to be considered

Update on NHS reforms

5. When the Health and Wellbeing Board last met, an update was given on the NHS reforms which covered:

- The Health and Social Care Bill, which is still passing through parliament at the time of this report writing
- The ICS Design Framework, a policy documents from NHS England laying out details of the governance and design of new Integrated Care Systems
- A model ICB constitution, setting out how one part of the ICS (the ICS NHS Body or ICB, which will run the NHS from day-to-day) is to be governed
- The HR framework governing the transition from CCGs to an ICB and associated functions.

6. Since this point more details have been released setting out the policy and local arrangements Humber Coast and Vale ICS are looking to build. The ICS has endorsed and agreed local arrangements for the planning of health and care services based on:

   - 6 places - East Riding of Yorkshire, Hull, North East Lincolnshire, North Lincolnshire, North Yorkshire and City of York;
   - 4 sector-based provider collaboratives - Mental Health, Learning Disabilities and Autism, Acute, Community Health & Care and Primary Care;
   - a Humber, Coast and Vale wide Integrated Care Board - operating through 2 strategic partnerships of the Humber and North Yorkshire & York and a number of committees and forums
   - a Humber, Coast and Vale wide Integrated Care Partnership

   The arrangements set out above have been approved by NHS England.

7. The Integrated Care Board (ICB) will be directly accountable for NHS spend and performance within the system. The proposed outline membership for the ICB for the HCV region is:

   - Independent Lay perspective (Chair and 2 non-executive directors)
   - Place perspective (one local authority member)

- Provider perspective (one member drawn from NHS trusts and foundation trusts and primary medical services (general practice) providers)
- System executive, clinical and professional (chief executive, director of finance, director of nursing, director clinical and professional, strategic partnership directors x 2, people director, director of transformation/NHSEI locality director)
- Subject matter experts (VCSE, CIC, public health, communities representative)

8. Guidance issued to help embed ICSs by April 2022 (subject to legislative approval) has indicated that each ICS is required to appoint a Chair and a Chief Executive. HCV Partnership has recently announced that it has appointed Sue Symington as its designate ICS Chair, and therefore designate Chair of the anticipated ICB and ICP. Final appointment to the role of Chair of the ICS, ICB and ICP is dependent on the passage of the Health and Care Bill through Parliament, and any potential amendments made to the Bill and the subsequent legislation.

9. The HCV Partnership (ICS), as the region's integrated care system, has also begun the process of appointing an ICS Chief Executive. As with the Chair, the ICS Chief Executive would become Chief Executive of the ICB should the proposed ICS legislation be passed into law.

10. The Integrated Care Partnership (ICP): the proposal is that HCV ICP base membership should be the 6 Health and Wellbeing Board chairs or other local government member, 6 place leaders, the ICB chair and chief executive, with other members of the ICS Executive in attendance as required.

11. As outlined in the document, the ICB board and ICP membership has been confirmed, and we have been informed the draft HCV ICB constitution will be released this month and the ICB first shadow meeting will be in January.

12. Recent guidance has confirmed that the development of place-based arrangements between local authorities, the NHS and providers of health and care will be left to local areas to arrange

National guidance recommends five place-based governance options available for ICSs to use, but a preferred option has not yet been decided by any of the places in HCV, including York.

13. It is anticipated that Humber Coast and Vale are soon to announce the process for identifying managerial and clinical leadership at 'place' level, including the process for appointing a Place Director in each area. Further clarity about HCVs starting point for place-based discussions will be after the Chief Executive has been recruited.

Role of the Health and Wellbeing Board

14. The new legislation includes several references to the role of Health and Wellbeing Boards.

15. Before the start of each financial year, an integrated care board (ICB) and its partner NHS trusts and NHS foundation trusts must prepare a plan setting out how they propose to exercise their functions in the next five years. The integrated care board and its partner NHS trusts and NHS foundation trusts must, in particular:
    - give each relevant Health and Wellbeing Board a draft of the plan or (as the case may be) the plan as revised, and
    - consult each relevant Health and Wellbeing Board on whether the draft takes proper account of each joint local health and wellbeing strategy published by it which relates to the period (or any part of the period) to which the plan relates

16. In addition, HWBBs are asked to give an opinion on
    - ICB / Trust forward plans
    - Joint capital resource use plans
    - Annual reports, which must reflect local Joint Health and Wellbeing Strategies
    - Performance assessment of integrated care boards carried out by NHS England

17. A relevant ICB must appoint a person to represent it on each local HWBB. Functions of a local authority under sections 116

and 116A of the Local Government and Public Involvement in Health Act 2007 are to be exercised by the Health and Wellbeing Board and the Integrated Care Board jointly.

18. Clarification has been sought on whether the HWBB is able to function as the local place-based partnership, and whilst a close alignment is encouraged, the view from others in the region is that they would need to be separate under a delegated committee arrangement.

19. Given this, it is imperative that we develop a strong role for the HWBB in the new system, both through the voice the Chair will have as a member of the HCV ICP, and as the body which sets the strategic direction for health and wellbeing which the York Alliance will work to.

Alliance Board meetings

20. The York Health and Social Care Alliance has met monthly since April 2021, with the membership, aims and purpose and terms of reference presented to the council Executive in March.

21. The Alliance's meetings since the last update to the Health and Wellbeing Board have been time-out sessions, which have had no formal papers or minutes, and have focussed on producing a 'maturity matrix' which all six 'places' within Humber Coast and Vale have been completing, in order to establish a baseline for how health and systems are working together locally, and where focus should lie to further improve and integrate services. Partners are asked to agree how far work has progressed on a scale from 'emerging' through 'developing', 'maturing' and 'thriving'. A summary of this self-assessment is included below:

Place Development Framework: Current Assessment (September 2021)

York

Domains	Emerging	Developing	Maturing	Thriving
Ambition & Vision				
System Leadership				
Design & Delivery				

Overall the existing work with partners across the place indicates we are already maturing with strong System Leadership in place. Ongoing actions around workforce and new governance arrangements will further move the place towards thriving throughout 2022-23.

We are working with partners at both North Yorkshire and the ICS/B on overall governance structures to space future actions.

Consultation

22. The work of the Alliance involves key partners from each health and care provider organisation in the city and all of them have been heavily involved in its work. A number of engagement events have been held to share the plans and details on NHS reforms with partners in the city, and more will be possible when the detailed structures have been agreed.

Options

23. The HWBB will receive further reports on the progress of the NHS reforms and the York Health and Care Alliance.

Strategic/Operational Plans

24. The Joint Health and Wellbeing Strategy is the overarching strategic vision for York, and the work of the York Health and Care Alliance supports the delivery of the desired outcomes.

Implications

- **Financial** – There are no financial implications as yet from this report. Any future decisions about finances take by the Alliance will be made through the governance of each partner organisation at this stage, while the Alliance is a partnership rather than a formally constituted body.
- **Human Resources (HR)** – There are no human resources implications as a result of this paper, but significant HR implications of the NHS reforms in general should be noted.
- **Equalities** – the Alliance aligns with the Health and Wellbeing Strategy in aiming to tackle and improve health inequalities
- **Legal** - There are no legal resources implications as a result of this paper, but significant legal and contractual implications of the NHS reforms in general as noted above
- **Crime and Disorder** - none
- **Information Technology (IT) –**none
- **Property** - none
- **Other** – none.

Risk Management

25. Governance processes are in place between the partners to manage the strategic risks of these reforms

Recommendations

26. The Health and Wellbeing Board are asked to:

- Note the update on the NHS reforms and work of the York Health and Care Alliance

Contact Details

Author:	**Chief Officer Responsible for the report:**
Peter Roderick *Joint Consultant in Public Health, Vale of York CCG and City of York Council* *Peter.roderick@york.gov.uk*	*Sharon Stoltz* *Director of Public Health* *City of York Council*
Report Approved ✓	**Date** 08.11.2021

Wards Affected: **All** x

For further information please contact the author of the report

Background Papers:

Health and Social Care Bill – available here

ICS design framework – available here

ICS Implementation Framework – available here

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Health and Wellbeing Board 17 November 2021
Report of the Manager, Healthwatch York

Healthwatch York Report: What people are telling us: Experiences of York GP Services. A snapshot report

Summary

1. This report is for information, sharing a report from Healthwatch York which looks at what people told us about GP services during the pandemic.

Background

2. Healthwatch York provides information and advice about health and care services, signposts people to support, and listens to their experiences when accessing health and care services. In carrying out this work during the pandemic, a significant proportion of the feedback received has related to GP services, and accessing GP appointments.

3. We also reached out to partner organisations York Carers Centre, York Mind and Community Voices York, who had all flagged up challenges they were experiencing around supporting people to access GP services.

4. We appreciate this has been a very difficult time for everyone working in health and social care. We aimed to produce a report that highlighted the pressures on both GPs and patients, and have shared this report to encourage further discussion of these challenges and consideration of ways we can collectively address them.

