Notice of a public meeting of
Health and Wellbeing Board

To: Councillors Runciman (Chair), Craghill, Looker and Waller
Siân Balsom – Manager, Healthwatch York
Dr Emma Broughton – Joint Chair of York Health & Care Collaborative
Zoe Campbell – Managing Director, Yorkshire, York & Selby - Tees, Esk & Wear Valleys NHS Foundation Trust
Sarah Coultman Lovell - York Place Director
Jamaila Hussain - Director of Prevention & Commissioning, City of York Council
Shaun Jones – Interim Director, Humber and North Yorkshire Locality, NHS England and Improvement
Martin Kelly - Corporate Director of Children's and Education, City of York Council
Simon Morritt - Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust
Mike Padgham – Chair, Independent Care Group
Alison Semmence - Chief Executive, York CVS
Sharon Stoltz - Director of Public Health, City of York Council
Lisa Winward - Chief Constable, North Yorkshire Police

Date: Wednesday, 15 March 2023

Time: 4.30 pm

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

A G E N D A

1. Declarations of Interest

At this point in the meeting, Members are asked to declare any disclosable pecuniary interests or other registerable interests they might have in respect of business on this agenda, if they have not already done so in advance on the Register of Interests.

2. Minutes (Pages 1 - 10)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 18 January 2023.

3. Public Participation

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

Please note that our registration deadlines have changed to 2 working days before the meeting. The deadline for registering at this meeting is at **5.00pm** on **Monday 13 March 2023**.

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

Webcasting of Public Meetings

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

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. Joint Strategic Needs Assessment - Annual Update (Pages 11 - 16)

This report provides members of the Health and Wellbeing Board with an update on the Joint Strategic Needs Assessment (JSNA), including work undertaken in the last year by the York Population Health Hub and planned work for the coming year.

5. Framework for the Action Plan and Population Health Outcomes Monitor of the new Joint Health and Wellbeing Strategy 2022-2032 (Pages 17 - 38)

At the January 2023 meeting of the Health and Wellbeing Board, members of the board agreed a framework for an action plan and a Population Health Outcomes Monitor for the new Joint Health and Wellbeing Strategy 2022-2023. This report presents a populated action plan (Annex A) and an amended Population Health Outcomes Monitor (Annexes B & C) for approval.

6. Joint Forward Plan Presentation

The production of a Joint Forward Plan between an ICB and local hospital trusts is a statutory duty. This presentation will summarise York's contribution to the plan, which must take due regard to local Joint Health and Wellbeing Strategies.

7. Update following the Children's Mental Health report to the Health and Wellbeing Board meeting, November 2022 (Pages 39 - 78)

This report provides an update following presentation of the Healthwatch York snapshot report on Children's Mental Health at the November meeting of the Health and Wellbeing Board.

8. Better Care Fund Update Presentation

This presentation will be providing the Health and Wellbeing Board with an update on the Better Care Fund.

9. Update on the Appointment of Independent Co-Chairs of the York Mental Health Partnership

This is a verbal progress update on the Appointment of Independent Co-Chairs of the York Mental Health Partnership.

10. Report of the Chair of the York Health and Care Collaborative (Pages 79 - 86)

This report is for information only. 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. Healthwatch York Reports: Dementia Support - Listening to People Living with Dementia in York (Pages 87 - 112)

This report is for information only and it aims to complete reporting of the work undertaken to help shape the dementia strategy through local engagement.

12. Urgent Business

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

Democracy Officer:

Margo Budreviciute
Telephone No – 01904 551088
Email – margo.budreviciute@york.gov.uk

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

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

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

☎ **(01904) 551550**

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Agenda Item 2

City of York Council | Committee Minutes

Meeting	Health and Wellbeing Board
Date	18 January 2023
Present	Councillors Runciman, Craghill, Looker and Waller Siân Balsom - Manager, Healthwatch York [until 17:06] Sarah Coltman Lovell - York Place Director Jamaila Hussain - Corporate Director Adult Social Care and Integration, City of York Council Martin Kelly - Corporate Director of Children's and Education Services, City of York Council David Kerr - Community Mental Health Transformation Programme & Delivery Lead (NYY&S) & TEWV Lead Master Coach (NYY&S) (substitute for Zoe Campbell) John Pattinson - Operations Director, Independent Care Group (substitute for Mike Padgham) Alison Semmence - Chief Executive, York CVS Sharon Stoltz - Director of Public Health, City of York Council Lisa Winward - Chief Constable, North Yorkshire Police [from 17:30]
In Attendance	Peter Roderick - Consultant in Public Health, City of York Council/NHS Vale of York Clinical Commissioning Group Tracy Wallis - Health and Wellbeing Partnerships Coordinator, City of York Council
Apologies	Zoe Campbell – Managing Director, Yorkshire, York & Selby - Tees, Esk & Wear Valleys NHS Foundation Trust Simon Morritt - Chief Executive, York & Scarborough Teaching Hospitals NHS Foundation Trust Mike Padgham – Chair, Independent Care Group

124. Declarations of Interest (16:36)

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.

125. Minutes (16:36)

Resolved: That the minutes of the last meeting of the Health and Wellbeing Board held on 16 November 2022 be approved as an accurate record.

126. Public Participation (16:37)

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

Flick Williams spoke on agenda item 4 – Healthwatch York Report: Cost of Living and praised the work the team completed but highlighted that the survey might be underrepresented. She provided further information on how the cost of living crisis has affected disabled people specifically, in particularly due the failure of the legacy benefits appeal and how some benefit recipients were denied the Government cost of living payment. She concluded by explaining that disabled people were facing increased fuel poverty and energy debt.

127. Healthwatch York Report: Cost of Living (16:42)

The Manager for Healthwatch York presented a report which examined the results of a survey exploring the health impacts of the rising cost of living. She noted that:

- In partnership with City of York Council, Healthwatch York analysed the Council Tax Support benefit and were engaging in phone conversations with residents who had acquired debts.
- There was a clear correlation between the residents with long-term physical and/or mental health conditions and living in poverty during the cost of living crisis.

- Healthwatch York would repeat this survey in early 2023 in an attempt to engage with more residents and to gauge the impact of the winter months.

She then praised the staff who work in the voluntary sector and help residents during this difficult time. The Director of York Place then confirmed that this report and the work of the voluntary sector would be discussed at other partnership meetings.

The Board then discussed the report, namely around the cost of living crisis, government benefits and health concerns around new-borns and infants, amongst others.

In response to questions from Members, the Director of Public Health, City of York Council, stated that there was real time data surrounding the adverse effects of the cost of living crisis as Public Health received death data from registrars on a weekly basis and that the Population Health Hub had been able to gather data and intelligence from partners to get an accurate picture.

Resolved: That Healthwatch York's report, Cost of Living: The impact of rising costs on people in York be received by the Board.

Reason: To keep up to date with the work of Healthwatch York and be aware of what members of the public are telling us.

128. York Health and Care Partnership Report (17:06)

The Director of York Place presented the report which provided an update to the Health and Wellbeing Board on the work of the York Health and Care Partnership (YHCP), including the progress to date and next steps. She noted that:

- The YHCP has faced system and operational pressures due to increased demand and industrial action, and there have been discussions and action plans on this to support each other.
- The Partnership agreed on a series of priorities and a set of strategic actions to support each priority. These actions are also linked to the York Health and Care Prospectus and York's Joint Health and Wellbeing Strategy.

- They continue to work with the York Population Health Club and have brought partners together to make key decisions on shared resources.

In response to questions, the Director of York Place and the Corporate Director Adult Social Care and Integration, City of York Council, explained that:

- The YHCP would be tracking and measuring its progress and improvements to check how patients were able to access health services, for example new data around GPs being analysed and included.
- The capacity and number of GP appointments has increased since the pandemic and there have been additional funds allocated to support this increase.
- The Better Care Fund would help to reach the strategic targets through its schemes and work with various partners. For example, its Home First approach had seen a 53% increase in the number of patients going home this time last year.
- The Partnership was able to work with partners to oversee the allocation and utilisation of the funds and ensure that the money and resources are in the correct places and schemes.

Resolved:

i. That the contents of the report and the progress made be noted by the Board.

ii. That the Board receives an update from the YHCP every 6 months.

Reason: To keep the Board updated on the work of the York Health and Care Partnership.

129. Framework for Delivery and Performance Management of the new Joint Health and Wellbeing Strategy 2022-2032 (17:32)

The Consultant in Public Health, City of York Council, presented a report on the suggested framework for an Action Plan and Population Health Outcomes Monitor for the new Joint Health and Wellbeing Strategy 2022-2023.

He stated the aim of these documents is to assure Members that the strategy makes a difference by showing the actions put in place and how they are tracked. He proposed that the action plan covers the first two years of the strategy's lifespan and is focussed around the 10 big goals set out in the Joint Health and Wellbeing Strategy before it demonstrated how the identified actions link to the big six ambitions contained in the strategy. He then went on to explain that the Population Health Outcomes Monitor is also linked to the ten big goals and is designed to provide Members with a holistic view of whether the strategy is making a difference to the health and wellbeing of York's population by using outcome data.

The Director of Public Health, City of York Council, also spoke on the importance of the wider determinants that impact public health, such as employment and housing, and how the Council can engage with numerous departments to create an environment to improve public health.

In response to questions from Members, the Consultant in Public Health and the Director of Public Health noted that:

- The framework was aimed at promoting health equity and reducing health inequalities but it should also fit in with the wider aspirations and strategies throughout York so can be amended to reflect this.
- Suicide attempts were not recorded officially so it was difficult to generate accurate numbers but there was ongoing work with partners to gain an understanding of these problems. An update would be brought to the Board.

Board Members were asked to comment on the following options:

i. Will the proposed action plan framework enable us to plan the right actions, and will the proposed outcomes monitor enable us to know if it's working?

ii. How many actions should be prepared for each of the 10 goals across the first 2 years of the strategy (suggestion is 2 or 3)

iii. How often would HWBB members like to be updated on progress against the actions and the status of the Population Health Outcomes Monitor?

iv. How do we ensure ownership of the actions in the plan by all organisations?

v. How do we maximise the co benefits between actions designed to improve health and wellbeing, and actions falling out of the Economic and Climate Change Strategies?

The Chair requested Members to send their responses to the above to the Health and Wellbeing Partnerships Coordinator.

Resolved:

i. That the draft action plan at Annex A and the draft performance management framework at Annex B, be noted and comments are sent to the Partnerships Coordinator.

ii. That the Board agreed to proceed with two documents above so that final versions can be presented to the Board in March 2023.

iii. That the Board be updated on the progress against the actions and the status of the Population Health Outcomes Monitor every three months.

Reason: To ensure that the Health and Wellbeing Board fulfils its statutory duty to deliver on their Joint Health and Wellbeing Strategy 2022-2032.

130. Humber and North Yorkshire Integrated Health and Care Strategy (17:52)

The Director of York Place presented the report and explained the approach taken to develop an Integrated Health and Care Strategy (ICS) for Humber and North Yorkshire. She provided some background on the ICS and then noted that:

- The Health and Care Act sets out the four core elements of an ICS these are Place, Provider/Sector Collaboratives, Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).
- The Strategy was developed through engagement with communities and stakeholders through a number of open sessions.
- There were a number of themes within the Strategy focussed on the wider determinants of improved health to ensure people start well, live well, age well and die well, and these included:

- Creating the conditions for change, to make it easier for people, communities and organisations to come up with solutions that will work best to improve their lives.
- Think person by listening and paying attention to what people tell us mattered the most to them
- Think family by considering different ways people consider a family and focussing on supporting families.
- Think community to recognise the assets in communities and use their strengths to implement health and care services.

In response to questions from Members, the Director stated that the report would be in the public domain and there would also be a website which detailed the strategy and it would be continuously updated to reflect any changes.

Members discussed the report and welcomed some of the concepts and ambitions detailed in the report. They also stated that they would like an action plan as to how the Strategy aligns with the work that has taken place in York.

Resolved:

i. That the update in the paper be noted

ii. That the final draft content of the Humber and North Yorkshire Integrated Health and Care Strategy (appendix A) be considered and approved.

iii. That the next steps be noted.

Reason: To keep the Board updated on the Humber and North Yorkshire Integrated Health and Care Strategy.

131. Progress on Appointment of Independent Chair to the Mental Health Partnership (18:12)

The Director of Public Health, City of York Council, provided a verbal update on the progress on the appointment of a new Independent Chair to the Mental Health Partnership.

She stated that the Partnership had previously advertised the new role but was unsuccessful in filling the position. The role will

be advertised again by the end of January with the applicant selection process in February so that the Chair can be in position by March. The Partnership has since changed the way in which they advertised for the role with more focus on recruitment through social media and existing network channels, amongst others.

The Chair concluded by inviting Members to send their recommendations or suggestions for the new role.

Resolved: That the update is noted by the Health and Wellbeing Board.

Reason: To keep the Board updated on the appointment of an Independent Chair to the Mental Health Partnership.

132. Urgent Business - Better Care Fund update (18:16)

The Corporate Director Adult Social Care and Integration, City of York Council, presented the paper and provided an update on the allocation of the Adult Social Care discharge funds. She noted that:

- There was a change in the allocation of money for the Adult Social Care discharge fund with local authorities now receiving 40% of the £500 million fund and the Integrated Care System (ICS) receiving the remaining 60%.
- The City of York Council received £609,834 and the ICS received £1,006,902 and the expenditure was overseen by the Better Care Fund (BCF) Delivery Fund.
- There were a number of schemes introduced and implemented to improve discharges from hospitals. They will be evaluated regularly to ensure they are successful.
- A home first approach was implemented to create additional community voluntary support around transport and increasing domiciliary care, amongst others.

She concluded by stating that since the publication of this report, an additional £200 million was allocated by the national government and the Board will receive a report on this at the next scheduled meeting.

Members discussed the report and in response to questions, the Corporate Director explained that there was a strong indication that the Adult Social Care discharge fund will carry into 2024 but that the BCF fund has been agreed for another two years and noted the importance of its schemes.

Resolved:

i. That the allocation of the Adult Social Care discharge funds be ratified.

ii. That the contents of the report be noted.

iii. That an update be provided to the partnership monthly.

Reason: To keep the Board updated on the allocation of the Adult Social Care discharge funds.

Councillor Runciman, Chair
[The meeting started at 4.34 pm and finished at 6.26 pm].

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Health and Wellbeing Board **15 March 2023**

Report of the Director of Public Health

Joint Strategic Needs Assessment – Annal Update

Summary

1. This report provides members of the Health and Wellbeing Board with an update on the Joint Strategic Needs Assessment (JSNA), including work undertaken in the last year by the York Population Health Hub and planned work for the coming year.