Main/Key Issues to be considered

5. Our report highlights that digitalisation has enabled GPs to provide more appointments than they would if face to face remained the 'default' option. It is also clear that for some, access has improved.

However, some people fear they are being left behind by the digitalisation of GP services, and these concerns are also being raised by organisations who work with those at risk of exclusion.

6. There are a number of recommendations within this report and these are as follows:

- Make patients more aware of options for call backs during evenings and weekends through Improving Access clinics - and work together to promote the Top Tips from “The Doctor Will Zoom You Now”.
- Provide clearer information regarding the provision of interpreter services.
- Review provision of interpreter services through contract monitoring
- Develop better information for patients exploring options in accessing healthcare, including details of AHP roles in Primary Care and the benefits of accessing these.
- Urgently review access to online services for parents –consider building in automatic transfer options at, for example, age 14 linked with a compulsory PSHE lesson in schools around digital health literacy, and with clear mechanism for enabling retention of this for those children who lack capacity to manage their own health appointments.
- Work together with those facing greatest difficulty in getting GP appointments to understand what could work better for them.
- Consider how we can contribute to the regional and national conversation around creating more GPs and other primary care health professionals.

7. All partners have identified the need to understand the barriers to accessing care and removing them as essential to the transformation of local health and care through the work of the ICS at place.

Consultation

8. In producing this report, we did not go out to public consultation, but used the experiences people had already shared with us, alongside experiences shared with partners.

Options

9. There are no specific options for the HWBB to consider however individual organisations are asked to note the recommendations in the Healthwatch York report and respond these within 28 days.

Implications

10. There are no specialist implications from this report.

- **Financial**

There are no financial implications in this report.

- **Human Resources (HR)**

There are no HR implications in this report.

- **Equalities**

There are no equalities implications in this report.

- **Legal**

There are no legal implications in this report.

- **Crime and Disorder**

There are no crime and disorder implications in this report.

- **Information Technology (IT)**

There are no IT implications in this report.

- **Property**

There are no property implications in this report.

- **Other**

There are no other implications in this report.

Risk Management

11. There are no risks associated with this report.

Recommendations

12. The Health and Wellbeing Board are asked to:

i. Receive Healthwatch York's report, What people are telling us: Experiences of York GP Services. A snapshot report.

ii. Respond directly to Healthwatch York within 28 days regarding the recommendations made to their organisation.

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

Contact Details

Author:	**Chief Officer Responsible for the report:**
Siân Balsom Manager Healthwatch York 01904 621133	

Report Approved ✓ **Date** 05.11.2021

☐

Wards Affected: All **All** ✓

For further information please contact the author of the report

Background Papers:

Annexes

Annex A – What people are telling us: Experiences of York GP Services. A snapshot report

Healthwatch-York-GP-Snapshot-Report-V2.pdf (healthwatchyork.co.uk)

What people are telling us: Experiences of York GP services

A snapshot report

In partnership with

York Carers Centre
Free Support for Unpaid Carers

mind for better mental health York

Community Voices York

ANNEX A

Experiences of GP Services

A snapshot report

ANNEX A

Background

Healthwatch was set up in 2013 to hear people's experiences of health and care services. From the early days of Healthwatch England and the network of Local Healthwatch a significant proportion of the feedback we hear relates to GP services. Even before the Covid-19 pandemic, this has also been a difficult time for GP practices. As far back as 2016 the Kings Fund were drawing attention to increasing demand, problems of recruitment and retention, and describing a 'crisis' in general practice.[i]

The Covid pandemic has understandably placed further strain on general practice. 75% of all Covid-19 vaccinations have been delivered by them. Across the UK that equates to approximately 75 million vaccinations. For York, at Askham Bar alone there have been 400,000 vaccinations. General practice are also responsible for the ongoing support and management of those patients on waiting lists for secondary care treatment. Healthwatch England report 5.6 million people across the country are waiting for treatment. Locally it is estimated there are around 35,000 patients in this position. All of these people are likely to need greater GP support whilst they wait.

British Medical Association, April 2021

As part of the British Medical Association's ongoing monitoring of the pressures in general practice, they reported several concerning trends, most notably:

- 50% of practitioners reported suffering from depression, anxiety, stress, burnout, emotional distress or another mental health condition
    - Which some felt was 'worse than before the start of the pandemic'
- 60% of respondents felt the level of exhaustion or fatigue was 'higher than normal'
- 30% had undertaken additional unpaid hours,
    - With 40% reporting they felt 'slight' or 'significant' pressure to work additional hours from their employer

The report also highlighted that:

- The number of patients per practice is 24% higher than it was in 2015, whilst the number of Full Time Equivalent GPs has fallen.

- There are now just 0.46 fully qualified GPs per 1000 patients in England, significantly below the average number of physicians per 1,000 patients in comparable nations (3.5).

You can see the full report at:

https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice

Healthwatch England: People's experiences of care, August 2020[ii]

Healthwatch England published “The Doctor will Zoom You Now” alongside National Voices, Traverse and PPL. This looked at people’s experiences following the rapid rollout of online and telephone consultations following the outbreak of Covid-19. Key takings from this report include:

- Remote consultations were a convenient option for most
- Allowed for quicker and efficient access to care
- Most felt the care received was adequate
- Majority wanted remote consultations to be offered in the future

The report concluded that:

"a blended offer including text, phone, video, email and in person appointments would provide the best solution [for both patients and professionals]"

The report also shared top tips for patients to get the most out of telephone and video consultations:

Top Tips for getting the most out of the virtual health and care experience

For Patients

- Ask for a timeslot for when your remote consultation will take place.
- Let your health care provider know how you prefer to talk by phone, video or in-person.
- Find somewhere quiet and confidential and, if this isn't possible or is tricky, make this clear when you are making your appointment.
- Start with a phone call if you're not confident with video technology.
- Ask for help if you need it and, if possible, do a practice run with a friend.
- Take some time to prepare in advance, consider what you want to say and key questions you would like to ask.
- Ask your health care provider to summarise the next steps at the end of the appointment.
- Remote consultations can be useful for routine appointments or ongoing care with a health care practitioner.
- Not all appointments are suitable for remote consultations, if you would like to see someone in-person please say so.

For Health and Care Professionals

- Provide a precise time window for appointments.
- Check that the person is in a confidential and safe place to have the phone or video call.
- Understand the person's level of confidence using technology and give people a choice of how to communicate.
- Proactively check what the patient needs, clarify what is happening next and who is responsible for the next stages of care.
- Slow down the pace of the consultation, demonstrate active listening.
- Use the chat function in video calls to make the appointment more interactive, share links to information or summarise next steps.
- Don't ask people to provide information you already have access to.
- Give guidance about how the appointment will work, offer demonstrations, provide an opportunity for a test run/provide some training.
- Seek feedback about peoples' experiences and use this to improve the service.

healthwatch National Voices TRAVERSE

6

Healthwatch England: GP Access During Covid-19, March 2021

Healthwatch England published a further report looking at GP access during Covid-19. The key issues raised were:

- **Communication:** Communicating information has not been a top priority for all GP practices. As a result, people were confused about how to get in touch with their GP, whether they could make an appointment and how, and what to expect if they attended the surgery in person.
- **Booking an appointment:** Before the pandemic booking an appointment was problematic. By autumn 2020, people started telling them about long waits when phoning services. People also reported problems with triage booking systems, and not being sure when their GP or other healthcare professional will call back. This left people feeling anxious.
- **Appointments not meeting people's needs:** While telephone appointments are convenient for some, others are worried that their health issues will not be accurately diagnosed. These were exacerbated for people with disabilities, long-term health conditions, those without access to the internet and for those whose first language is not English.
- **Access to regular treatment and medication:** People were unable to get the medication and treatment that they need to manage their condition due to difficulties accessing regular check-ups.

You can see the full report at:

https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20210215%20GP%20access%20during%20COVID19%20report%20final_0.pdf

What NHS publications are saying

Within the NHS there is a growing belief that modern primary care must include a wider range of health professionals.

"The vision for the NHS… is a primary care provider that offers more services centred around a multi-disciplinary team. ...NHS England has already committed to an extra 1,500 clinical pharmacists in general practice by 2020/21." – NHS England[iii]

Feedback from the NHS Long Term Plan consultation delivered by the Healthwatch network indicates there is some appetite for this:

"People want GP surgeries to give them access to different health professionals who can help them with particular issues. ..... People suggested this might help reduce the burden on GPs and waiting times."

You can read the NHS Long Term Plan: Healthwatch Evidence Summary at:

https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20190129%20-%20Appendix%20A%20-%20NHS%20Long%20Term%20Plan%20Evidence%20Summary%20.pdf

GP Patient Survey Data 2021

The GP Patient Survey is an England-wide survey, providing practice- and CCG- level data about patients' experiences of their GP practices. It is completed by Ipsos Mori for NHS England. The full slide pack for NHS Vale of York CCG can be found here.

https://gp-patient.co.uk/downloads/slidepacks/2021/03Q%20-%20NHS%20VALE%20OF%20YORK%20CCG.pptm

Across the Vale of York, 3,386 questionnaires were returned, just under half of those sent out.