Background

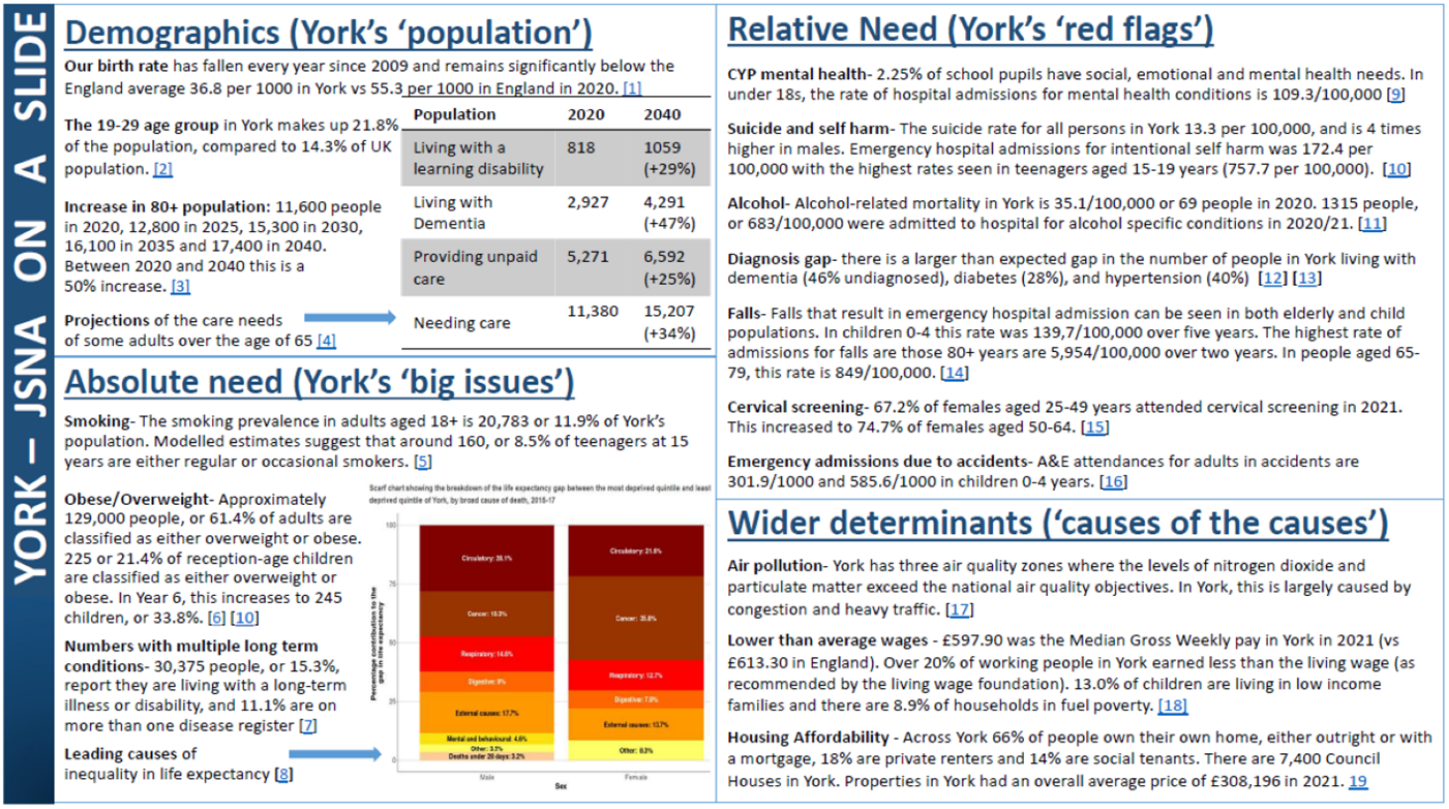
2. Health needs assessments (HNA) are a key 'tool' within the public health field and specialism, used internationally as a coherent and robust tool to understand the needs and inequalities of populations and to underpin planning and decision-making. Whilst a variety of approaches can be beneficial, most HNAs incorporate elements of epidemiological assessment (e.g. trends in disease prevalence, service activity), comparative assessment (evidence and data from other areas) and stakeholder/patient assessment (e.g. focus groups, surveys).

3. Work on the JSNA is closely aligned to local work on a 'population health management' approach to health and care services. Because of this, the JSNA working group now sits as part of the Population Health Hub (PHH). The hub's purpose is to put the development and delivery of population health management (PHM) programmes and the data which sits within the JSNA at the heart of local decision-making in health, care and other services.

4. Since 2013 it has been a statutory duty of CCGs and Local Authorities (and since 2022 for ICBs and Local Authorities) through the Health and Wellbeing Board, to produce a Joint Strategic Needs Assessment, which usually consists of:

- an overarching narrative summary on the needs of a population
- deeper pieces of work on specific groups within that community 'topic-specific' needs assessments.

5. In York, the PHH steering group oversees the production of the overarching JSNA narrative alongside. This can be found in four 'life course' sections (Start Well, Live Well, Mental Health and Age Well). A summary is shown below:



Summary of work in 2022

6. Topic specific needs assessments are in-depth pieces of work, usually taking several months to complete. They require a collaborative approach across the local authority and partner organisations, to collate the relevant data, gain insight and feedback from professionals and service users and then produce the assessment with recommendations. During 2022/23 reports were produced on:

- *SEND Phase 2:* This report was the follow up to the phase 1 report, with phase two focusing on the 17-25 age range. The

report produced a number of recommendations for the SEND improvement board to take forwards.

- *Pharmaceutical Needs Assessment:* The updated PNA was covers the time period 2022-2025, and was updated as per legislation requiring the Health and Wellbeing Board to have an up to date PNA that is refreshed every three years. Overall there is adequate choice of pharmacies and a good geographic spread of pharmacies in York. The majority of people are within reasonable walking or travel distance of a pharmacy. Overall, there is good pharmaceutical service provision in most of York.

- *Early Years:* The early years JSNA is part of a wider programme of work being undertaken to better understand the health and wellbeing needs of children and young people within York. The York schools survey, undertaken across primary and secondary schools (Year 4, 6, 8, 10 and 12) asked questions on a range of topic areas such as worry, happiness, relationships, bullying, activity, smoking, drugs and alcohol. The early years needs assessment covers conception through to five years old, considering a breadth of topic areas across health, education and wider determinants.

- *Sexual Health:* The needs assessment looked at the current and emerging sexual health needs of people living in York. This is to help inform the re-commissioning of the City of York sexual health service for 2023-2025.

- *Drugs and Alcohol:* A health needs assessment (HNA) was developed to inform the re-commissioning of community-based drug and alcohol misuse treatment services in the City of York. As drug and alcohol services in York are jointly commissioned, the HNA investigating the needs of both alcohol and drug users was decided.

7. These needs assessments formed a part of a larger work programme of the Population Health Hub, with three key strands:

- Enabling: There were also two newsletters produced about the outputs of the PHH, which were circulated to local authority, NHS and third sector organisations. Additionally, a lunch and learn sessions was delivered in partnership with York CVS, where the Public Health Team at City of York Council, Changing

Lives and York Foodbank shared insights on poverty and deprivation in York. Work has continued on the data infrastructure which underpins population health management, including improving primary care coding, sharing data between agencies, and developing the use of the RAIDR case-finding tool.

- Analysing: Alongside the JSNA the PHH also produced many data pack outputs, all of which are publicly accessible on the website. The topics covered in the data packs included Cost of Living: Understanding and Reducing Health Impacts, A&E Activity by LSOA, PCN Ward Populations and CORE20PLUS5 in York Place of Humber and North Yorkshire ICB. The data packs were utilised by local organisations to support funding applications.

- Doing: a number of PHM projects were completed or initiated, including:

a. Living well with Diabetes
b. Respiratory social prescribing
c. Waiting well
d. Brain Health Café

Planned work in 2023/2024

8. There are three needs assessments planned at this time for completion:

Gypsy Traveller: At present, we know there are gaps in data about the members of this community who live in York, and this is also reflected nationally. Working with a local organisation, we plan to undertake primary data collection to better understand the needs of this population. This data should complement recent national qualitative data that looked at the lived experiences of this community.

Women's health: In the summer of 2022, a national women's health strategy was produced, highlighting the key inequalities faced by women in accessing healthcare across the life course. It is hoped that by highlighting the problems faced by women at local level, the local system can help to address some of the issues identified.

York Population Planning: A report was produced in 2019 charting the expected population growth across the city in the years 2020-2025. It incorporated the proposed housing developments as outlined in the draft local plan, alongside predicted demands on primary care and adult social care caseloads. In light of the latest census data, the introduction of ICBs and place-based working and the introduction of CYC's three new 10 strategies (Health and Wellbeing, Climate Change, Economic), it has been proposed that now would be a good time to update the document.

9. Additionally, it is anticipated that further topic specific needs assessments will arise, either through requests from officers within the local authority and/or external organisations, or in response to local requirements for reactive needs assessments.

10. The JSNA website will also be updated during the 2023/2024 year, to make it more accessible and engaging. It will also bring it in line with other more modern websites, with an aim of increasing the visibility and usefulness of the JSNA and PHH content. The new website will be managed with the CYC Web Services team and the project is expected to take 3-6 months to compete.

11. Further editions of the newsletter are planned to be circulated in the summer and winter. Another lunch and learn session is also currently being planned to be delivered in the Spring.

Implications

12. There are no specialist implications of this report.

Recommendations

13. The Health and Wellbeing Board are asked to:

    i. Note the content of this report and comment on how the JSNA and work of the Population Health Hub can be further disseminated

    ii. Comment on the use of the JSNA within their own organisations, and suggest how this use could be increased

Reason: To keep the HWBB updated on the work of the Population Health Hub and the JSNA.

Contact Details

Author:

Phil Truby
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City of York Council
01904 553959

Chief Officer Responsible for the report:
Chief Officer's name: Peter Roderick
Title: Consultant in Public Health

Report Approved ✓ **Date** 02.03.2023

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
All content relating to the overarching JSNA and the associated health needs assessments can be accessed on the JSNA website at www.healthyork.org

Glossary
CCG – Clinical Commissioning Group

CQC – Care Quality Commission

EYIB – Early Years Improvement Board

ICB – Integrated Care System

JSNA – Joint Strategic Needs Assessment

LSOA – Lower Super Output Area

NHS – National Health Service

PHM – Population Health Management

PHH – Population Health Hub

PNA – Pharmaceutical Needs Assessment

SEND – Special education need and disability

Health and Wellbeing Board **15 March 2023**

Report of the Consultant in Public Health, City of York Council

Framework for the Action Plan and Population Health Outcomes Monitor of the new Joint Health and Wellbeing Strategy 2022-2032

Summary

1. At the January 2023 meeting of the Health and Wellbeing Board (HWBB) members of the board agreed a framework for an action plan and a Population Health Outcomes Monitor for the new Joint Health and Wellbeing Strategy 2022-2023.

2. Taking into consideration the comments made at the January meeting this report presents a populated action plan (Annex A) and an amended Population Health Outcomes Monitor (Annexes B & C) for approval.

Background

3. The HWBB's new Joint Health and Wellbeing Strategy 2022-2023 was developed throughout 2022. Its high-level goal is to reduce the gap in healthy life expectancy between groups in the city.

4. Ambitions and Goals in the Strategy were identified using the evidence in the JSNA, through workshops and through public engagement, a process which is explained directly in the Strategy itself ('How we made this Strategy').

5. The strategy sits alongside two other major city strategies for the city (the Economic Strategy and the Climate Change Strategy).

Next steps

6. Action Plan: actions for each of the ten big goals set out in the new Joint Health and Wellbeing Strategy have now been identified. These cover the first 18-24 months of the strategy's lifetime. Links have been made to show how these actions link to the six big ambitions

contained in the strategy. Additionally, there are columns to show the lead HWBB member for the action, and if the action has cross over benefits with the Economic and Climate Change strategies.

7. The action plan will be a living document with lead HWBB members for the actions being asked to provide regular progress updates.

8. Population Health Outcomes Monitor: this has now been amended based on the discussion had at the January 2023 HWBB meeting. It is linked to the ten big goals and is designed to provide board members with a holistic view of whether the strategy is making a difference to the health and wellbeing of York's population, using outcome data rather than data on what health and care services are 'doing'. We have deliberately chosen a small but broad number of indicators, enabling board members to avoid either 'flying blind' (not enough data) or 'flying in a blizzard' (too much data).

Consultation and Engagement

9. As a high-level document setting out the strategic vision for health and wellbeing in the city, the new Health and Wellbeing Strategy capitalised on existing consultation and engagement work undertaken on deeper and more specific projects in the city. Co-production is a principle that has been endorsed by the HWBB and will form a key part of the delivery, implementation, and evaluation of the strategy

10. The actions in the action plan have been identified in consultation with HWBB member organisations and those leading on specific workstreams that impact the ten big goals.

11. The performance management framework has been developed by public health experts in conjunction with the Business Intelligence Team within the City of York Council.

Options

12. There are no specific options for the HWBB in relation to this report. HWBB members are asked to approve the action plan at Annex A and the Population Health Outcomes Monitor at Annexes B & C

Implications

13. It is important that the priorities in relation to the new Joint Health and Wellbeing Strategy are delivered. Members need to be assured that

appropriate mechanisms are in place for delivery. The Terms of Reference for the Health and Wellbeing Board and its governance arrangements will be reviewed together with its relationship to the new NHS partnership arrangements in the coming months.

Recommendations

14. Health and Wellbeing Board are asked to approve the documentation at Annexes A, B and C.

    Reason: To ensure that the Health and Wellbeing Board fulfils its statutory duty to deliver on their Joint Health and Wellbeing Strategy 2022-2032.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Peter Roderick Consultant in Public Health, City of York Council peter.roderick@york.gov.uk	Peter Roderick Consultant in Public Health, City of York Council
	Report Approved ✓ **Date** 03.03.2023

Specialist Implications Officer(s)
None

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes:
Annex A: Action Plan
Annexes B and C: Population Health Outcomes Monitor

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York HWB Strategy 2022-2032 Action Plan (Year 1 + 2)

				6 big ambitions							
			Action	1. Become a health generating city	2. Prevent now to avoid later harm	3. Start Good Health and Wellbeing Young	4. Make good health more equal across the city	5. Work to make York a mentally healthy city	6. Build a collaborative health and care system	HWBB Leadership (member or sub)	Co-benefits
10 big goals	1. Reduce the gap in healthy life expectancy between the richest and poorest communities		*Overarching priority which will be achieved if all other priorities are successful*								
	2. Reducing anxiety scores and increasing happiness scores by 5%	A1	Continued to develop the community mental health hub and its role in improving the mental health of users		x			x	x	Chair of MH partnership (TBC)	E
		A2	Further embed a trauma-informed approach into systems in York to recognise people's experiences as individuals, each with gifts, talents and skills	x	x			x		Chair of MH partnership (TBC)	
		A3	Continue to support the VCS to capitalise on the community assets and community connections we have in York.	x	x			x		Chair of MH partnership (TBC)	E
	3. Bring smoking rates down below 5% for all population groups	A4	Continue joint working between Public Health and Public Protection to increase the amount of intelligence around illicit tobacco and utilise this intelligence to direct enforcement activity		x	x				Peter Roderick	E
		A5	Implement Tobacco Dependency Treatment service in York Hospital in both Acute and Maternity pathways		x		x			Simon Morritt	E
		A6	Increase the number of successful smoking quits through the health trainer service to 200 in 23/24		x		x	x		Peter Roderick	E CC
	4. Reduce from over 20% to 15% the proportion of York residents drinking above the Chief Medical Officer's alcohol guideline (no more than 14 units a week)	A7	Roll out of alcohol harm reduction online tool and supporting app (Lower My Drinking) to residents over the age of 18 in York embedding into services and pathways across the city, with a target of 15,000 AUDIT questionnaire completions on the website by July 2024		x	x				Peter Roderick	
		A8	Make Alcohol Identification and Brief Advice training available to organisations working with York residents to support conversations with individuals and enable signposting to appropriate services		x				x	Peter Roderick	
	5. Reverse the rise in the number of children and adults living with an unhealthy weight	A9	Support adult residents to achieve a healthy weight through the York Weight Management pathway		x					Fiona Phillips Peter Roderick	CC
		A10	Continue to deliver the National Child Measurement Programme and support those children identified as having an unhealthy weight		x	x	x			Fiona Phillips	
		A11	Work with parents through the Healthy Child Service to support healthy eating at the earliest opportunity, through routine appointments, supported breast feeding and clear nutritional advice		x	x	x			Fiona Phillips	
		A12	Deliver the HENRY approach in our 0-5 year population		x	x				Fiona Phillips	
		A13	Support the implementation of HENRY awareness for professionals		x	x			x	Fiona Phillips	
	6. Reduce health inequalities in specific groups	A14	Use health inequalities grants to fund targeted work including by local VCSE organisations to enable them to address health inequalities	x	x		x		x	Peter Roderick Sharon Stoltz	E
		A15	Identify and address barriers to accessing appropriate health services by people experiencing poverty through the Poverty Truth Commission	x	x		x		x	Alison Semmence	E
	7. Reduce both the suicide rate and the self-harm rate in the city by 20%	A16	Undertake a suicide audit and present a report with key findings to the Health and Wellbeing Board and other forums (Year 1)					x	x	Sharon Stoltz	
		A17	Roll out the YES campaign supported by the Humber and North Yorkshire health inequalities fund to screen the Suicide Prevention film in training across the city (Year 1)		x			x		Sharon Stoltz	
		A18	Refresh and relaunch the 2018-2023 York Suicide Safer Community Strategy (Year2)					x	x	Sharon Stoltz	
	8. Improve diagnosis gaps in dementia, diabetes and high blood pressure to above the national average, and detect cancer at an earlier stage	A19	Deliver an increased number of blood pressure checks and pulse monitoring through GP, community and pharmacy routes, to increase the number of people diagnosed and treated for cardiovascular diseases		x		x			Sarah Coltman-Lovell Emma Broughton	
		A20	Increase the number of people identified with diabetes through targeted NHS Health Checks		x		x			Sharon Stoltz Emma Broughton	
		A21	Support the implementation of the Dementia Strategy		x				x	Jamaila Hussain	
		A22	Reduce the numbers of York patients waiting over 62 days for a cancer diagnosis, and achieve the 75% target for the 28 day Faster Diagnosis Standard		x				x	Simon Morritt	E
	9. Reduce sedentary behaviour, so that 4 in every 5 adults in York are physically active	A23	Ensure that the built environment supports children and young people to access green space to enable increased activity, using the local plan to inform the development of playparks and community spaces through the planning process	x	x	x	x			Fiona Phillips	CC
		A24	Support the implementation of the Physical Activity and Sport Strategy		x	x		x		Fiona Phillips	CC
	10. Reduce the proportion of adults who report feeling lonely from 25% to 20% of our population	A25	Support more people in the city to increase social connection through social prescribing and local area coordination thereby reducing or preventing illness	x	x			x	x	Alison Semmence	E
		A26	Support the development of thriving people and communities through asset based community development, neighbourhood action plans and community hubs which prioritise addressing loneliness	x	x			x		Alison Semmence	E CC
		A27	Support the development of relational centred practice including intergenerational approaches to addressing loneliness through Age Friendly York and our social connections programme	x	x			x		Alison Semmence Jamaila Hussain	E
		A28	To identify gaps in provision for those at greatest risk of loneliness and lead partnership action to fill the gaps					x	x	Alison Semmence	