A key question asked is "Overall, how would you describe your experience of your GP practice?" 83% of survey respondents for Vale of York said it was either Very Good or Fairly Good. This is in line with national satisfaction levels (also 83%).

Another useful question is "Were you satisfied with the appointment (or appointments) you were offered?" Here again we are very close to national figures. 81% of people responded "Yes, and I accepted an appointment". 17% said "No, but I still took an appointment." 2% replied "No, and I did not take an appointment." Nationally, the results were 82%, 16% and 2% respectively.

These results give a clear indication that overall, satisfaction levels remain high despite the challenges of the pandemic.

Key findings

Every month Healthwatch York reviews what people tell us about their experiences. This information is gathered via our signposting, information and advice work and our online feedback centre. We also work in partnership with other organisations to hear what all communities across York are saying. Worryingly, but perhaps unsurprisingly, we can see from our data that York residents' experiences of accessing GP services matches the trends found by Healthwatch England, The British Medical Association and NHS England.

A summary of our findings:

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

Recommendations are made at the end of this report.

What people are telling us

What we have heard: April 2021 to date

Selected comments from our signposting, information and advice work, and our online feedback centre since April 2021. These comments are in people's own words wherever possible. Where this hasn't been possible, these are shown as a story, though all names used throughout this report have been changed.

Positives

"Got a reminder that I was due a blood pressure check. Booked an appointment at my convenience via NHS app. Turned up, let in, explained I'd not used it before. Quick explanation, clear instructions printed out. Sorted out in minutes. Fab!"

"I fell ill over the weekend.... Filled in the online triage form with all the details on Sunday. Got a GP phone call not long after 9am on Monday morning.... E-prescription sorted to collect from my preferred pharmacy. So the whole thing works brilliantly for people who can use this system."

"Great service from (my GP practice) who did a home visit to give a Covid jab to relative with learning disabilities. Both times staff were friendly and supportive and explained everything they were going to do. This helped him to stay calm and it was a positive experience...."

Negatives

People reported problems with booking appointments. Here are some examples:

"You can't book a non- urgent appointment until 10am. Phoned every day this week at 10am exactly. By the time you get through the voice system, all the slots have gone."

"Awaiting call from doctor booked [some time ago]. Attempted to make GP appointment by calling in at (2 different) surgeries to no avail"

"I am appalled by the lack of patient care from my GP practice. I… am put on hold for hours to find that no same day appointments are available…. I ..... wish to see a GP in person ..... my colleagues are working as normal doing the most high-risk job in regards to covid19. We provide…. appointments and

care that day or book in asap. I do not understand why my GP cannot match this high standard of care."

*"I have found it *literally* impossible ..... to speak to my own GP, [who has] supported me through 15 years of having lengthy episodes of severe depression. The only way to get a GP appointment..... is to call the 'urgent care' line at bang on 8am for a same-day appointment..... I was told to do so today [as a matter of emergency]. I called the number only to find that I was already 'in a queue above 30'. I was later [told] that they have 15 people answering calls simultaneously for this one small group of surgeries, so this immediately illustrates the scale of the problem. [When I got through] today's appointments with my GP had gone. I was offered a phone appointment later today with a different doctor, but that's not what I need, or want....."*

"Appalling system. You're left on hold for hours or have to call back later. Online system not fit for purpose. They get back to say you might have an appointment in 14 days' time. The only time you can see anyone face to face is when you click urgent, and this means a life-or-death situation. Like many I will have to find another GP practice."

"It is so incredibly difficult to get through to the surgery! The call back option is helpful but requires you having the phone with you at all times, and being able to answer the call. We .... have been incorrectly told we need to ring back next day for an appointment with a GP, and having waited for 2 hours are then told we did not need to do this....."

"..... part of the problem is the attitude of the call centre staff, who seem determined to avoid offering even telephone appointments ..... Example lady ..... is told to go to see a pharmacist rather than being offered appointment! When she does this the pharmacist says she needs to insist with the GP practice that at least a telephone appointment is offered. ..... the criticism is of the call centre not the GP. I wonder if the GPs even know of the problem of the call centre staff's behaviour?"

Trevor has developed a new health condition which is having a considerable impact on his quality of life. He was unable to reach his GP by phone to make an appointment. On visiting the surgery, he was told he couldn't book an appointment in person at the time. He used the online booking system to request a telephone appointment. After hearing nothing from them, Trevor called again and was told he wouldn't get a telephone appointment for weeks.

He is really concerned for others in his situation who are digitally excluded and worries that many will be left without the help they need.

Edward has ongoing complex health needs and has found it increasingly difficult since Covid to access the care he needs. He sees a different doctor each time which means they must start from the beginning every time. He feels there is no continuity of care and no consistent treatment.

Janet reported that it is increasingly difficult for carers when call backs are appointed "within the next 10 hours". She complained to the GP surgery and then sought support from several other organisations to get a response to this complaint. She eventually gave up on her complaint at this time as it was "too draining when you are one up against teams of people and it doesn't feel like it makes any difference".

Other notable accounts include:

Access and transport

Albert is over 90. He needs to visit a surgery regularly for blood tests and quarterly injections. He no longer drives but is able to walk to his nearest surgery. However it has been closed for over a year. He wants to maintain his independence and travel to a surgery on foot but this is impossible for the other group sites. Although he would prefer to stay with his current GP, he needs to know if it won't reopen so he can move to another surgery within walking distance. Family has emailed his practice asking what the future of the surgery is but have had no acknowledgment or reply.

Accessing GP records

Margaret requested a copy of her GP Medical Records and (after a long time) she received a copy but in an unusable "hotch-potch," with things omitted and not in chronological order. For example, some sheets provided start with one letter on the front but on the back, it is the end of a completely different letter.

Feedback from October 2020 to March 2021

Positive

We received a very high volume of positive feedback around the flu jab service offered by GPs. These are just some examples:

“Had a text a month before, attended the surgery at the time allocated. I walked straight in and was out within a few minutes. Very helpful staff, felt safe and extremely efficient.”

“Quick, easy, responsive service when getting both Pneumonia and flu jab. Felt safe and was done in a covid secure setting.”

Richard is in his in late 60's. He requested an alternative flu vaccine due to his needle phobia. He contacted his surgery who made a telephone appointment with the practice nurse. Following the call his request was accepted and he received the liquid vaccine at his surgery. He would not have had the jab if the liquid vaccine had not been offered.

Other positive experiences

June contracted Covid-19 last March and was left with ongoing fatigue. For 10 months her non-York GP refused to see her face to face. Eventually some tests showed very low long term iron levels. After moving to York, she had a very thorough and personable consultation with her new GP. June reports feeling really listened to for the first time. The GP efficiently booked in follow up tests and has prescribed her the correct medication. June felt reassured by the GPs prompt and personable approach.

"I was seen within a few days of contacting the practice and my GP fast tracked me to dermatology at the hospital. She was very reassuring about what it might be and took time to explain [the] process. I was seen at hospital and treated in less than a month from seeing my GP"

Examples of negative feedback

Again, most of the comments from October 2020 to March 2021 related to problems accessing appointments.

Louise contacted us with concerns about GP access. Her daughter Emma had major health concerns that she was anxious about seeking support for. When she called the surgery first thing, there were already 30 people waiting. When Emma finally got through, the receptionist pushed her as to whether she felt that matter was urgent. Feeling anxious already, Emma was unsure and ended up with no appointment at all.

"[I] have been trying to get through for days to book a flu vaccine for my child. Online services still not available for children so had to call the usual number. Tried several times and lines so busy told by automated voice to call back

later. Finally get through to be told those appointments come out on a Wednesday so call back then. Why do the letters not say that then? ....."

Some people specifically highlighted concerns about delays to care as a result of the pandemic. This also impacted on accessing private care:

Frank has been unable to get a CT scan via his GP. His surgery told him that the delay is due to the impact of Covid. He has sought private treatment, but the provider is waiting for a GP referral letter. Frank is concerned that his condition is deteriorating, and he is very worried.

Sarah has previously undergone invasive surgery to treat cancer. She recently developed severe pain, and both she and her husband David are concerned that the cancer may have returned. The GP practice could only offer a phone appointment with a 10 day wait. David feels this is not good enough.

There were also comments about the quality of care.

Idris had symptoms that impact considerably on his quality of life. He has been accessing the GP to find medications that will work. His condition has been affecting his work and his wellbeing. He feels that he has been discriminated against because English is his second language and he has not been able to express his needs. He feels that his ethnicity has meant that the GP has not really listened and taken his concerns seriously.

"The postnatal care I have received during the Covid pandemic has been almost non-existent. Whilst I understand the restrictions that are place and the need to minimise face to face contact, there is still a minimum level of care that should be expected I don't feel this is being provided ....."

"..... I have been genuinely scared to contact [my GP] after recently spending months chasing up standard ..... and general issues with the decline in my mental health. .....I found the GP barely knew anything about me or my disability..... I felt that the basic duty of care towards people like myself was clearly being ignored.....”

We also heard from people about challenges accessing medication.

"My usual repeat prescription from the pharmacy was refused. The GP contacted me to say they would dispense the medication (from their pharmacy rather than the one I chose). When I asked why this was the case, I was told that the Doctors insisted as it was a 'critical funding stream'. I believe this is

contravention of guidelines and there is no clear method of raising a complaint with the GP"

We also received comments about challenges of navigating the system during the pandemic.

Professional called raising concern around lack of support available for Alice, a mum who was losing her vision. Alice was bounced between different medical practices. Alice then sought the support of a voluntary organisation who also struggled to get through to the GP for an appointment.

The professional spoke to the Eye Clinic Liaison Officer (ECLO) who managed to get Alice seen as a matter of urgency, bypassing the GP. The ECLO arranged a taxi to and from the appointment.

Case studies from our partners

"Generally, through conversations with carers, there is a feeling of being overwhelmed at the thought of getting an appointment. This is mainly around constant changes to systems causing confusion. Our carers are being told to ring on the day; are not able to book ahead; no [consideration is made toward] work/caring roles; there's a lack of available appointments. Trying to obtain an appointment becomes such a task and can go on for days." – York Carers Centre

Adult carer experiences

James: James is a carer who was feeling suicidal. He felt unable to access his GP due to poor experiences with the GP in the past. Staff obtained consent to contact the GP on James's behalf.

The reception team were understanding, and James was soon contacted by a doctor experienced in managing MH concerns.

The organisation feels confident when signposting individuals to this GP practice. They feel reassured that James is getting the right care for their MH concerns and so can focus their efforts to support him on issues related to being a carer.

Mary: Mary is a carer who is already under a lot of pressure. She was unable to get through to her GP after making 4 attempts on different occasions.

After obtaining consent, staff contacted the surgery and were told that there was no communication from the Doctor on the system, so Mary would have to call back the following morning.

The staff member explained the difficulties and pressures that Mary was under. These were noted by the reception staff, and Mary was invited to call back at a more convenient time for her.

Mary was able to speak to the right professional and received an appointment. Mary was pleased to have received the support she needed.

Fred: Fred is a carer who struggled to get an appointment with his GP and asked us to call on his behalf.

We explained the pressures that the carer was under, and the surgery were able to offer an appointment that afternoon.

Gaining access to the GP is still an ongoing issue for Fred. This has an impact on his ability to provide care themselves. "We know carer's do not often prioritise their own needs, and as a society we need them to be able to maintain their caring roles."

Alan: Alan, a carer, called his surgery for a non-emergency appointment at 8am Monday morning as surgery opened. He was number 6 in the queue. He was on hold for 25 minutes then told all GP appointments had gone and he would need to call back at 8am the next day.

When they called the following day, they were met with the same outcome. The carer tried this every day for 12 days. He became very angry and expressed their frustration with the reception team. As a result, Alan was given a telephone appointment the next day.

Frances: Frances rang the surgery for an urgent appointment for the person they care for. She was told by the automated service that calls were high and she was offered the call back service. As the person they care for lives an hour away, they set off with the phone on hands free in the car. She arrived at the house of the person they care for 65 mins later but still no call back. After a further 40 minutes Frances rang 111 and took the person they care for to A&E.

Lilian: Lilian has had grave difficulty in accessing their GP for important pain relief. She feels extremely upset by the way one receptionist treated her. She responded to one of Lilian's concerns with "Join the queue with thousands of others" before having the reception window abruptly shut on her.

Lilian felt "shocked by the ruthlessness" and felt she had failed her partner (who she cares for full time) by not being able to get him an appointment when he was in debilitating pain.

"[We are concerned] that people with mental health issues aren't able to access their GP when they need to. We worry that people's mental health will worsen [from] trying to access an appointment for something completely unrelated, due to stress, worry and anxiety." – York Mind

This is supported by what our clients share with us:

"From my own experience, I have found it very difficult to access an appointment. I have had numerous health issues over the last year ……. I now have anxiety just trying to ring the GP's….. Monday mornings are dreadful trying to get through, so I am already anxious about making the call."

Emily's story: Emily's daughter Lucy is 18-year-old. Lucy has considerable mental health issues. Emily reported that Lucy simply could not access a GP. Due to Lucy's age, Emily is unable to represent her on health issues. Lucy is currently taking her exams and so is not available to speak to a doctor when such a wide time slot for a call is given. They have both found the process incredibly stressful and upsetting. They feel that there appears to be no understanding by the reception staff that the system does not work for them.

Lorna, who is deaf

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

I need to change GP as some in York are more accessible through the online portal. I know that I [could] make [some hospital appointments] online during [the] pandemic and it all went smoothly."

Sarah

"[There was an] assumption that I would be free all day to answer a GP call. My job involves talking to people on the phone. I am not going to hang up when my personal phone rings. I asked the receptionist what would happen if I was unable to take the call. She said I would have to call the surgery and apologise. I replied that I would not be apologising for being in employment. Surely one could be given an appointment with an approximate time?"

Charlotte

"A few weeks ago, I called a GP Practice with a customer who doesn't have a phone. We gave the [GP Practice] number of the pay phone to give him a call back. The customer agreed to sit in the common room waiting for the call approximately 4pm. No call was made according to the customer. How would someone access GP advice without a phone?"

Support worker for Jen

"Jen works full time (in health care /care role). I tried many times to book an appointment and had to do so each morning or call back the next day because the surgery felt it was urgent. When I called again they said it wasn't urgent so she couldn't get a priority appointment. They also told me she would get a call back which didn't happen. We gave up at times then tried again. In the end

she has registered with a different surgery. [The new surgery] said this is how it is across York.

..... [Jen] has been having some physical difficulties / pain and it has impacted on her over time and I have seen a decline in her emotional wellbeing recently. These issues could be linked."

Susan

"I rang the doctors after putting off for some time and they offered me an appointment in two weeks' time (it wasn't urgent) and said the doctor would ring me on that day between 9am and 6pm. How can that be conducive, and I was committed during the day with meetings and important things hence missed the calls from the doctor. Why could they not offer a ten min slot? If I had to visit, I would be given a time. How [do] they expect anyone to wait all day ….."

Annabel

"I'm going to run out of painkillers because my GP won't put them on repeat prescription and they have ignored the request I made last week."

Robert

"I got a text inviting me for my flu jab and it included an email address for my doctors. I couldn't make the one hour slot so emailed to ask if I could get there 20 minutes later. The email bounced back saying it wasn't an email address...."

Conclusion

Despite the significant pressures on GP services, they have increased the number of appointments available. These increases are because of greater use of telephone and online consultations. They would not be possible with a return to face-to-face appointments as the 'default' setting for primary care, especially whilst PPE / infection control measures are in place to reduce the spread of Covid-19.

But demand continues to outstrip supply. With virtually all GP practices now using online triage tools, the fear is that those most able to use these systems will continue to receive the benefits of high-quality primary care services. What we must now collectively work on are ways of improving access for those least able to communicate in a digital-by-default society. The key to this is patients working together with general practice to get this right.

There are some simple steps we can take immediately – where people are in work or full-time education and unable to take telephone calls during the day, we need to increase awareness of evening and weekend appointments. We need to encourage people to be clear about times they can be available, as well as times that they can't be.

We also need to improve access for parents. Current digital solutions do not allow parents to make appointments for their child or children. Given the speed at which digital solutions have moved in the last 18 months, this should be relatively straight forward. If this is designed with plans in place for how ownership of the account can be transferred, linked to education on how to use the system, we can improve digital health literacy for future generations.

Taking these simple steps should help improve the experiences of those able to use technology. The aim of this must be to increase our capacity to provide face to face appointments and health interventions for those who need them most. Patients are part of the solution to this – if those of us with the skills to do so embrace online and telephone consultations, we can play an active role in improving access for those who cannot.

This will be a significant challenge. But if we fail to tackle it, we risk deepening and entrenching health inequalities, which can take generations to overturn.

Responses to this report

Before publishing our reports, we ask key local stakeholders to look for any factual errors or clarifying comments.

We would like to thank NHS Vale of York Clinical Commissioning Group for clarifying the following:

"The number of patients per practice is 24% higher than it was in 2015."

This figure is slightly misleading as it is influenced largely by practice mergers. So, for example, if two practices merge, the number of patients per practice will be 200% higher. There will, however, still be the same number of clinical and administration staff serving those patients.

"There are now just 0.46 fully qualified GPs per 1000 patients in England, significantly below the average number of physicians per 1000 patients in comparable nations (3.5)"

This also needs clarifying. General Practice has employed a significant number of additional roles to create a more diverse workforce supporting GPs manage patients' health. This includes, for example, clinical pharmacists carrying out medication reviews with patients and specialist MSK physio roles (MSK accounts for 20%+ of GP appointments). So while it's true to say GP numbers have fallen nationally, the teams are larger and more diverse. This is reflected in your recommendation *"Develop better information for patients exploring options in accessing healthcare, including details of AHP roles in Primary Care and the benefits of accessing these"* which VoYCCG has promoted extensively this summer (and continues to do).