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Health and Wellbeing 10 Year Strategy (2022-2032) 2022/2023

No of Indicators = 33 | Direction of Travel (DoT) shows the trend of how an indicator is performing against its Polarity over time.

Produced by the Business Intelligence Hub February 2023

				Previous Years										
			Collection Frequency	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Target	Polarity	DOT
Goal 01: Reduce the gap in healthy life expectancy	PHOF17	Slope index of inequality in life expectancy at birth - Female - (Three year period)	Annual	4.3	4.2	5.2	6.2	6.2	5.7	-	-	-	Up is Bad	◀▶ Neutral
		Regional Rank (Rank out of 15)	Annual	2	3	3	3	3	3	-	-	-		
	PHOF37	Slope index of inequality in life expectancy at birth - Male - (Three year period)	Annual	7.2	7.7	8.9	8.4	8.3	8.4	-	-	-	Up is Bad	◀▶ Neutral
		Regional Rank (Rank out of 15)	Annual	3	3	2	3	3	3	-	-	-		
	PHOF98	Difference in healthy life expectancy at birth between females and males (yrs)	Annual	-0.2	-0.3	-0.6	-0.2	0.6	-0.7	-	-	-	Neutral	◀▶ Neutral
		Benchmark - National Data	Annual	0.7	0.5	0.4	0.5	0.3	0.8	-	-	-		
		Benchmark - Regional Data	Annual	0.5	0.2	-0.2	0.6	0.7	1	-	-	-		
Goal 02: Support good mental health	PHOF18	% of people with a self-reported high anxiety score	Annual	23.66%	22.00%	24.20%	20.90%	25.60%	27.10%	25.30%	-	20.30%	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	19.37%	19.90%	20.00%	19.70%	21.90%	24.20%	22.60%	-	-		
		Benchmark - Regional Data	Annual	21.52%	21.20%	21.20%	20.60%	22.10%	24.90%	22.30%	-	-		
		Regional Rank (Rank out of 15)	Annual	12	12	14	7	15	11	14	-	-		
	PHOF19	% of people with a self-reported low happiness score	Annual	6.74%	8.30%	9.50%	11.30%	9.00%	8.80%	10.80%	-	5.8%	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	8.75%	8.50%	8.20%	7.80%	8.70%	9.20%	8.40%	-	-		
		Benchmark - Regional Data	Annual	9.92%	9.50%	9.10%	9.40%	9.80%	10.30%	7.90%	-	-		
		Regional Rank (Rank out of 15)	Annual	1	5	9	12	4	7	14	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 03: Reduce smoking rates	PHOF188	Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)	Annual	14.60%	12.60%	9.00%	11.50%	11.90%	11.70%	9.20%	-	5%	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	16.90%	15.50%	14.90%	14.40%	13.90%	13.80%	13.00%	-	-		
		Benchmark - Regional Data	Annual	18.60%	17.70%	17.00%	16.70%	15.70%	14.70%	14.10%	-	-		
		Regional Rank (Rank out of 15)	Annual	2	2	1	1	2	3	1	-	-		
	PHOF187	Smoking prevalence among adults aged 18-64 in routine and manual occupations (APS) (2020 definition)	Annual	28.10%	26.40%	24.60%	18.60%	26.90%	22.30%	-	-	5%	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	28.10%	26.50%	25.70%	25.40%	24.50%	24.50%	-	-	-		
		Benchmark - Regional Data	Annual	30.00%	28.90%	28.20%	27.40%	27.60%	25.50%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	4	4	3	1	6	5	-	-	-		
	PHOF10	% of women who smoke at the time of delivery - (CYC)	Quarterly	12.30%	11.10%	10.40%	11.60%	10.40%	10.30%	8.00%	-	5%	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Quarterly	11.00%	10.70%	10.80%	10.60%	10.40%	9.60%	9.10%	-	-		
		Benchmark - Regional Data	Quarterly	14.60%	14.40%	14.20%	14.40%	14.00%	13.10%	12.00%	-	-		
		Regional Rank (Rank out of 15)	Annual	4	2	1	2	1	3	1	-	-		
	PHOF195	Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS)	Annual	29.80%	28.50%	21.30%	30.30%	19.30%	26.30%	-	-	5%	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	33.00%	30.30%	27.80%	26.80%	25.80%	26.30%	-	-	-		
		Benchmark - Regional Data	Annual	34.80%	31.60%	29.80%	28.20%	27.60%	27.50%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	3	5	2	10	1	4	-	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 04: Reduce proportion of residents drinking over14 units of alcohol a week	LAPE12	Admitted to hospital with alcohol-related conditions (Broad): Males, all ages (per 100,000 population) - (New methodology)	Annual	-	2,742	2,911	3,099	3,051	2,455	-	-	-	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	-	2,525	2,574	2,737	2,809	2,290	-	-	-		
		Benchmark - Regional Data	Annual	-	2,716	2,728	2,808	2,796	2,292	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	7	10	11	11	9	-	-	-		
	LAPE13	Admitted to hospital with alcohol-related conditions (Broad): Females, all ages (per 100,000 population) - (New methodology)	Annual	-	978	970	1,085	1,121	943	-	-	-	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	-	840	858	915	943	805	-	-	-		
		Benchmark - Regional Data	Annual	-	933	942	986	992	831	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	10	9	10	12	11	-	-	-		
	PHOF191	Percentage of adults drinking over 14 units of alcohol a week - (4 year Aggregated)	Annual	-	-	-	21.40%	-	-	-	-	15%	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	-	-	-	22.80%	-	-	-	-	-		
		Benchmark - Regional Data	Annual	-	-	-	21.20%	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	-	-	9	-	-	-	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 05: Reduce unhealthy weight	NCMP03	% of reception year children recorded as being overweight (incl. obese) (single year)	Annual	22.37%	20.83%	24.07%	23.65%	21.40%	NC	22.70%	-	-	Up is Bad	◀ ▶ Neutral
		Benchmark - National Data	Annual	22.14%	22.63%	22.38%	22.59%	23.00%	27.70%	22.25%	-	-		
		Benchmark - Regional Data	Annual	22.39%	22.19%	22.93%	23.68%	24.10%	29.50%	23.73%	-	-		
		Regional Rank (Rank out of 15)	Annual	8	3	9	9	3	NC	3	-	-		
	NCMP04	% of children in Year 6 recorded as being overweight (incl. obese) (single year)	Annual	27.99%	29.05%	31.78%	29.97%	33.80%	NC	31.54%	-	-	Up is Bad	◀ ▶ Neutra
		Benchmark - National Data	Annual	34.17%	34.25%	34.32%	34.29%	35.20%	40.90%	37.76%	-	-		
		Benchmark - Regional Data	Annual	34.63%	34.64%	34.71%	35.09%	35.80%	42.20%	39.19%	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	3	1	4	NC	1	-	-		
	NCMP10	Absolute gap in % of Year 6 recorded obesity between highest and lowest York ward (3 year aggregated)	Annual	13.10%	19.48%	15.80%	14.40%	18.62%	-	19.68%	-	-	Up is Bad	▲ Red
	PHOF44a	% of adults (aged 18+) classified as overweight or obese (New definition)	Annual	59.30%	59.40%	56.70%	57.60%	62.30%	63.60%	-	-	-	Up is Bad	▲ Red
		Benchmark - National Data	Annual	61.40%	61.50%	62.00%	62.10%	62.80%	63.50%	-	-	-		
		Benchmark - Regional Data	Annual	64.40%	65.70%	64.30%	65.20%	65.00%	66.50%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	2	1	1	4	4	-	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 06: Reduce health inequalities	PHOF40	Gap in employment rate for mental health clients and the overall employment rate	Annual	69.30%	68.50%	63.90%	56.40%	58.00%	56.60%	-	-	-	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	67.20%	67.40%	68.20%	67.60%	67.20%	66.10%	-	-	-		
		Benchmark - Regional Data	Annual	64.00%	63.80%	64.50%	63.70%	63.00%	62.80%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	15	14	6	1	1	3	-	-	-		
	PHOF41	Gap in employment rate for those with learning disabilities and the overall employment rate	Annual	66.30%	69.20%	68.60%	70.10%	71.30%	68.90%	74.30%	-	-	Up is Bad	◀▶ Neutra
		Benchmark - National Data	Annual	68.10%	68.70%	69.20%	69.70%	70.60%	70.00%	70.60%	-	-		
		Benchmark - Regional Data	Annual	65.90%	66.10%	66.10%	68.00%	67.70%	67.80%	69.40%	-	-		
		Regional Rank (Rank out of 15)	Annual	9	12	8	11	12	7	15	-	-		
	PHOF75a	Excess under 75 mortality rate in adults with serious mental illness (New Definition Aug 2021)	Annual	-	-	431.7	385.5	410.2	425.3	-	-	-	Up is Bad	▲ Red
		Benchmark - National Data	Annual	-	-	355.4	365.2	383.1	389.9	-	-	-		
		Benchmark - Regional Data	Annual	-	-	335.7	336.7	348.4	344.2	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	-	14	13	12	14	-	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 07: Reduce the rates of suicide and self-harm	PHOF107	Suicide rate - Female (per 100,000 population)	Annual	5.1	6.7	8.6	7.3	5.6	5.5	6.3	-	5	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	4.7	4.8	4.7	4.7	4.9	5	6.2	-	-		
		Benchmark - Regional Data	Annual	4.6	4.6	4.8	4.8	5.9	6.1	6.5	-	-		
		Regional Rank (Rank out of 15)	Annual	9	12	13	14	7	4	10	-	-		
	PHOF108	Suicide rate - Male (per 100,000 population)	Annual	22.9	19	18.5	16.9	18.2	21.4	20.2	-	16	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	15.8	15.3	14.7	14.9	15.5	15.9	15.9	-	-		
		Benchmark - Regional Data	Annual	17.2	16.5	16.6	16.7	18.3	19.2	18.8	-	-		
		Regional Rank (Rank out of 15)	Annual	15	13	11	6	6	12	9	-	-		
	PHE02	Hospital stays for self harm, per 100,000 population	Annual	254.3	231.8	207.9	189.9	163	172.4	-	-	152	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	196.5	185.3	185.5	196	192.6	181.2	-	-	-		
		Benchmark - Regional Data	Annual	190.3	NA	194.6	205.8	196.9	172.7	-	-	-		
		Regional Rank (Rank out of 15)	Annual	14	11	9	9	13	7	-	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 08: Improve diagnosis gaps in dementia, diabetes & high blood pressure & detect cancer at an earlier stage	PHE11	Estimated dementia diagnosis rate (%) for people aged 65+ as recorded on practice disease registers	Annual	-	-	60.40%	62.20%	60.50%	57.20%	53.20%	55.10%	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	-	-	67.90%	67.50%	68.70%	67.40%	61.60%	62.00%	-		
		Benchmark - Regional Data	Annual	-	-	71.30%	71.20%	71.60%	70.20%	63.20%	63.10%	-		
		Regional Rank (Rank out of 15)	Annual	-	-	15	15	15	15	14	14	-		
	PHOF192	Estimated diabetes diagnosis rate	Annual	70.1	71.2	67.9	71.3	-	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	74.6	76.2	77.1	78	-	-	-	-	-		
		Benchmark - Regional Data	Annual	78.1	80	80.6	81.9	-	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	13	13	15	15	-	-	-	-	-		
	PHOF193	Estimated hypertension diagnosis rate (Vale of York)	Annual	-	-	-	-	60.5	-	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	-	-	-	-	66.5	-	-	-	-		
		Benchmark - Regional Data	Annual	-	-	-	-	67.7	-	-	-	-		
		Regional Rank (Rank out of 15)	Annual	-	-	-	-	-	-	-	-	-		
	PHOF194	Percentage of cancers diagnosed at stages 1 and 2	Annual	55.00%	52.60%	56.30%	51.70%	51.10%	49.30%	-	-	-	Up is Good	◀ ▶ Neutral
		Benchmark - National Data	Annual	54.80%	54.60%	54.30%	54.50%	54.90%	52.30%	-	-	-		
		Benchmark - Regional Data	Annual	53.00%	52.70%	51.90%	52.30%	53.40%	50.60%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	5	6	1	8	12	12	-	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 09: Reduce the proportion of adults who are physically inactive from 1 in 5 to 1 in 7	HLTH55	Access to Healthy Assets & Hazards Index (Persons, All ages) - % of the population who live in LSOAs which score in the poorest performing 20% on the AHAH index	Annual	-	5.10%	5.40%	NC	NC	NC	NC	3.20%	-	Up is Bad	◀▶ Neutral
		Benchmark - National Data	Annual	-	21.20%	21.1.%	NC	NC	NC	NC	22.60%	-		
		Benchmark - Regional Data	Annual	-	22.20%	14.10%	NC	NC	NC	NC	19.90%	-		
		Regional Rank (Rank out of 15)	Annual	-	4	7	NC	NC	NC	NC	1	-		
	PHOF02a	% of adults (aged 19+) that are physically inactive (<30 moderate intensity equivalent minutes per week)	Annual	21.08%	18.28%	13.81%	15.77%	17.60%	21.21%	-	-	15%	Up is Bad	▲ Red
		Benchmark - National Data	Annual	22.33%	22.24%	22.23%	21.39%	22.90%	23.38%	-	-	-		
		Benchmark - Regional Data	Annual	24.66%	24.08%	24.06%	22.66%	24.20%	24.24%	-	-	-		
		Regional Rank (Rank out of 15)	Annual	1	1	1	1	1	3	-	-	-		
	PHYS08	% of children in school years 1-11 that are active for 60+ minutes everyday	Annual	-	NC	49.20%	40.50%	NC	41.81%	NC	-	-	Up is Good	◀▶ Neutral
		Benchmark - National Data	Annual	-	NC	43.26%	46.81%	44.89%	44.63%	47.20%	-	-	Neutral	◀▶ Neutral
		Benchmark - Regional Data	Annual	-	-	41.27%	45.88%	43.22%	46.40%	45.70%	-	-		
		Regional Rank (Rank out of 15)	Annual	-	-	3	12	NC	7	NC	-	-		
	PHYS12	Proportion of adults who do any walking or cycling for any purpose at least three times per week.	Annual	-	57.80%	60.40%	56.00%	60.50%	58.90%	55.00%	-	-	Up is Good	▼ Red
		Benchmark - National Data	Annual	-	45.70%	47.00%	47.20%	47.70%	46.00%	45.60%	-	-		
		Benchmark - Regional Data	Annual	-	43.60%	44.20%	44.70%	45.90%	44.60%	43.00%	-	-		

			Collection Frequency	Previous Years								Target	Polarity	DOT
				2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023			
Goal 10: Reduce the proportion of adults who report feeling lonely	ASCOF1I1	Proportion of people who use services who reported that they had as much social contact as they would like	Annual	45.80%	49.50%	44.50%	43.40%	45.50%	35.40%	39.70%	(Avail Oct 23)	-	Up is Good	◄► Neutral
		Benchmark - National Data	Annual	45.40%	45.40%	46.00%	45.90%	45.90%	34.40%	40.60%	(Avail Oct 23)	-		
		Benchmark - Regional Data	Annual	46.00%	45.60%	47.50%	48.00%	46.20%	NC	40.20%	(Avail Oct 23)	-		
		Regional Rank (Rank out of 15)	Annual	9	6	12	14	10	NC	11	(Avail Oct 23)	-		
	PHOF112	Loneliness: Percentage of adults who feel lonely often / always or some of the time	Annual	-	-	-	-	25.69%	NA	NA	-	20%	Up is Bad	◄► Neutral
		Benchmark - National Data	Annual	-	-	-	-	22.26%	NA	NA	-	-		
		Benchmark - Regional Data	Annual	-	-	-	-	21.49%	NA	NA	-	-		
		Regional Rank (Rank out of 15)	Annual	-	-	-	-	13	NA	NA	-	-		
	PHOF99	% of adult social care users who have as much social contact as they would like (65+ yrs)	Annual	41.00%	48.70%	41.30%	37.00%	40.40%	NC	39.20%	-	-	Up is Good	◄► Neutral
		Benchmark - National Data	Annual	43.70%	43.20%	44.00%	43.50%	43.40%	NC	37.30%	-	-		
		Benchmark - Regional Data	Annual	44.80%	44.40%	44.90%	44.60%	43.40%	NC	36.80%	-	-		
		Regional Rank (Rank out of 15)	Annual	13	5	12	15	11	NC	6	-	-		

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Health and Wellbeing 10 Year Strategy (2022-2032) - 2021/2022

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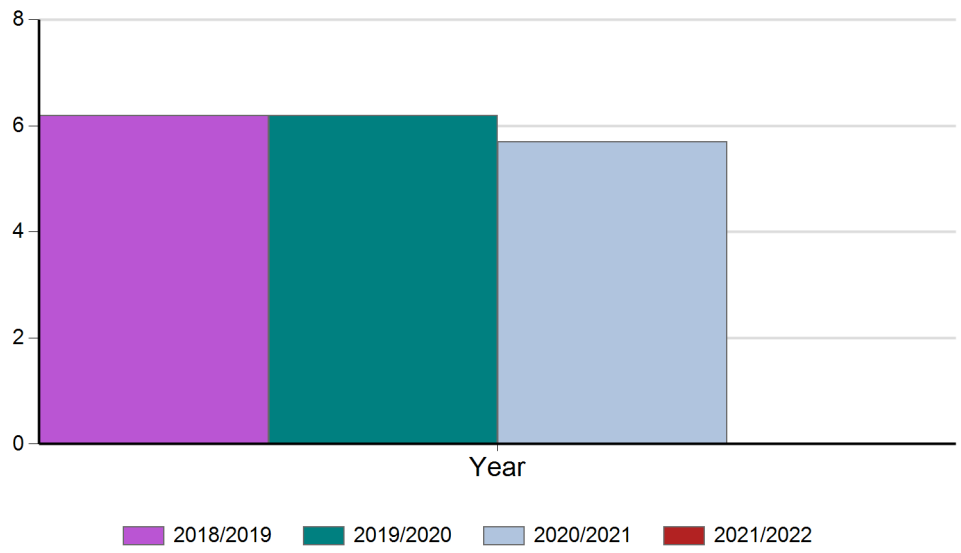
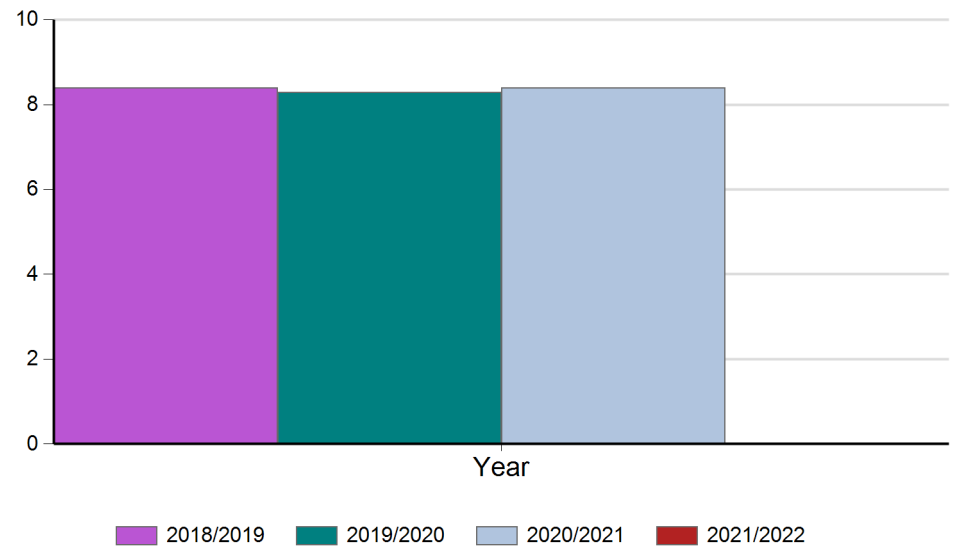
Produced by the Business Intelligence Hub March 2023

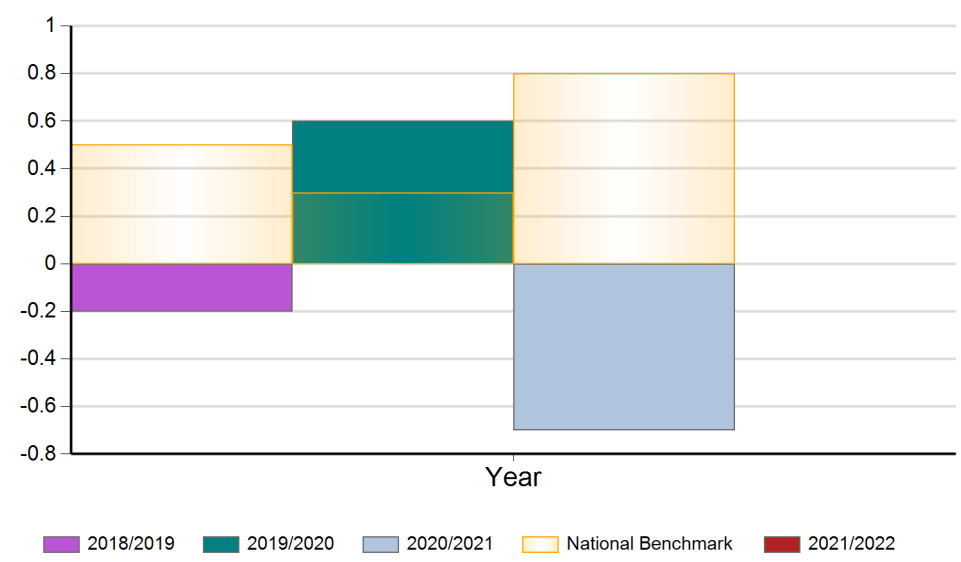
Slope index of inequality in life expectancy at birth - Female - (Three year period)



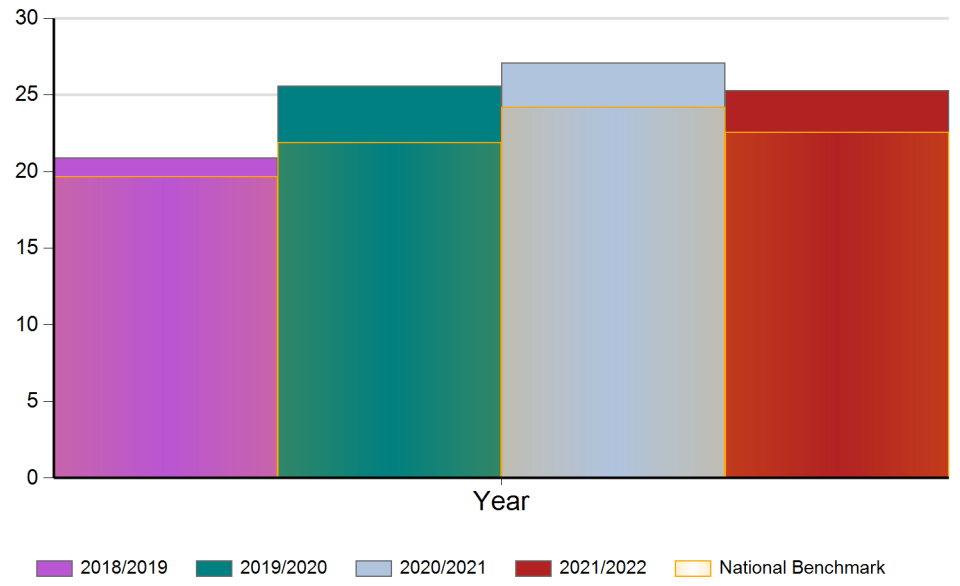
Slope index of inequality in life expectancy at birth - Male - (Three year period)



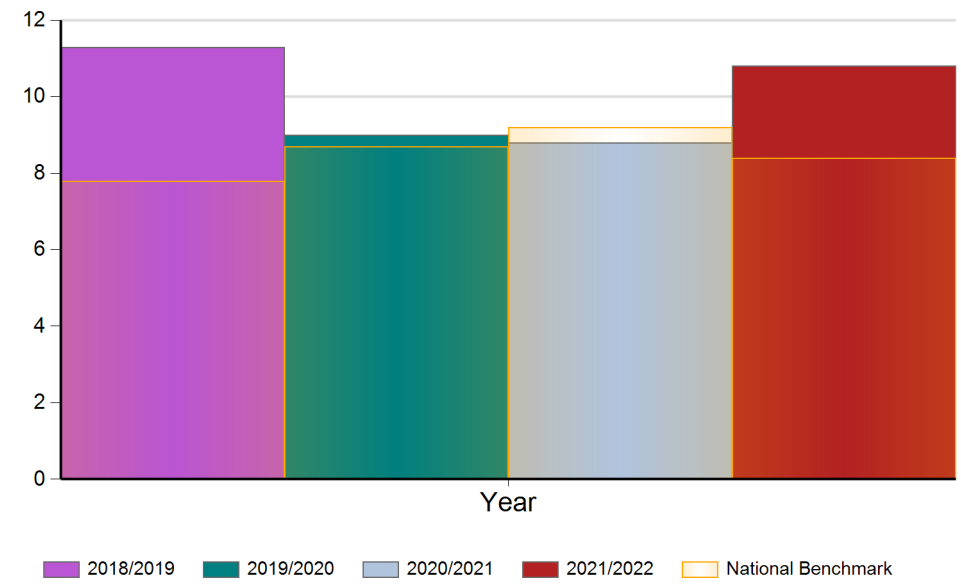
Difference in healthy life expectancy at birth between females and males (yrs)



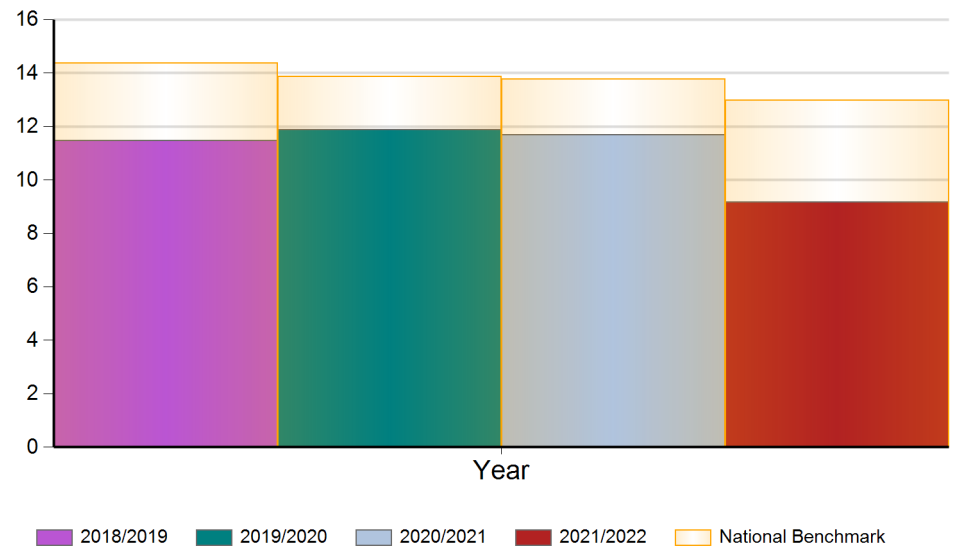
% of people with a self-reported high anxiety score



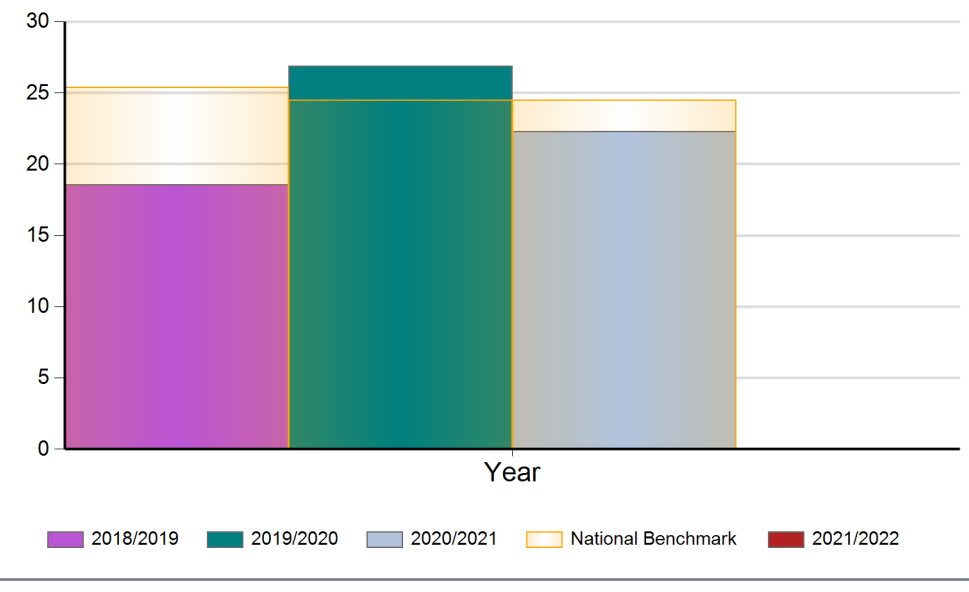
% of people with a self-reported low happiness score