We note the recommendations and are addressing those we can, and influencing others where we are able. Given the higher-than-average demand across all health and care services this summer, and likely to increase still further as we head into winter, making sure patients can access the most appropriate care in the most-timely manner remains one of our top priorities. Thank you again for a fair and balanced report on people's experience of York GP services.

We would also like to thank Professor Mike Holmes, Chair of Nimbuscare, and his colleagues in practice for the following clarifications and comments:

“There are now just 0.46 fully qualified GPs per 1000 patients in England, significantly below the average number of physicians per 1,000 patients in comparable nations (3.5).”

This data needs additional clarification. For England it talks about GPs, for comparable nations it refers to physicians. There are other physicians within the NHS in England who do not work in general practice. So this may not be a fair comparison.

The opening comment relating to the proportion of feedback Healthwatch receives nationally and locally about general practice is not surprising. We are doing most of the health care in this country, certainly the majority of consultations (around 85% of NHS activity with 10% of the NHS budget).

We do not just see minor illness, we assess, manage and co-ordinate care from cradle to grave. We see the full spectrum of physical and social issues. We have a huge task and we see the impact of this on patients and colleagues every day.

I think this report reflects the true strain that general practice is under. I suspect we are holding our heads above water better than most but patients are definitely feeling frustrated and staff equally so.

This report could highlight to Government the difficulties both patients and practices are facing. This is an insoluble problem without more resources and more manpower.

ANNEX A

Recommendations

Actions needed	By whom
Make patients more aware of options for call backs during evenings and weekends through Improving Access clinics - and work together to promote the Top Tips from “The Doctor Will Zoom You Now”.	GP Practices, PCNs, and the CCG / ICS across York: Healthwatch York to share and promote
Provide clearer information regarding the provision of interpreter services.	GP Practices
Review provision of interpreter services through contract monitoring	NHS Vale of York CCG / York Health and Care Alliance
Develop better information for patients exploring options in accessing healthcare, including details of AHP roles in Primary Care and the benefits of accessing these	GP Practices, PCNs, and the CCG / ICS across York: Healthwatch York to share and promote
Urgently review access to online services for parents –consider building in automatic transfer options at, for example, age 14 linked with a compulsory PSHE lesson in schools around digital health literacy, and with clear mechanism for enabling retention of this for those children who lack capacity to manage their own health appointments.	NHS England
Work together with those facing greatest difficulty in getting GP appointments to understand what could work better for them.	PCNs, Healthwatch York, Public Health at City of York Council.
Consider how we can contribute to the regional and national conversation around creating more GPs and other primary care health professionals	York Health and Care Alliance, PCNs

[i] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf

[ii] https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/The_Dr_Will_Zoom_You_Now_-_Insights_Report_0.pdf

[iii] https://www.england.nhs.uk/gp/case-studies/the-evolution-of-general-practice-broader-networks-multi-disciplinary-teams/

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Health and Wellbeing Board 4th November 2021

Report of the Chair of The York Health and Care Collaborative.

Summary

1. The Health and Wellbeing Board is asked to consider a report on the work of the York Health and Care Collaborative which is attached at Annex A.

2. The Collaborative is chaired jointly by Dr Emma Broughton and Dr Rebecca Field, who will present the report at the meeting.

Background

3. The York Health and Care Collaborative is a multi-agency group that brings together a range of organisations involved in health and care in the city. As such it contributes to the delivery of the Joint Health and Wellbeing Strategy and is instrumental in the implementation of the NHS Long Term Plan in York.

Consultation

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

Options

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

Strategic/Operational Plans

6. The work of the York Health and Care Collaborative contributes to the implementation of the NHS Long Term Plan (2019) which is a strategic objective for all NHS Organisations

7. York Health and Care Collaborative priorities for 2021/2022 cover, prevention, ageing well/frailty, mental health and children and young people, all of which align with the Joint Health and Wellbeing Strategy.

Implications

8. It is important that the priorities of the Joint Health and Wellbeing Strategy and the objectives of the Long-Term Plan in relation to integration are delivered.

Recommendations

9. The Health and Wellbeing Board are asked to;

   a. note the report of the Chair of the York Health and Care Collaborative

Reason; there is a shared objective of improving the health and wellbeing of the population. The York Health and Care Collaborative is unique in bringing together; providers and commissioners of health and social care services (from the NHS and City of York Council), colleagues from City of York Public Health together with the voluntary sector as a means of working on joint priorities to achieve this objective. The York Health and Care Collaberative agreed to provide regular updates on its work and progress.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Dr Emma Broughton Dr Rebecca Field	Dr Emma Broughton Chair of York Health and Care Collaborative
	Report Approved [x] **Date** 5.11.21

Wards Affected: **All** [x]

For further information please contact the author of the report

Background Papers:
None

Annexes

All annexes to the report must be listed here.
Annex A – Report of the Chair of the York Health and Care Collaborative November 2021

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ANNEX A

Report of York Health and Care Collaborative; Update July 2021

1. Introduction

This report provides update on the work of the York Health and Care Collaborative (YHCC); briefly outlining the progress that has been made since the last report in July 2021.

2. Progress on Priorities

Alcohol Pilot update:

The primary care alcohol pilot is funded by CYC and delivered by Changing Lives, supporting those that are not dependent on alcohol but are consuming hazardous amount of alcohol which may become a bigger problem in the future. The pilot will comprise of two link worker posts, one post has been recruited to and the second is currently out to advert. The first post has had a staff member in place for 6 weeks, their initial focus has been completing their induction and understanding the local recovery focused system.

An 8 week programme has been developed based upon Acceptance Commitment Therapy (ACT), which will be the support delivered to residents who access the service. Promotional materials have been finalised and are ready to go to print, with the link worker beginning discussions with GP practices to promote the service. It was initially anticipated that the service would target delivery in one PCN area, however following discussions between CYC and Changing Lives, it has been agreed that all PCNs will be able to refer into the service. Changing Lives are working with GP practices to co-locate the link workers within practice sites, making the service as accessible as possible to residents.

The programme will work with those scoring close to and under 16 on the Alcohol Audit Score (detail in Table 1 below). YHCC attendees from Primary Care have been asked to monitor their lists for patients that may be eligible to be part of this pilot once it starts.

Table 1

Risk Level	AUDIT-C Score	AUDIT Score	Action
Lower	0-4	0-7	Re-enforce positive behaviour PHE How Are You? Quiz Very Brief Advice (MECClink)
Increasing	5-7	8-15	Refer to CYC Health Trainers
Higher	8-10	10-18	Refer to GP alcohol worker (ACP) (if at the lower end, use clinical judgement and patient preference to decide between CYC Health Trainers and ACP) (WoNE, PMG, YMG and York City Centre PCNs only, referral link to follow)
Possible Dependence	11-12	20-40	Refer to YDAS

ANNEX A

Community Mental Health Programme:

First Contact Mental Health workers are now in post in primary care. Learning from these roles will be discussed at YHCC meetings so that planning for next year can start. There are discussions about PCNs working together to share roles and recruit a variety of professionals from different speciality areas.

There is progress in the 'Connecting our City' project with planning around the development of three mental health hubs. The outcomes of a workshop held in October will be shared with primary care at the November YHCC meeting so that patients can be informed of the services that are available. The location of the hubs has not been decided yet, but it has been agreed that people will self-navigate to the hubs which will work with mental health workers from primary and secondary care. Social prescribers will also be essential in this work.

There is a pathway to recovery for those discharged from Foss Park. A social worker and a peer support will work with people about to be discharged to make sure they have access to all the support that they will need. Social prescribers will work with the individual as soon as they are admitted, to identify who might need the most support at discharge. Evidence from the pilot showed that 85% of those discharged went home alone so this work is a priority. There will be an opportunity for primary care to work with these teams. Further discussions around possible support will be brought to YHCC in November.

Learning Disabilities

The main focus of the September meeting was Learning Difficulties (LD). The objectives of the meeting were:

- To improve data sharing to help identification of people with a learning disability and increase the number of people on the practice LD registers. This work will be supported by the population health hub.
- To explore how to improve people's health and wellbeing outcomes by improving onward referral for support
- To understand the training that the TEWV Community Learning Disability team can offer to primary care provider to support with identification and ongoing care for patients with an LD.

There was a push during the pandemic to increase the number and quality of health checks that were delivered for those on the LD register. As a result, all Vale of York practices delivered more health checks than in any of the years before the pandemic.

It was agreed that care providers need to flag up themes where access for people with LDs is not as good as it should be. Through identifying these gaps, processes can be put in place to improve health and social care outcomes.

The YHCC meetings will be used as a place for providers to share methods that have improved the identification of those that are eligible for health checks in addition to methods that have had little success in engaging those with an LD, such as sending letters.