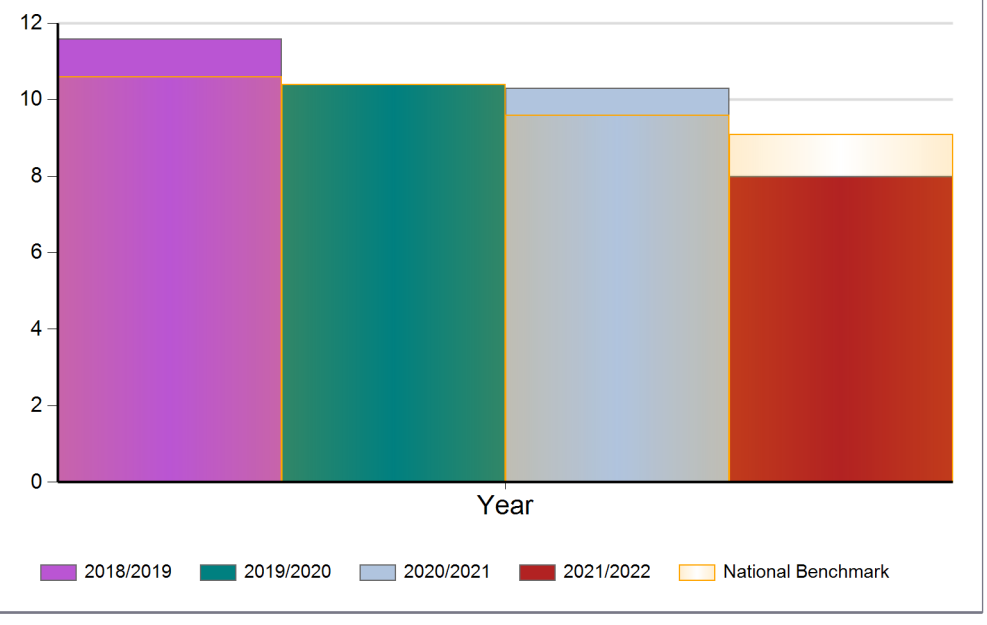
Smoking Prevalence in adults (18+) - current smokers (APS) (2020 definition)



Smoking prevalence among adults aged 18-64 in routine and manual occupations (APS) (2020 definition)



% of women who smoke at the time of delivery - (CYC)



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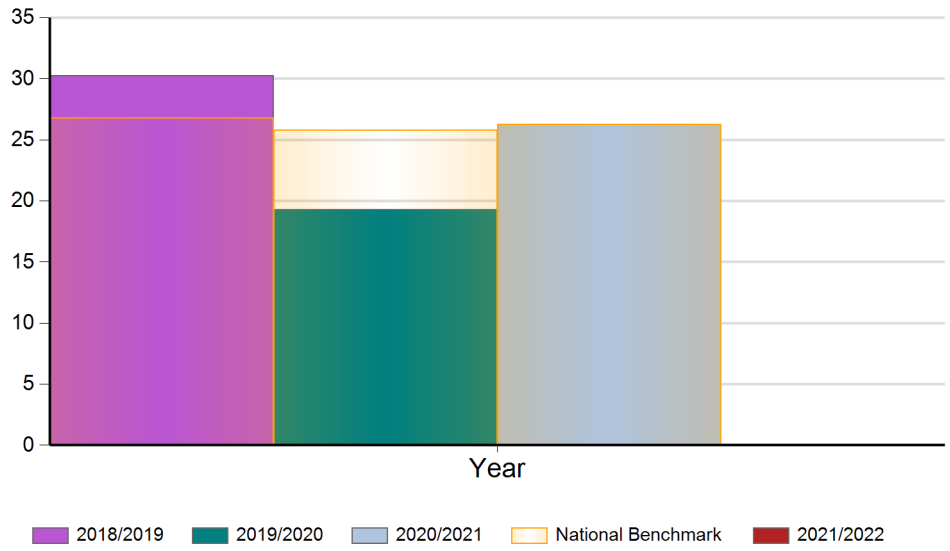
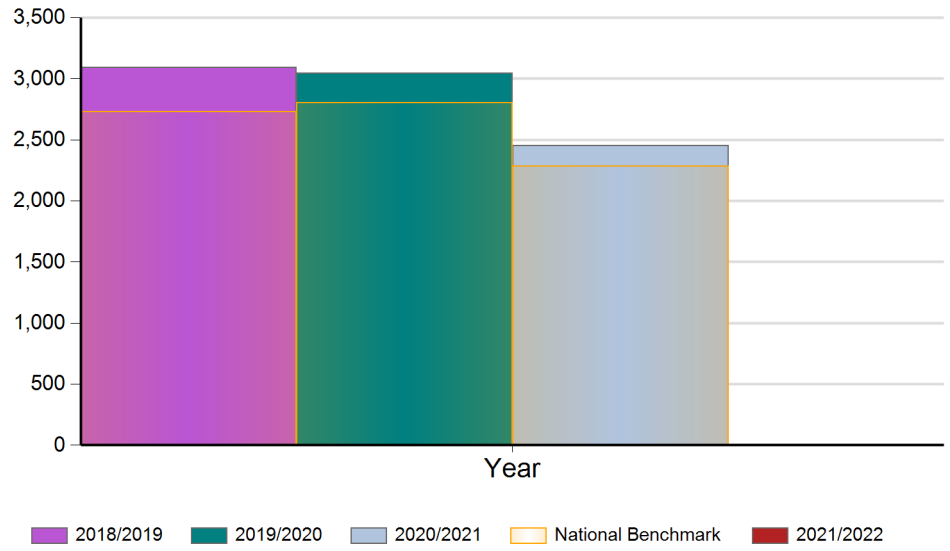
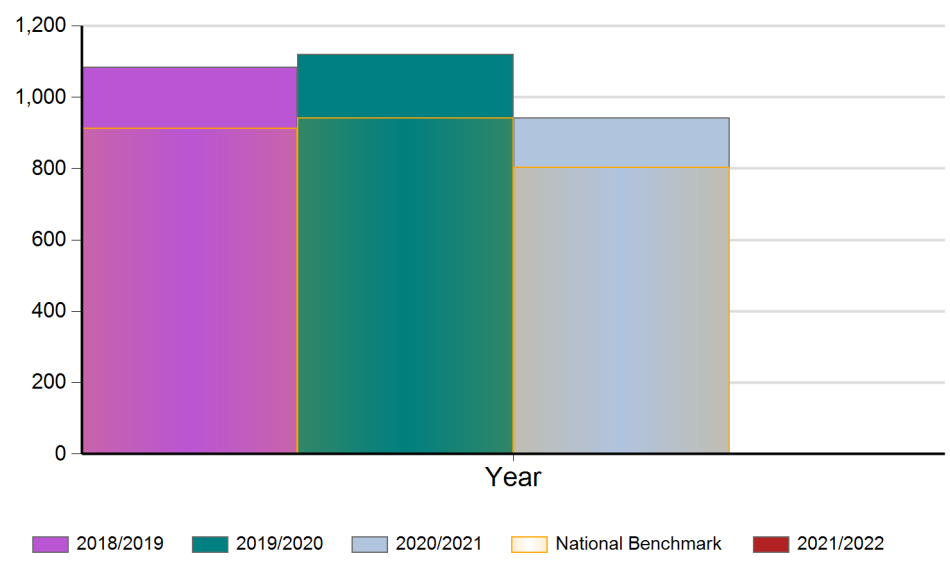
Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS)



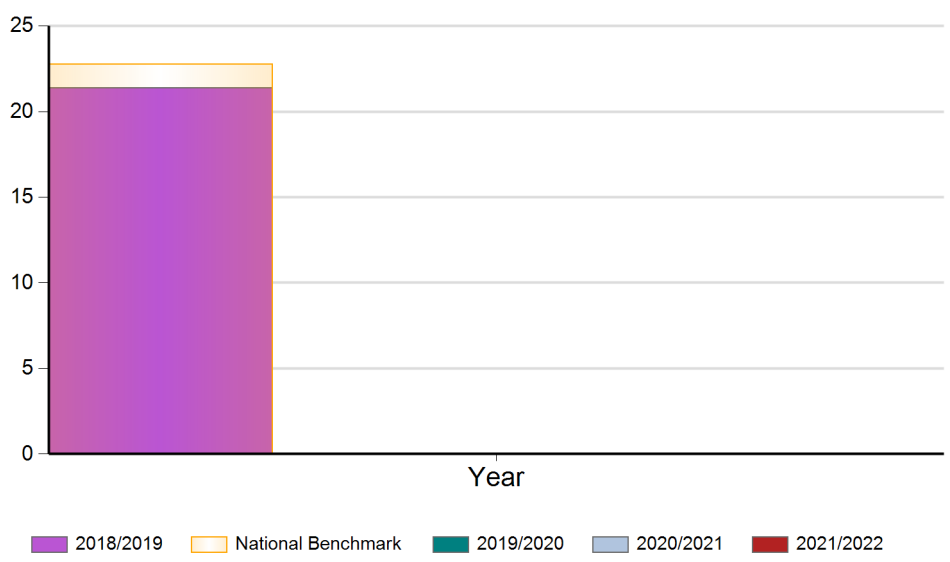
Admitted to hospital with alcohol-related conditions (Broad): Males, all ages (per 100,000 population) - (New methodology)



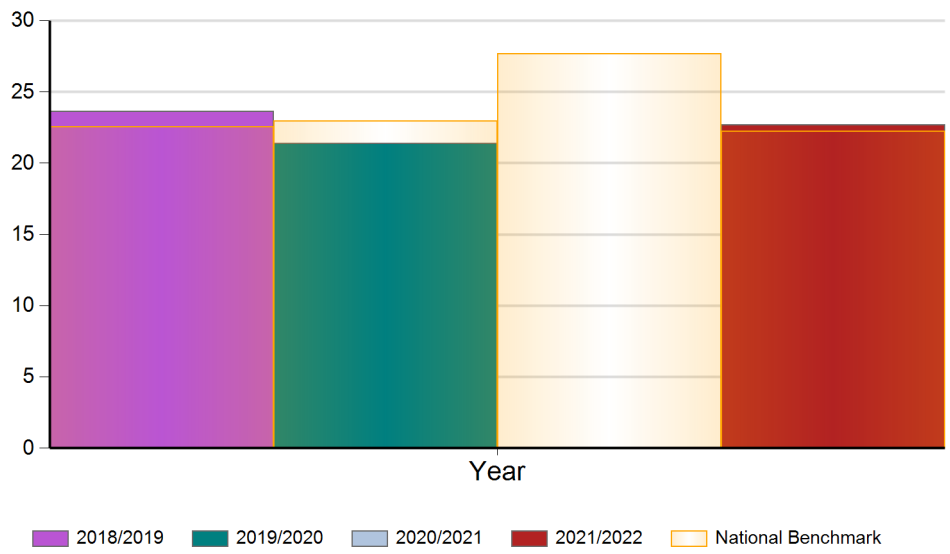
Admitted to hospital with alcohol-related conditions (Broad): Females, all ages (per 100,000 population) - (New methodology)



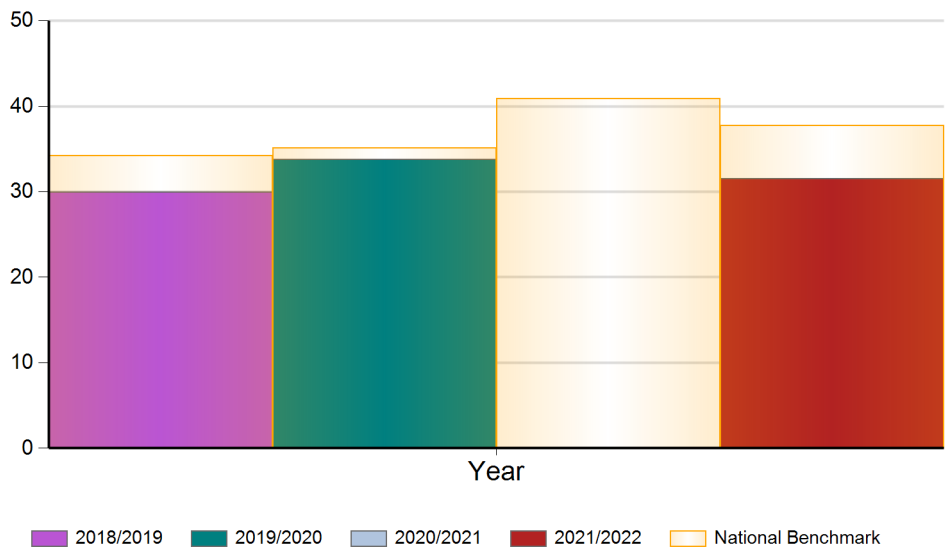
Percentage of adults drinking over 14 units of alcohol a week - (4 year Aggregated)



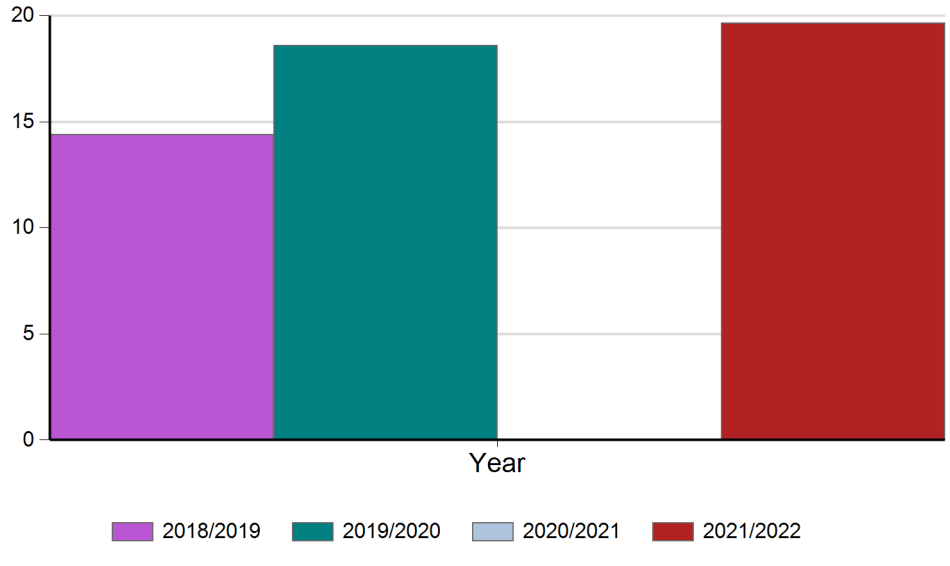
% of reception year children recorded as being overweight (incl. obese) (single year)



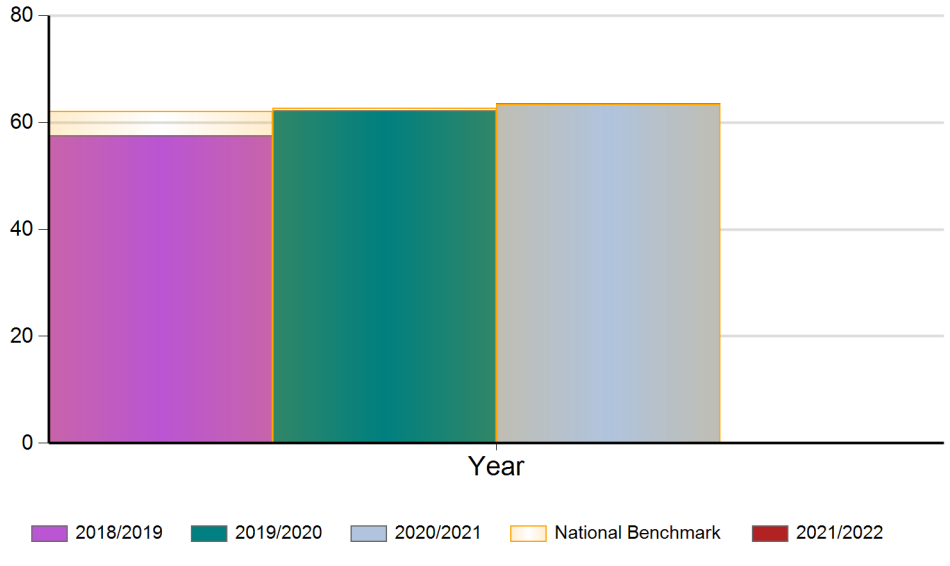
% of children in Year 6 recorded as being overweight (incl. obese) (single year)



Absolute gap in % of Year 6 recorded obesity between highest and lowest York ward (3 year aggregated)



% of adults (aged 18+) classified as overweight or obese (New definition)



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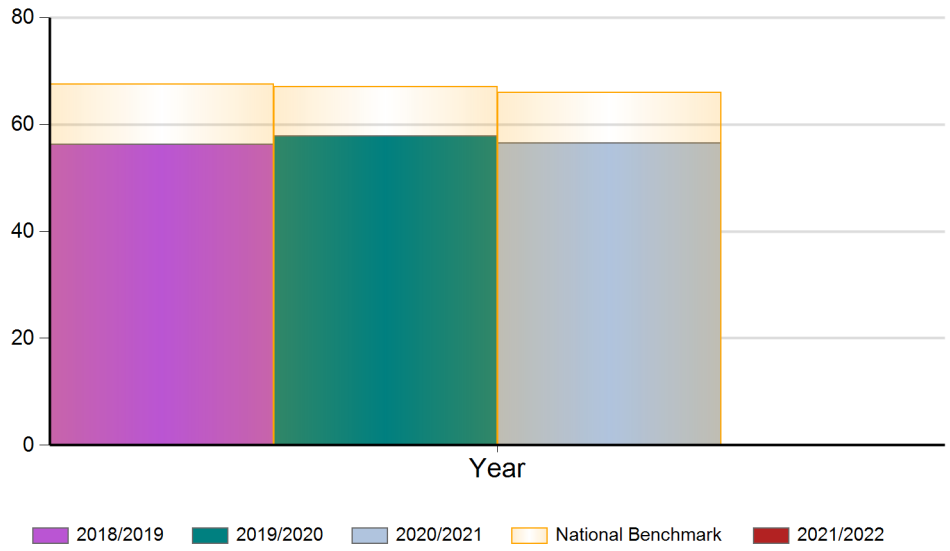
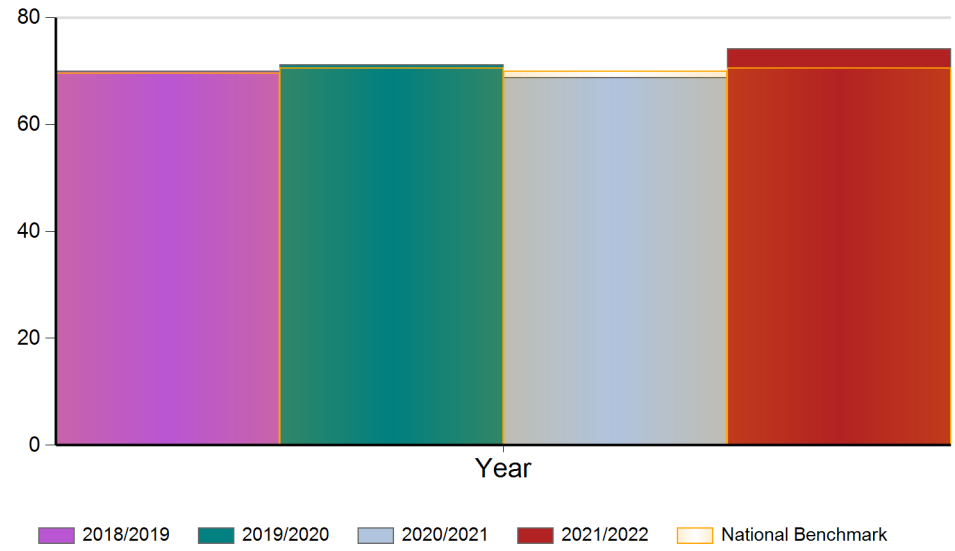
Produced by the Business Intelligence Hub March 2023

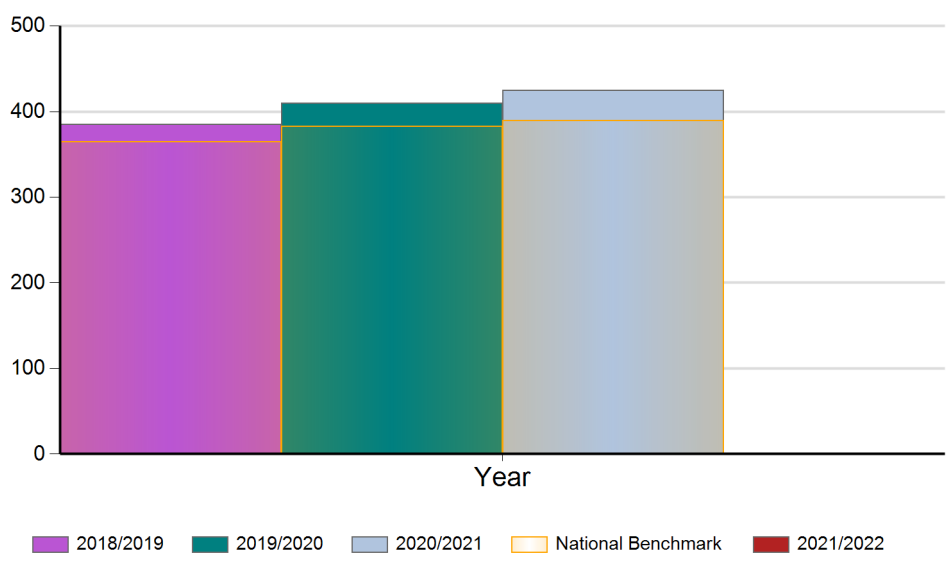
Gap in employment rate for mental health clients and the overall employment rate



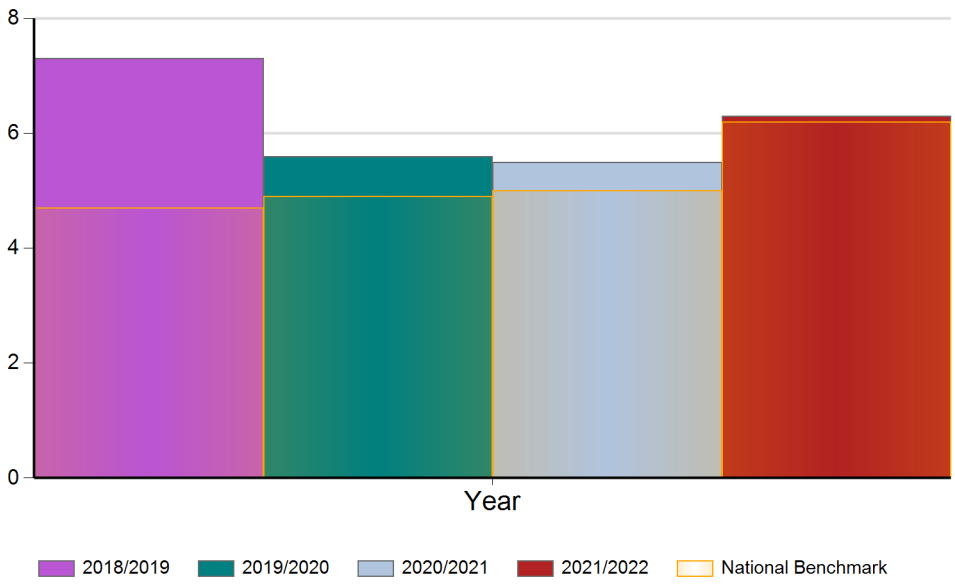
Gap in employment rate for those with learning disabilities and the overall employment rate



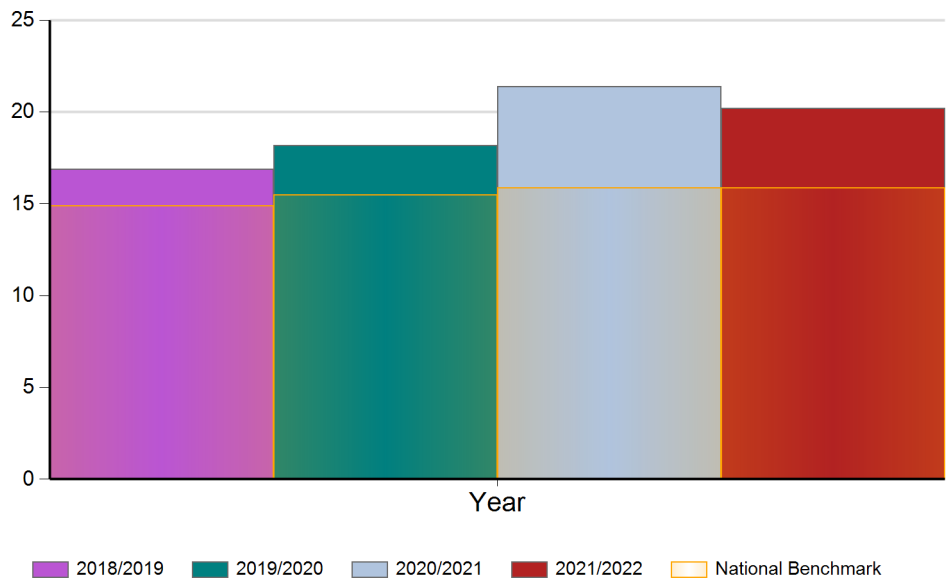
Excess under 75 mortality rate in adults with serious mental illness (New Definition Aug 2021)



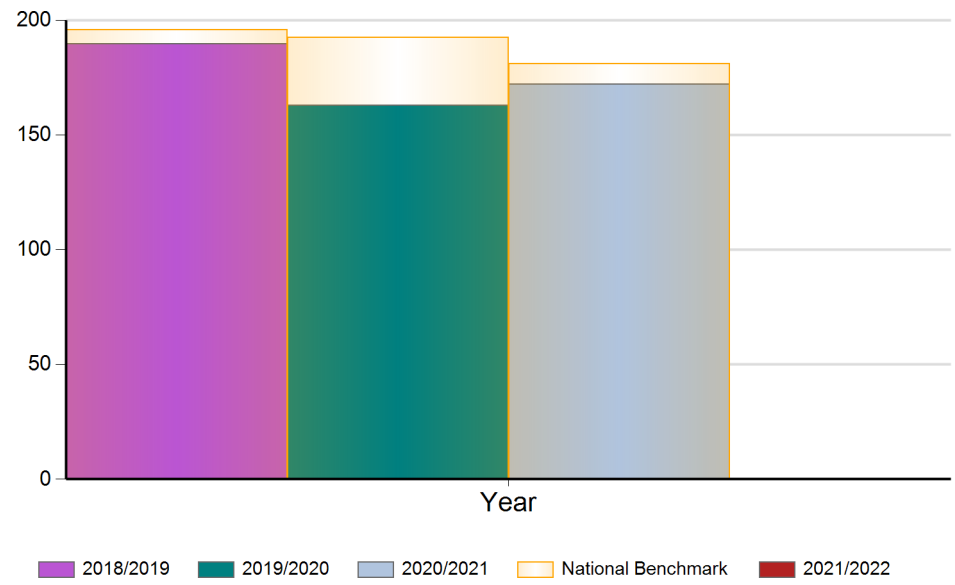
Suicide rate - Female (per 100,000 population)



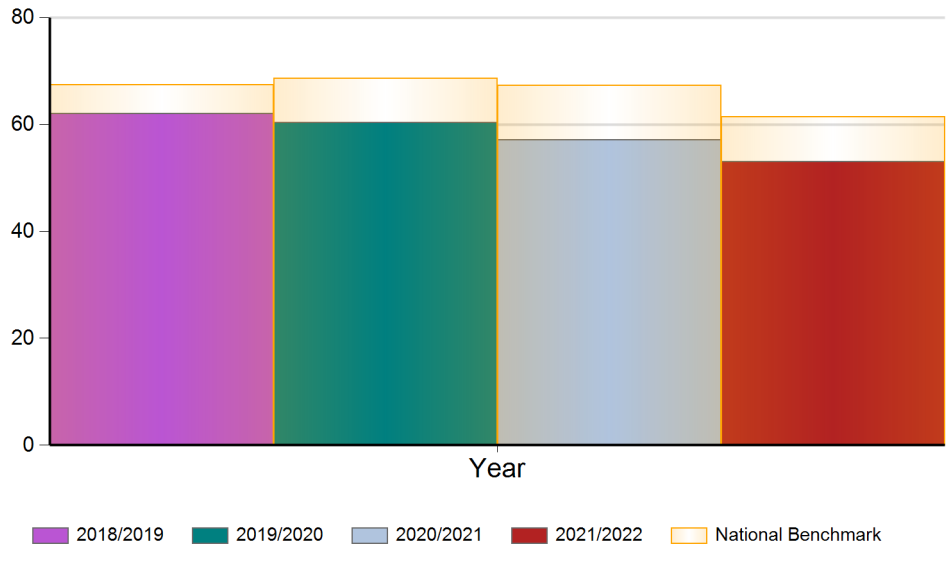
Suicide rate - Male (per 100,000 population)



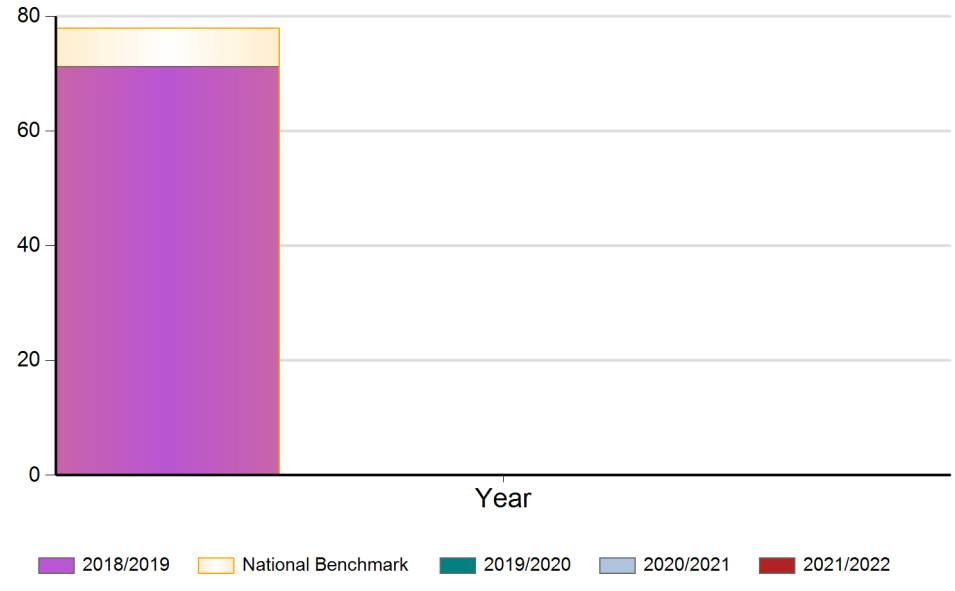
Hospital stays for self harm, per 100,000 population



Estimated dementia diagnosis rate (%) for people aged 65+ as recorded on practice disease registers