York CVS records where there are gaps for those with an LD and works with providers to try and fill these gaps and meet needs. The intention is to build on the existing services with local providers to improve access, rather than introducing new services.

The LD team, the council and GP practices all hold different LD registers, but information governance rules prevents the information from being shared between providers. One of the

ANNEX A

key priorities of the Population Health Management hub for LD is to look at how to combine these lists.

The meeting identified that there was a training gap around Learning Difficulties and an action was taken from the meeting to discuss the options available for training with representatives from TEWV.

Carers in York

Representatives from the York Carers Strategy Group attended the YHCC meeting in September. The session was designed to give a greater insight into the lives and needs of carers to the health and care providers and commissioners within YHCC. This was very warmly received by the group.

End of Life Care

St Leonard's delivered a workshop at the October YHCC meeting which gave providers and commissioners across the city an understanding of the current pressures faced by the hospice. The meeting was also attended by York Trust's Lead Nurse for End of Life Care.

The workshop looked at the service provision for palliative and end of life patients and what the current gaps were. The following feedback was provided by the group for consideration by the hospice:

- Feedback should be taken from service users in a structured way to include how people are and what they think could be done to improve, this information can then be considered in shaping the service in the future.
- When looking at coordination of services, having one single point of access through the nursing workforce is beneficial. This helps to remove duplication and minimise inefficiency, especially as we move into winter.
- There is a need to get carers group to have discussions earlier to try to educate and equip them to deal with situations that may take place outside of service hours.
- There are inefficiencies around medication and the amount of time to get pain relief to patients can be high.
- There may be a need for a small team in the community to be able to deliver intrathecal injections.

Population Health Management (PHM)

The York Population Health Hub has been set up with 3 main priorities:

- Supporting the York health and care system to use population health data and PHM as a tool
- Improving the JSNA to make it more useful. This will involve refreshing the JSNA core process and getting better date from seldom heard communities
- Leading tangible PHM projects which show the benefits of this approach. Projects include diabetes, LD/Autism and Complex Needs. Further information around the diabetes project is included below:

The diabetes project is being run in conjunction with York CVS. There is a cohort of around 400 patients enrolled. The project aims to help people live well with diabetes and to help prevent further long term conditions developing. Weight management, blood pressure management and social prescribing all form part of this work.

The main focus of the November YHCC meeting is going to be prevention.

ANNEX A

Update from the YHCC Frailty Steering Group

The frailty steering group have identified the following priorities:

- Common adoption of Rockwood[1] clinical frailty scoring
- The use of common templates across all health providers
- The use of common frailty coding across all health providers

The group have agreed that the Rockwood scoring methodology is the most appropriate to use across both primary and secondary care providers. The Ardens Frailty Template and the Enhanced Summary Care Record will be used for reporting and sharing frailty scoring between providers.

The group has recommended sending a survey to all Vale of York GP practices to find gaps and identify what support is needed in assessing and recording frailty scores. The aim is to be able to identify and code all frail patients in a way that recognises those that are the highest priority without overwhelming the system. Once the priorities of the group have been met, work will start to build separate pathways for people that have been assessed as having mild, moderate or severe frailty.

Minutes of the YHCC meetings for September and October are embedded below, for further detail:


2021 09 30 YHCC minutes.docx


2021 10 28 YHCC minutes.docx

York Health and Wellbeing Board

Health and Wellbeing Board

November 17th 2021

Report of the Director of Prevention, Commissioning and Education.

Better Care Fund Update

Summary

1. This report is to provide an update on:

- the national BCF reporting process
- 2020-21 Performance return for sign off
- the planning arrangements for 2022-23
- review of BCF Performance and Delivery Group Terms of Reference.

Background

2. The background information on the BCF has been previously to the Health and Wellbeing Board (HWBB), with quarterly updates which is now the established routine, most recently in July 2021.
3. The government did not publish a Policy Framework and Planning Requirements for 2020-21, and HWBBs were not required to submit a plan for the year. The traditional processes have been interrupted by the pandemic. The York plan has largely followed the pattern of previous years, and we have referred to it as a 'roll forward' of the schemes from 2019-20.
4. During September 2021 a BCF framework and guidance was published and the expectation for a completed plan has been requested.

Key Issues for consideration

National reporting process for the 2021-22 BCF Plan -

5. The Better Care Team (NHSE&I) issued the BCF Planning template for 2021-22 in October 2021. The draft plan was submitted by the October deadline, but will require approval and sign off by the HWBB before it can be formally approved by NHSE. The full planning template can be seen at https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/
6. Attached at Annex 2 is the 2021-22 planning template for approval by the HWBB.

Performance update –

7. There are four key performance indicators (non-elective admissions, delayed transfers of care, people staying at home after discharge into reablement services and admissions of older people to residential/nursing care homes) which have been associated with the BCF since its inception, and which have been reported to the HWBB in previous years. During the pandemic the reporting requirements changed, for example there is now no submission on Delayed Transfers of Care, and the non-elective admissions to hospital cannot be compared to earlier years due to the drastic change in circumstances across the health and care system, and introduction of same day emergency care.
8. **Non-elective admissions:** in 2020-21, there were 20,126 non-elective admissions reported by the York Teaching Hospital Foundation Trust, a 20% reduction on the number of non-elective admissions in 2019-20 (25,254). This was mainly due to the effects of the Covid-19 pandemic, where some people who may have ordinarily have been taken to hospital, or had died at home, were not admitted.
9. **People staying at home after discharge from hospital into reablement/rehabilitation services:** in 2020-21, 85% of older people (aged 65 or over) that were discharged into reablement/rehabilitation services were found to be still living at home 91 days after leaving hospital. This is higher than the national average (79%) and higher than the Yorkshire and Humber regional average (76%).

10. **Admissions of older people into residential/nursing care:** During 2020-21, there were 135 admissions of older people (aged 65 or over) into residential/nursing care homes in York that were arranged by City of York Council, giving a rate of 347 per 100,000 population. This is a considerable improvement on the 2019-20 rate (540 / 100,000) and is well below the national (498 / 100,000) and Yorkshire and Humber regional (550 / 100,000) averages. The Covid-19 pandemic had an effect in that admissions to all care homes nationally fell substantially during 2020-21, but it also reflected the CYC policy of not sending people directly to care homes following a hospital discharge. These numbers may change as the discharge to assess programme continues

Progress of the Better Care Fund Review

11. As highlighted in the July report to the board, a review of schemes was undertaken by representatives across the system where the following key messages applicable to the programme were highlighted;

a. Make improvements to the business processes and contractual arrangements between commissioners and scheme providers to simplify bureaucracy, reduce duplication, increase clarity and timeliness. Treat schemes proportionately in relation to reporting requirements. Where possible place schemes on a sustainable, secure footing for the longer term.

b. Use the positive review findings in 2020-21 as the baseline for future plans and consider all opportunities to add value and further improve outcomes in future. Develop our thinking around the range of currencies we apply to gauge the value of schemes.

c. Develop an intermediate/reablement care end to end approach.

d. Schedule an End to End review of Equipment and Assistive Technology and related services as a further area for whole system planning and improvement.

e. Provide a clear narrative on the history and heritage of the York BCF Plan – differentiate between the schemes where BCF provides 100% of the budget and those where BCF makes a contribution to a larger budget.
    - 100% BCF: Review Group and Partners can instigate or direct review / redesign / service improvement
    - BCF contribution: BCF partners are stakeholders who support wider system experts to review / redesign / improve services. BCF can influence and shape direction of travel towards integration, prevention, collaboration.
    - Group schemes according to high level themes within the financial plan to highlight interdependencies and opportunities for further collaboration.

These detailed findings will continue to inform the agenda of the Better Care Fund Performance and Delivery Group as we begin to plan for longer term investments from 2022 onwards.

Future Planning Arrangements

12. The detailed planning guidance has been made available. As a team we are exploring the implications if the changes in particular around sane day admissions. A clear update will be provided to the board in the next quarter.

13. The financial plan for 2021 – 22 was developed and supported by the Performance and Delivery Group in June 2021 and approved by the HWBB on 21st July 2021. No major variations are anticipated and the latest plan is appended at **Annex 1.**

Review of Terms of Reference

14. Following the BCF guidance received by the BCF national team. The group is currently updating the ToRs to include the changes in reporting. The BCF group feel that the current membership is working well and represents a good partnership approach and decision making.

Consultation

15. The BCF Plan 2021-22 was developed in a collaborative process with partners across health, social care and the community and voluntary sector, and is co-produced with the scheme providers, taking account of the learning from the review process. The BCF Performance and Delivery Group discussed the draft financial plan at the June meeting, and confirmed the investment intentions for 21/22

Options

16. This report is a update for the HWBB for 20/21

Analysis

17. *n/a*

Strategic Direction /Operational Plans –

18. The Joint Health and Wellbeing Strategy is the overarching strategic vision for York; this plan supports the delivery of the desired outcomes.

19. The York BCF Plan 2017-19 provided the foundation for the BCF Plan 2019-20 and 2020-21. It has evolved each year in line with refreshed intelligence and national directives.