Estimated diabetes diagnosis rate



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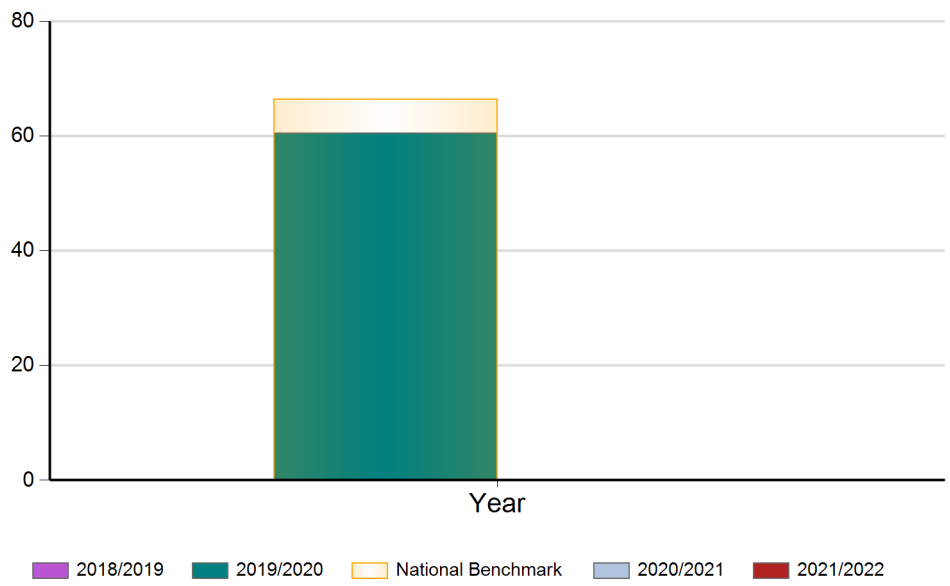
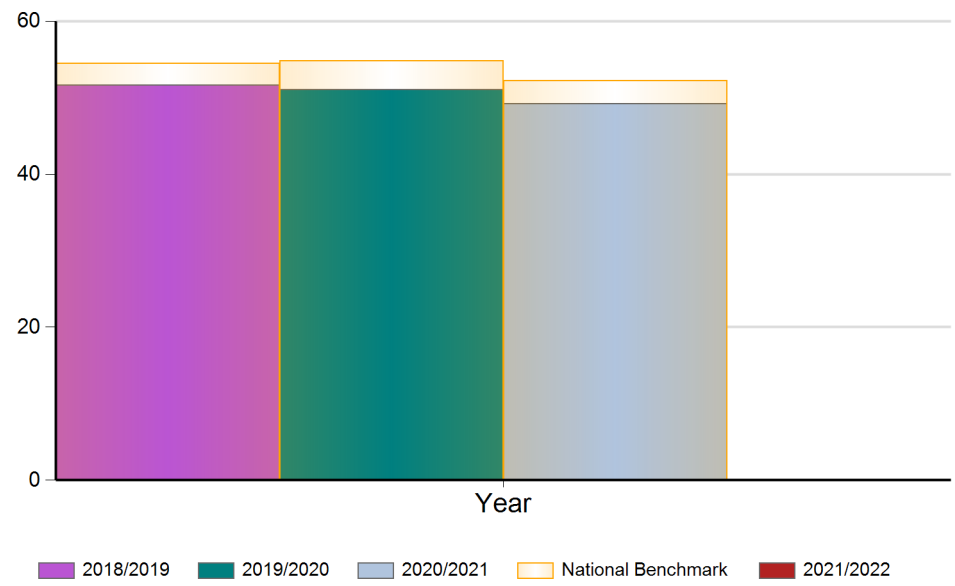
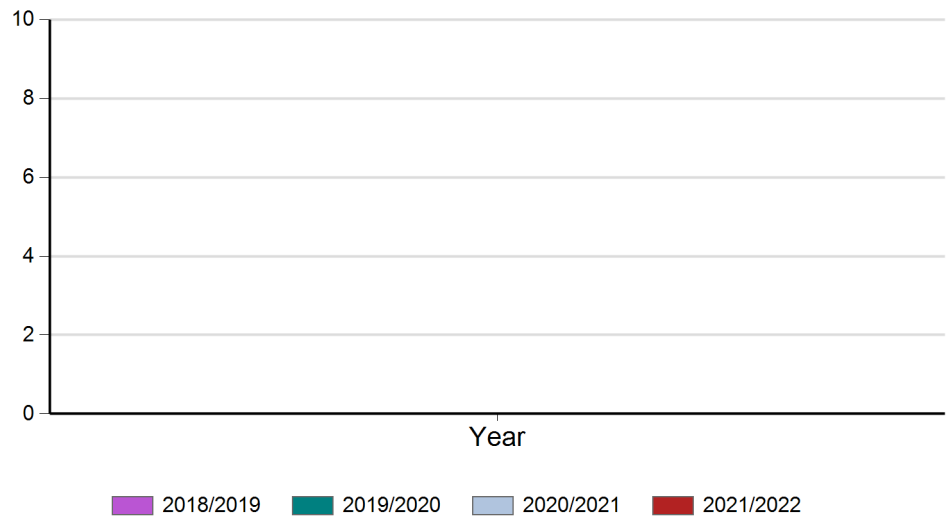
Estimated hypertension diagnosis rate (Vale of York)



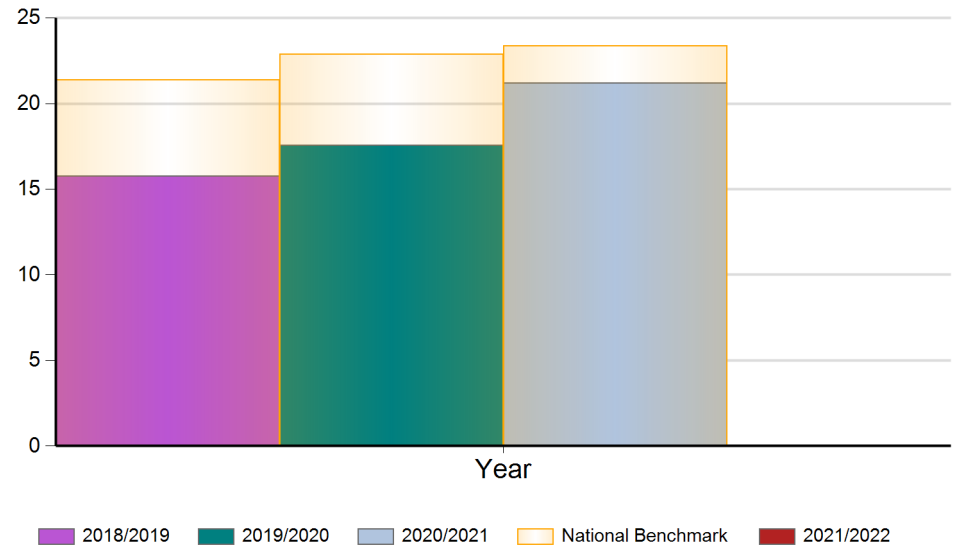
Percentage of cancers diagnosed at stages 1 and 2



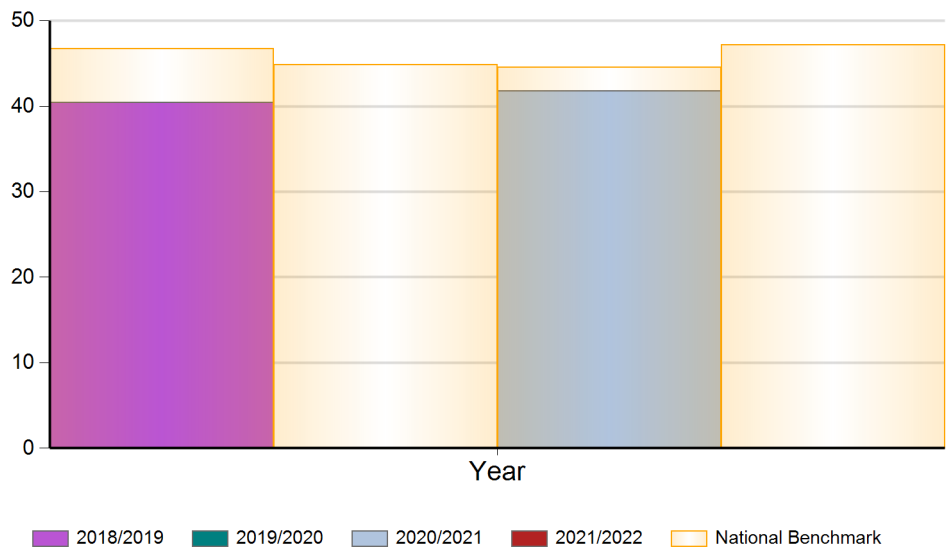
Access to Healthy Assets & Hazards Index (Persons, All ages) - % of the population who live in LSOAs which score in the poorest performing 20% on the AHAH index



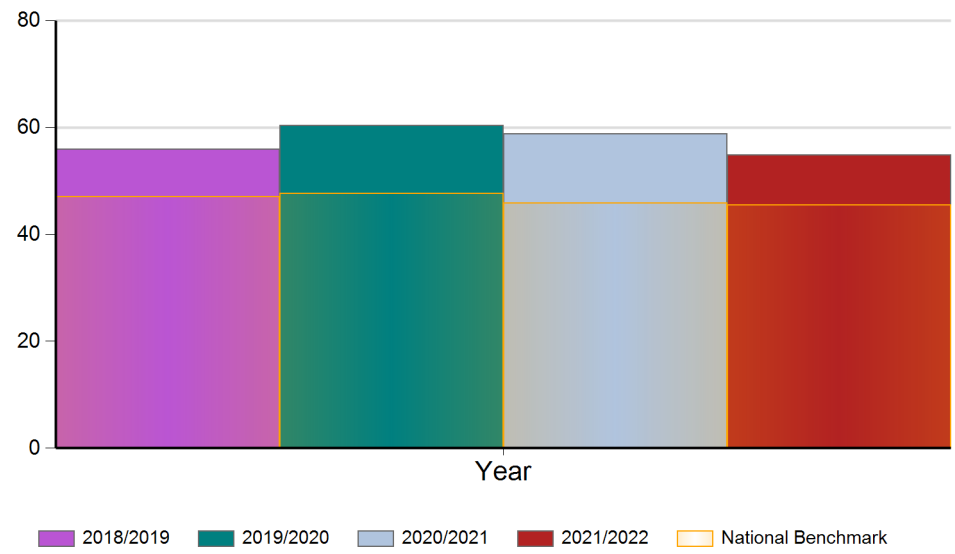
% of adults (aged 19+) that are physically inactive (<30 moderate intensity equivalent minutes per week)



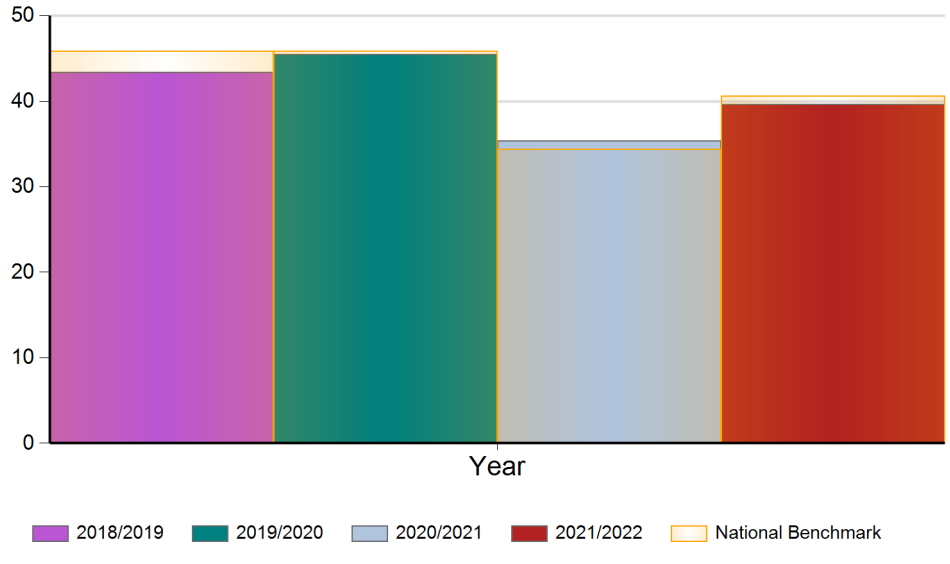
% of children in school years 1-11 that are active for 60+ minutes everyday



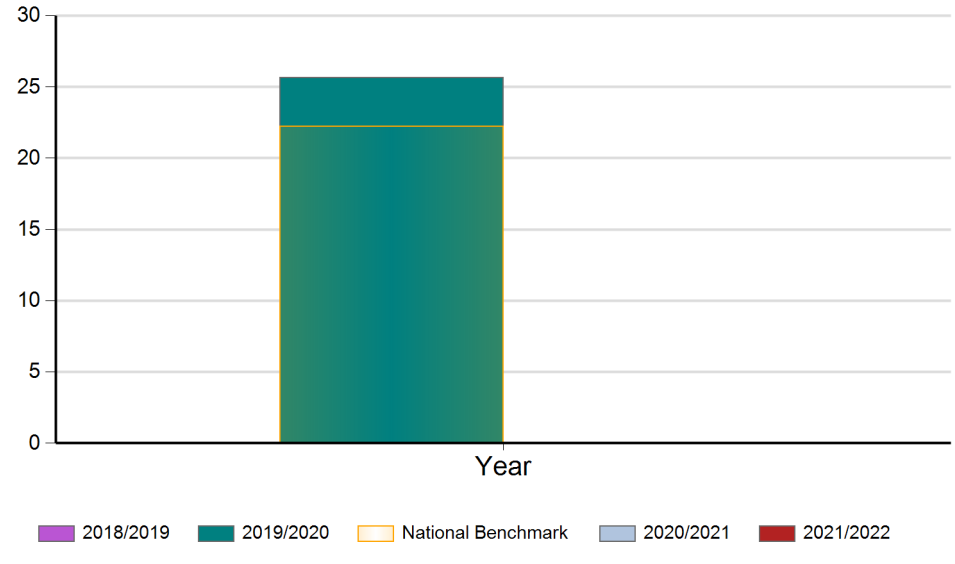
Proportion of adults who do any walking or cycling for any purpose at least three times per week.



Proportion of people who use services who reported that they had as much social contact as they would like



Loneliness: Percentage of adults who feel lonely often / always or some of the time



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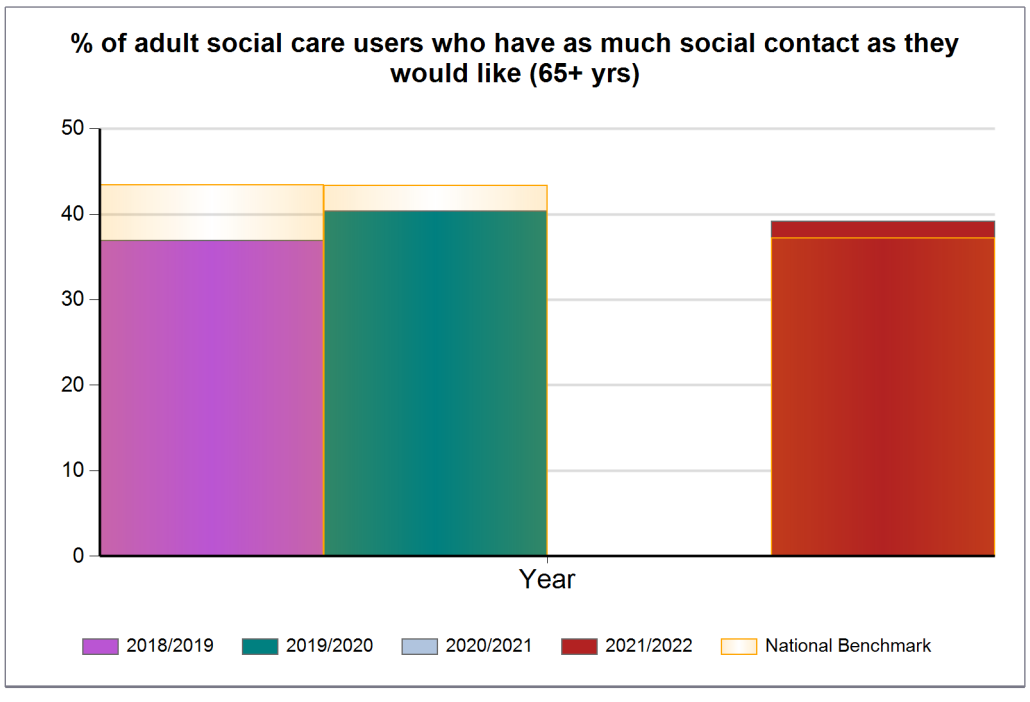

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Health and Wellbeing Board 15 March 2023
Report of the Manager, Healthwatch York

Update following the Children's Mental Health report to the Health and Wellbeing Board meeting, November 2022

Summary

1. This report provides an update following presentation of the Healthwatch York snapshot report on Children's Mental Health at the November meeting of the Health and Wellbeing Board.