20. This work is congruent with the Council Plan and the NHS Long Term Plan. The NHS White Paper further promotes the policy objectives of BCF.

21. BCF schemes have been central to the COVID-19 pandemic response, including the processes and ways of working between the NHS and local authority embedded via the BCF have been a key part of the supporting the HDP response.

22. The schemes attached in appendix 1 highlight the number of schemes that are in place and support a preventative admission avoidance approach as well as supporting timely discharges.

23. The schemes are reviewed on a quarterly basis to ensure that each scheme demonstrates best outcomes for people as well as ensuring the greatest impact.

24. There are a number of schemes that have been enhanced to support community provision and admission avoidance. In particular care rooms, additional dementia support, enhancing community/voluntary sector support as well as Local area co-ordinators. This additional activity support the direction of prevention and supporting people to live well for longer within their own communities.

25. Following an in depth review during July 2021, Venn consulting are to commence work to help review re-ablement and intermediate care with a view to exploring a whole prevention pathway approach including key aspects of community and voluntary sector support

Implications -

- **Financial** – The financial plan has been developed with the detailed support of the finance officers of the CCG and council and approved by the HWBB on 21st July 2021. No major variances are anticipated at this point. It is compliant with

regulations, and will be monitored quarterly through the BCF Performance and Delivery Group. Any future decisions about investment or disinvestment would be consulted upon with partners and would have legal governance and assurance through the section 75 agreement used to establish the BCF pooled budget.

- It should be noted however that following the publication of the NHS guidance for H2 (October – March) at the end of September 2021 this included a mandated reduction to the overall CCG minimum contribution of £72k from £13.4m to £13.3m. This has been off-set by reducing the level of lift and shift of core contract expenditure for health and social care schemes where the BCF contributes in part to a larger overall budget

- The total BCF budget for 20/21 is £20,010,10

- **Human Resources (HR)** – many of the schemes funded through BCF are supported by staff on fixed term contracts. The prevalence of short-term funding and fixed term employment contracts remain a significant risk to the stability and continuity of our system.

- **Equalities** - none

- **Legal** - none

- **Crime and Disorder** - none

- **Information Technology (IT) –** information technology and digital integration forms part of the system wide improvement plan, relevant representatives from statutory agencies attend the project board, and there are plans to engage non-statutory services and the patients, customers and families in our developments. The national and regional work on this agenda guides our local work.

- **Property** - none

- **Other** – none.

Risk Management

26. Governance processes are in place between the partners to manage the strategic risks of the BCF as part of our whole system working.

Recommendations

27. The Health and Wellbeing Board are asked to:

- Receive the York Better Care Fund update for information,
- Agree the attached 21/22 BCF return
- Agree delegated authority for future returns to be signed off by the Director of Prevention and Commissioning appropriate CCG lead in partnership with the HWBB chair Cllr Runciman

  The HWBB is the accountable body for the Better Care Fund.

Contact Details

Author:
Jamaila Hussain
Director,Prevention, Commissioning and,Education
People Directorate
City of York Council

HWWB Chair:
Cllr Carol Runciman
HWBB Chair
City of York Council

Phil Mettam
Accountable Officer
NHS Vale of York CCG

Report Approved *tick* **Date** *Insert Date*

Report Approved *tick* **Date** *Insert Date*

All *x*

Wards Affected: *List wards affected or tick box to indicate all [most reports presented to the Health and Wellbeing Board will affect all wards in the city – however there may be times that only a specific area is affected and this should be made clear]*

For further information please contact the author of the report

Background Papers:

Annexes – All –

Annex 1 – 2021 - 22 schemes
Appendix 2 Attached

BCF Schemes 2021-22

Scheme	Expenditure (all figures in £000)
Urgent Care Practitioners	£509.78
Street Triage	£159.05
Disabled Facilities Grant and falls prevention	£1,468.00
Reablement contract	£1,130.62
Packages of Care – Care at Home	£4,411.11
Packages of Care - Placements	£731.96
Contribution to social work staff capacity – BAU and Statutory Duties	£867.00
Carers' Centre	£363.00
Carers' Support	£145.00
Carers' support workers posts	£168.67
Be Independent	£458.25
Out of Hospital Services	£6,270.77
Local Area Co-ordination	£293.62
Live Well York	£50.98
Health Champions	£35.00
Ways to Wellbeing	£160.68
Alcohol Prevention	£48.55
Small Tasks at Home	£30.60
Cultural Commissioning	£30.00
Community Response Team (CRT)	£128.55
Rapid Assessment and Therapy Service (RATS)	£214.82
Self-Support Champions	£102.00
Home From Hospital	£54.00
Hospice at Home (H@H)	£203.00
York Integrated Care Team (YICT) / Priory Outreach	£997.29
A Bed Ahead and Vaccinations outreach	£89.51
Fulford Nursing Home & other Step Up / Down beds	£520.90
Venn Capacity and Demand	£40.00
BCF Support Role	£20.00
IT support for single care record	£10.00
Move Mates	£40.00
Dementia Support	£31.70
NQ Project manager	£20.00
CCG VCS contracts	£174.00
Health Champion - additional hours	£8.00
Additional OT in step down beds (M1-6 only)	£23.70
Total Expenditure	£20,010.10

Glossary

A&E – Accident and Emergency
BCF – Better Care Fund
BI – Be Independent
CCG – Clinical Commissioning Group
CYC – City of York Council
DHSC - Department of Health and Social Care
DToC – Delayed Transfers of Care
ED - Emergency Department
GP – General Practitioner
HR – Human Resources
HSG – Human Support Group
HWBB – Health and Wellbeing Board
IT – Information Technology
KPI – Key Performance Indicator
LAC – Local Area Co-ordinator / Local Are Co-ordination
MDT – Multi-Disciplinary Team
NHS - National Health Service
NHSE&I - NHS England & Improvement
RATS - Rapid Assessment and Therapy Service
SDEC - Same Day Emergency Care
VOYCCG – Vale of York Clinical Commissioning Group
YTH – York Teaching Hospital

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

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Health and Wellbeing Board:	York
Completed by:	
E-mail:	
Contact number:	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Director of Prevention, Commissioning and Education
Name:	Jamaila Hussain

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 17/11/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor			
	Clinical Commissioning Group Accountable Officer (Lead)		Phil	Mettham	phillip.mettham@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Michael	Ash-McMahon	m.ash-mcmahon@nhs.net

	Local Authority Chief Executive		Ian	Floyd	ian.floyd@york.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Michael	Melvin	michael.melvin@york.gov.uk
	Better Care Fund Lead Official		Jamaila	Hussain	Jamaila.hussain@york.gov.uk
	LA Section 151 Officer		Debbie	Mitchell	Debbie.Mitchell@york.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	BCF Programme Officer		Samantha	Maynard	Samantha.maynard@york.gov.uk
	BI Lead		Terry	Rudden	terry.rudden@york.gov.uk
	Finance Lead Officer		Steve	Tait	Steve.tait@york.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

ANNEX 1

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: York

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,467,977	£1,467,977	£0
Minimum CCG Contribution	£13,331,151	£13,331,151	£0
iBCF	£5,210,953	£5,210,953	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£20,010,081**	**£20,010,081**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,857,055
Planned spend	£6,823,442

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,315,910
Planned spend	£6,566,889

Scheme Types

Assistive Technologies and Equipment	£381,000	(1.9%)
Care Act Implementation Related Duties	£608,000	(3.0%)
Carers Services	£850,670	(4.3%)
Community Based Schemes	£7,101,842	(35.5%)
DFG Related Schemes	£1,467,977	(7.3%)
Enablers for Integration	£30,000	(0.1%)
High Impact Change Model for Managing Transfer	£273,000	(1.4%)
Home Care or Domiciliary Care	£4,509,384	(22.5%)
Housing Related Schemes	£162,543	(0.8%)
Integrated Care Planning and Navigation	£997,290	(5.0%)
Bed based intermediate Care Services	£602,382	(3.0%)
Reablement in a persons own home	£1,305,349	(6.5%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£85,680	(0.4%)
Prevention / Early Intervention	£803,644	(4.0%)
Residential Placements	£586,500	(2.9%)
Other	£244,820	(1.2%)
Total	**£20,010,081**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,727.0	0.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	9.9%	11.4%
	LOS 21+	5.3%	6.4%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	95.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	347	312

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.9%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

ANNEX 1

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: York

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
York	£1,467,977
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,467,977**

iBCF Contribution	Contribution
York	£5,210,953
Total iBCF Contribution	**£5,210,953**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

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

CCG Minimum Contribution	Contribution
NHS Vale of York CCG	£13,331,151
Total Minimum CCG Contribution	**£13,331,151**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£13,331,151**	

	2021-22
Total BCF Pooled Budget	**£20,010,081**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: York

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,467,977	£1,467,977	£0
Minimum CCG Contribution	£13,331,151	£13,331,151	£0
iBCF	£5,210,953	£5,210,953	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£20,010,081**	**£20,010,081**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,857,055	£6,823,442	£0
Adult Social Care services spend from the minimum CCG allocations	£6,315,910	£6,566,889	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	DFG and Falls	DFG	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£1,467,977	Existing
2	Packages of Care - Care at Home	Care package pressures due to demographic changes	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£2,830,727	Existing
3	Packages of Care - Care at Home	Care package pressures due to demographic changes	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£1,127,657	Existing
4	Packages of Care - Care at Home	Care package contingency re Winter and COVID pressures	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£157,000	Existing
5	Packages of Care - Care at Home	Care package contingency re Winter and COVID pressures	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£137,000	Existing
6	Contribution to social work staff	Contribution to Social Work post	Care Act Implementation Related Duties	Other	Early Intervention and Prevention	Social Care		LA			Local Authority	Minimum CCG Contribution	£145,000	Existing

7	Carers Support	Carers centre, support worker posts and carers support	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£676,670	Existing
8	Contribution to social work staff	Implementation of Care Act	Care Act Implementation Related Duties	Other	Early Intervention and Prevention	Social Care		LA			Local Authority	Minimum CCG Contribution	£463,000	Existing
9	Local Area Coordination	Community Facilitator	Prevention / Early Intervention	Other	Early Intervention and Prevention	Social Care		LA			Local Authority	Minimum CCG Contribution	£25,620	Existing
10	Reablement contract	Reablement (Human Support Group)	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£1,130,620	Existing
11	FNH and other Step-up/Step-down beds	10 discharge to assess beds plus 1 flat at Marjorie Waite Court	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum CCG Contribution	£188,882	Existing
12	Telecare and Falls	Be Independent	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£196,000	Existing
13	Community Equipment	Be Independent	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum CCG Contribution	£185,000	Existing
14	Home adaptations	Be Independent	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£77,250	Existing
15	Packages of Care - Care at Home	Increased Reablement capacity	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Charity / Voluntary Sector	iBCF	£174,729	Existing
16	Self-support champions	Self-support champions	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	iBCF	£102,000	Existing
17	Ways to Wellbeing	Social Prescribing - Ways to Wellbeing	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	iBCF	£160,680	Existing
18	Live Well York	Improved curation of Information and advice	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	iBCF	£50,980	Existing
19	Alcohol prevention	Alcohol advice	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	iBCF	£48,552	Existing
20	Contribution to social work staff	7 day working	High Impact Change Model for Managing Transfer	Other	Chg 5. Seven-Day Services	Social Care		LA			Local Authority	iBCF	£259,000	Existing
21	Local Area Coordination	Local Area Coordination	Prevention / Early Intervention	Other	Early Intervention and Prevention	Social Care		LA			Local Authority	iBCF	£268,000	Existing
22	BCF support role	Performance Support role	Other		Performance management	Social Care		LA			Local Authority	iBCF	£20,000	Existing
23	Venn capacity and demand	Capacity and demand exercise	Other		Capacity and demand planning exercise	Social Care		LA			Private Sector	Minimum CCG Contribution	£10,000	Existing
24	Physiotherapy in step-down beds	Physiotherapy in step-down beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£18,000	Existing

25	IT support for single care record	CYC IT post	Enablers for Integration	System IT Interoperability		Social Care		LA			Local Authority	iBCF	£10,000	Existing
26	CRT	Community Response Team (Expanding care at home)	Community Based Schemes	Integrated neighbourhood services		Community Health		LA			NHS Community Provider	iBCF	£110,550	Existing
27	Home from Hospital	Home from Hospital	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£27,000	Existing
28	Home from Hospital	Home from Hospital	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Charity / Voluntary Sector	iBCF	£27,000	Existing
29	Packages of Care - Placements	5 Additional Short term Stepdown/up beds.	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£39,780	Existing
30	Packages of Care - Placements	Res and nursing beds over Winter	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£228,480	Existing
31	Packages of Care - Placements	Secure capacity to enable placements to be made to reduce impact	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£358,020	Existing
32	Packages of Care - Placements	Retaining Home Care Packages "open" for 4 weeks	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care		LA			Private Sector	iBCF	£14,000	Existing
33	Packages of Care - Placements	Live in Care	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	iBCF	£85,680	Existing
34	Packages of Care - Placements	Be Independent falls Support	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	iBCF	£20,000	Existing
35	YICT	York Integrated Care Team	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£997,290	Existing
36	Urgent Care Practitioners	Urgent Care Practitioners	Community Based Schemes	Other	Rapid / Crisis response	Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£509,775	Existing
37	Hospice at Home	Hospice at Home (extended hours and part funded with NYCC)	Home Care or Domiciliary Care	Domiciliary care packages		Community Health		CCG			Local Authority	Minimum CCG Contribution	£170,000	Existing
38	MH Crisis response	Street Triage	Community Based Schemes	Other	Street Triage	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£159,050	Existing
39	CCG Out of Hospital commission	Incl. Specialist Nursing, Integrated Community Teams, Community	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£4,673,822	Existing
40	CCG Out of Hospital commission	Incl. Specialist Nursing, Integrated Community Teams, Community	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	iBCF	£1,596,950	Existing
41	A Bed Ahead and Vaccinations	Changing Lives - A Bed Ahead	Housing Related Schemes			Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£85,293	Existing
42	FNH and other Step-up/Step-down beds	Fulford Nursing Home	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	iBCF	£198,900	Existing

43	Rapid Assessment and Therapy Service	RATS Extended Hours	Other		Rapid / Crisis response	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£164,820	Existing
44	Rapid Assessment and Therapy Service	RATS Extended Hours - Social Worker	Other		Rapid / Crisis response	Social Care		CCG			Local Authority	Minimum CCG Contribution	£50,000	Existing
45	A Bed Ahead and Vaccinations	Vaccinations	Prevention / Early Intervention	Other	Vaccination of Homeless	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£4,212	Existing
46	FNH and other Step-up/Step-down beds	4 nursing short stay beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum CCG Contribution	£84,120	Existing
47	FNH and other Step-up/Step-down beds	4 nursing short stay beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£49,000	Existing
48	Dementia Support	Dementia - support to individuals and carers	Community Based Schemes	Other	Dementia support	Mental Health		LA			Charity / Voluntary Sector	iBCF	£31,695	Existing
49	NQ project	Northern quarter project manager (grade 9)	Enablers for Integration	Programme management		Social Care		LA			Local Authority	Minimum CCG Contribution	£20,000	Existing
50	CCG VCS contracts	Various CCG VCS contracts	Carers Services	Other	Various	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£174,000	Existing
51	Move Mates	Move the Masses	Prevention / Early Intervention	Other	Voluntary sector	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£40,000	Existing
52	Cultural commissioning	Various VCSE small grants	Prevention / Early Intervention	Other	Voluntary sector	Social Care		LA			Charity / Voluntary Sector	iBCF	£30,000	Existing
53	Small Tasks at Home	Small grants maintaining people's homes	Prevention / Early Intervention	Other	Voluntary sector	Social Care		LA			Charity / Voluntary Sector	iBCF	£30,600	Existing
54	Hospice at Home	End of Life Project	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£33,000	Existing
55	Health Champions	Health Champions	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£35,000	Existing
56	Health Champions	Health Champions additional hours	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	iBCF	£8,000	New
57	Additional OT	Additional OT in step down beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			NHS Community Provider	iBCF	£23,700	New

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Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: York

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		1,727.0		schemes are in place to support admission avoidance and support patients to self manage care and signs of deterioration. Schemes such as local area co-ordinators as well as social prescribers linking into primary care enbale targeted support. Short term crisi care is also in place to provide short term dom care options.

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	9.90%	11.40%	The national ambition of reducing inpatient stays of 21 days or more to 12% has been achieved. (query if this target is for ages 65+). The Q3 and Q4 targets are based on the achievement so far in 21/22 using 19/20 average performance figures.
	Proportion of inpatients resident for 21 days or more	5.30%	6.40%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.00%	The proportion of patients discharged to their usual place of residence in 21/22 to August is 95%. This is an increase on 20/21 (93.9%) *and the ambition is to keep the performance at above 95%*

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	586	540	347	312	additional home care provision has been comissionedto supportcare at home including innovative support through care rooms. Data shows that the number of people accessing residential or nursing care has increased due to the impact of COVID and increase numbers of D2A discharges into care home beds and increase in
	Numerator	227	209	135	124	
	Denominator	38,739	38,735	38,874	39,734	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

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

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.3%	80.6%	87.9%	a full review is underway to support the developmenst of a single early intervention pathway, to improve and support independence outcomes for people. Patients support through reablement has fallen due to increase in dependancy. The impact of COVID has also affected flow. Partners have worked together and jointly provide short
	Numerator	43	29	29	
	Denominator	51	36	33	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: York

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	As stated in section 3 and narrative BCF plan		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	As described in section 5 and 6. as well as narrative plan sunitted to HWBB		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	as agreed in section 5a		
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	as agreed in section 5a		
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	Identifed in sections 5b, 6		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	as agreed planning document		