Background

2. At the November meeting it was agreed an update on progress against recommendations should come back to the Health and Wellbeing Board.

Main/Key Issues to be considered

3. The report contained key findings and recommendations. These are outlined in the update report alongside commentary from member organisations on progress against these recommendations.

Consultation

4. There has been no further consultation with the public to develop this update.

Implications

5. 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 equalities implications in this report, as it highlights particular challenges experienced in the main by disabled people.

- **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

6. There are no risks associated with this report.

Recommendations

7. The Health and Wellbeing Board are asked to:

   i. Receive this update report

Reason: To keep the Board informed on progress in improving support for children's mental wellbeing in the city.

Contact Details

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

Report Approved ✓ **Date** 03.03.2023

Wards Affected: All **All** ✓

For further information please contact the author of the report

Background Papers:
Children's Mental Health report, November 2022:
https://www.healthwatchyork.co.uk/wp-content/uploads/2022/11/Nov-22-Childrens-mental-health-a-snapshot-report-FINAL-2.pdf

Annexes
Annex A – Update report
https://www.healthwatchyork.co.uk/wp-content/uploads/2023/03/Childrens-Mental-Health-update-report-March-2023.pdf

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Children's Mental Health

An update report, March 2023

healthwatch York

Contents

Acknowledgements: Cover photo cropped from an image by Katherine Chase on unsplash (child next to a tree looking out over a beach)

Background

In November 2022 we published a snapshot report detailing what people had told us about children's mental health support in the city. This included detailed feedback from a number of parents, local teachers, and VCSE partner organisations.

The report contained a number of key findings, and recommendations for Health and Wellbeing Board partner organisations. The report was presented to the Health and Wellbeing Board on 16 November 2022.

The discussion was minuted as follows:
Members considered a report which provided a summary of what people have recently told Healthwatch York about accessing children's mental health support. The Manager of Healthwatch York detailed the report and explained that it is a discussion around the City's approach to children's mental health and how it is able to make people feel more confident to access the help and support they need. She also discussed the need to analyse how the system works to ensure children get help and support, but that they are also aware of the options available to them.

The Director of Operations and Transformation for Tees, Esk and Wear Valleys NHS Foundation Trust welcomed the feedback from the report before acknowledging communication issues mentioned by families in accessing support and noting that partnership working and having numerous routes of access is very important. He also explained that long waiting times continue to be an issue with young people waiting 12 weeks for a mental health assessment, 2-3 weeks for an urgent referral, and 1-2 years for a neurodevelopmental assessment.

Members discussed the report and argued that the iThrive model and the Child and Adolescent Mental Health Services are not communicated, and not understood well by parents and that further support is necessary by

the NHS. The Director of Operations and Transformations for NHS explained to Members that there have been changes in the Trust so there will be a focus on improving the services provided alongside giving families and schools increased support. He then agreed to provide a projected timeline of when these changes would occur and when results will be seen to the Board.

The mental health of students was discussed, with Members stating that York needs to pay closer attention to them due to their vulnerability, with particular support necessary for ethnic minorities and those part of the LGBTQ+ community. Members discussed the need for the prevention of some of the causes of mental health issues too.

Resolved:

i. That the Healthwatch York's report, Children's Mental Health: A Snapshot Report is received by the Board.

ii. That the Board Members are reminded to respond directly to Healthwatch York within 28 days regarding the recommendations made to their organisation.

iii. That Healthwatch York provides an updated report to the Board following the end of their consultations.

Reason: To keep up to date with the work of Healthwatch York and be aware of what members of the public are telling them.

Resolved:

i. That Tees, Esk and Wear Valleys NHS Foundation Trust provide a projected timetable for changes and results to Members of the HWBB.

Reason: To keep the Board updated with the NHS's projects and policies in relation to children's mental health.

Key findings in November's report

A summary of our findings:

- The current process lacks the flexibility to recognise the individual needs of parents and children; for example some families struggle with appointments being given during school drop off and pick up times.
- There is a need for better awareness of training and resources available to teachers, schools and those involved in the initial referral
- The pathway through the referral process is unclear, and the reliance on forms prior to, or instead of, conversations can leave parents and professionals ill-informed on how best to assist moving the referral process forward
- There is a clear need for better administration processes
- There is heavy reliance on self-advocacy or parental advocacy to make sure the child can access the care they need
- It is unclear to parents what triggers a CAMHS diagnosis and in which circumstances you should be signposted to other services
- There is a need for more effective partnership working between organisations working to support children's mental wellbeing

Recommendations made

Healthwatch York worked with York Minds Youth Group to review the experiences gathered within this report. The group have set recommendations based on these experiences. These recommendations come from young adults who have, or who are currently, using mental health services.

Actions needed	By whom
1. Provide teachers with support when completing referral information on behalf of a child. Giving an understanding of what information is needed, why, and how this relates to special educational needs or disabilities, and educational health and care plan.	TEWV and CYC
2. Hold a conversation at the first point of contact with CAMHS outlining service options and the expected journey following referral.	TEWV
3. Provide information on 'who, what, why, when' as part of their journey to receiving support. E.g. who will you see, for what and why that decision has been made.	TEWV, CYC, YH&CP
4. Improve administration processes in accordance with current GDPR.	TEWV
5. Address staff capacity in order to support staff with answering parents', childs, and professionals' questions through the referral pathway.	TEWV
6. Better signposting support. On first contact with CAMHS, direct individuals to relevant training and information workshops available.	TEWV, CYC, YH&CP

Initial responses included in the report

Tees Esk and Wear Valleys NHS Trust (TEWV)

TEWV confirmed "We use all parts of the working day so appointments will be offered during school drop off and pick up as well as other times of the day. We have to maximise the use of clinical time. What works for one family will not work for another, but there also needs to be a better understanding that for a specialist service, in the same way as for other specialist appointments in acute hospital settings, outpatient clinics have to run to maximise appointment time."

They also questioned why there would be a lack of clarity as to what triggers a CAMHS diagnosis. They clarified that a diagnosis can only be provided following the assessment and information gathering process and provided by a qualified clinician.

In response to some concerns, we made a number of changes to the report to better explain data and reflect the wider CAMHS workforce.

City of York Council, Education and Skills Directorate

CAMHS is not the only support that is available for children and young people and families where there are concerns about mental health. The School Wellbeing Worker Service, which is jointly funded by City of York Council and health is a universal service working with all primary and secondary schools in York. The service provides a wide range of support including whole school training and individual casework and group work sessions in schools. The Wellbeing in Mind team (NHS funded Mental Health Support Team) works with 8 schools (primary and secondary) to provide interventions both in school and also with families. City of York Council have commissioned additional counselling support from York Mind and also commissioned York Mind to deliver the Department for Education Wellbeing for Education return resources to schools between 2020 and

March 2023. All secondary schools in York have accessed the Department for Education Senior mental health leader training in the last year.

The case studies in the report do highlight a need to ensure that there is better communication about the different ways that children, young people and families and teachers can access support in York. In the case of teachers this is important as very often SENCos and pastoral leaders are aware of the support available but this information may not be as accessible for class teachers and subject staff in secondary schools.

York Health and Care Partnership

The comments in the report appear to relate solely to specialist CAMHS services, which are commissioned to treat children and young people with moderate to severe mental health difficulties. The report does not reference the wider and long standing CAMHS offer in York which is commissioned across the NHS and City of York Council. This includes

- School Well-Being Service
- Wellbeing in Mind Team
- The support service working with children with complex needs arising from autism
- The embedded mental health nurse working with the Youth Justice Service
- York Mind's counselling service.

The report should also reference within the definition of CAMHS the work of third sector organisations who support the emotional and mental well-being of children and young people, such as The Island or IDAS.

All the above have an important preventative as well as therapeutic role: the delivery model in York is iThrive, which focuses on what enables children and young people to manage their emotional ups and downs and know and be confident in seeking advice and help when they need it. Thus the approach, particularly in schools and fostered by the School Well-Being Service, is focused on what makes for a thriving and nurturing environment. Resource is put into other support, all with a role in

prevention and early intervention: this includes the All About Autism Hub run by York Inspirational Kids, an autism social prescriber, and a mental health social prescriber due to work in primary care in an early advice and intervention role.

The Integrated Care Board, as successor to Vale of York Clinical Commissioning Group, has a firm commitment to children and young people's mental health and well-being, alongside the City of York Partnership of statutory and third sector agencies in the City.

Responses for the Health and Wellbeing Board

Tees, Esk and Wear Valleys NHS Foundation Trust

City of York Council

Humber and North Yorkshire Health and Care Partnership

Update March 2023

Since the report to the Health and Well-Being Board, Healthwatch York have had discussion with CYC, ICB and TEWV to consider the recommendations made. The following are key points from those discussions, which indicate progress to date and where further progress will be made:

Helping deliver the iThrive model

We acknowledge that there is work to do on helping make sure children's mental health is everybody's business. Although there is a lot of support already available in schools, the whole schools workforce may not be fully aware of the most appropriate support for each child. The SENDIASS (Special Educational Needs and Disability Information and Advice Support Service) role can play an important part in providing impartial, confidential advice to children, young people and their families. There is a need to improve awareness of the potential role SENDIASS can play in providing support to schools to understand their legal responsibilities towards children and young people with special education needs and/or disabilities.

Waiting times at CAMHS: we acknowledge there is still work to do to improve this further but waiting times are heading in the right direction:

- Significant improvement in autism assessment waiting times over 2019: average wait is now 150 days, down from 315 days

- Improvement in waiting times for initial assessment across all referrals, currently average 25 days, down from 90 days.
- Positive feedback about all Children's Mental Health services – CAMHS, School Wellbeing Service, Wellbeing in Mind – has been received, through the friends and family test, and service feedback forms. couple of examples

New Things in place

Well-Being in Mind Team: we have approval for a second team in York, which include a focus on children electively home educated or struggling to get into school.

Yorminds website: a co-produced offer for children and young people aged 12 and above, with advice, signposting and articles.

Broadened York Mind counselling offer for children and young people, now from age 12.

Autism social prescriber in post, working with children and families awaiting assessment or in receipt of a positive diagnosis.

Autism mythbusting
FAQs which show what the facts are for children and families in York
https://www.yor-ok.org.uk/families/Local%20Offer/autism-mythbusting.htm

Improved CAMHS assessment waiting paperwork and signposting – please see the appendices for details

The ICB Children and Young People Mental Health Plan sets out the actions across the ICB: in York we are setting up a multi-agency delivery group to prioritise and move the plan. Some of the actions in the plan are reflected below.

Things planned

There is no lack of ambition for the emotional and mental well-being of children and young people in York. The inception of the ICB is now bringing the commissioning resources closer together in the Place Board, and the York Place Prospectus emphasises children's health and well-being, and the challenges facing the 'Covid Generation'. It focuses on preventative and early support.

The overall system ambition is to move to an integrated approach, with a single route into support across primary care, schools, and the wider community offer. There are a number of models for this approach which can reduce cross referrals, waiting times and ensure children and young people have more rapid access to advice and support. We have some of the building blocks in place, and some of the ideas set out below will further support this. Not all are approved and scoped, and not all are funded.

- Primary Care First Contact Worker to support children in primary care before a referral on to CAMHS and improve CAMHS/primary care liaison
- Family Hubs will roll out from June 2023 and offer advice and signposting alongside the development of access to early advice, particularly for parents of babies and young children Improve joint working and commissioning: this is necessary, both for the health and well-being of our children and young people, and also for the best use of scare resources we have available.
    - Operational delivery group for York Place, we aim to have 1 plan and see it through to completion with joint commitment and planning. There are limited quick wins, mainly in how we communicate across all our partners.
    - Opportunity to explore options / preferences for potential peer support and initial information and advice. This is an excellent opportunity to work more closely and directly with HWY support in engaging young people / parents in this.

- Explore enhanced offer for children whilst they are waiting for support: this is across all levels of need not just the specialist CAMHS service.
- Better explanation of pathways to help children, young people, families and professionals understand what support is available and that emotional and mental well-being is not just a matter for the NHS: also, to set expectations; for example, what happens if you pay for a private assessment but then wish to return to the NHS pathway

Challenges

There remain significant challenges:

- Resources: time to devote to analysis, planning and strategy; funding is frequently time limited, and there are multiple demands and priorities; people as staffing in frontline services may be below establishment levels and are stretched.
- Redistribution of funds where pump priming not an option: there is limited or no scope to twin track funding whilst new approaches are trialled and embedded
- Nature of transformational change; it takes time, patience and can be a rocky road

Final thoughts

We are all agreed that children, young people, families and professionals are right to be concerned when they feel that there is insufficient support available or that they are waiting people.

We are also committed to finding approaches across the whole of the system in York, not just health where a lot of children are automatically referred, but also into school and social activities.

We are also looking to focus more on preventative and early intervention work, this takes time because funding has historically been directed at specialist services.

This will translate into work that can enable us to communicate better, provide more information on how to look after emotional and mental well-being and what is the support available when things are not right, whilst we do further work on more challenging, systemic and long-lasting changes

Tees Esk and Wear Valleys NHS Foundation Trust

Direct responses to the recommendations made

Recommendation 1: It was disappointing to see this recommendation as the support requested is already available. It is easier for schools who are working alongside a WiMT team as they have access to them but there is also the Wellbeing in Schools Teams. Both do a significant amount of training in schools supporting teachers. They offer direct work, signpost to other services and support, and assist with referrals. An example would be the consultation clinics WiMT offer. At the clinics a teacher can come to discuss a child in confidence (so no names) and check if it would be an appropriate referral to WiMT or if it needs to go elsewhere in the system. These also provide an opportunity for learning generally and to pick up useful strategies and information.

Recommendation 2: We currently have an on-going piece of work with our SPA team. This includes looking at how we process referrals, communication with referrers and signposting options if the referral is not right for TEWV CAMHS. This also links to the work on educating the system as we receive a lot of referrals that we would not offer a service to and should have been referred to other providers. This includes looking at our service leaflets that covers the point below as to who we are and what we provide. This is all part of a larger piece of work that is due to be completed by the end of August 2023.

Recommendation 4: This is also part of the SPA work referenced above. We can also say that all staff must complete as part of their mandatory training Information Governance training. Compliance is monitored by managers.

Recommendation 5: Staffing is a National problem in the NHS so not sure how reasonable this is as an action to increase staffing numbers. In York we have seen an improvement in our vacancy rates more recently and are successfully appointing to previous long-standing vacancies but this will remain an on-going concern as we are also seeing an increase in referrals and acuity, especially ADHD/ASD and demand is outstripping capacity. In relation to support there is a need for pre and post ASD diagnostic support for parents in York that is not something TEWV is commissioned to provide.

Recommendation 6: This is also part of the SPA work referenced above but also something for all agencies to be part of. Important to consider collectively whether this is just about better signposting or also identifying gaps in service.

Humber and North Yorkshire
Specialised Mental Health, Learning Disability and Autism
Provider Collaborative

Humber and North Yorkshire Specialised Mental Health, Learning Disability and Autism Provider Collaborative (HNYPC) response to York HWBB Report relating to Children's' Mental Health

The HNY PC are working closely with the Integrated Care Board (ICB), and local place partners to ensure that when a child or young person (CYP) requires admission to a mental health unit that this is embedded as part of a whole pathway.

Building on the iThrive approach, work is focusing on improving the pathways in and out of inpatient care, with a particular focus on reducing

length of stay (as it is known that lengthy inpatient admissions are not always helpful) and keeping young people as close to home as possible so that they can maintain relationships with community CAMHS and social care professionals.

Current programs of work to meet the increasing pressures following COVID:

1. Eating disorder.

There has been an increase in the number of CYP needing inpatient admission for eating disorders, including naso-gastric tube feeding. HNYPC have worked hard to ensure CYP who require admission receive this and as such a higher number of out of area admissions have been necessary to ensure needs are met and best outcomes are achieved for CYP. HNYPC has allocated significant additional funding and is working with providers to develop the following:

- Flexible alternatives to admission to hospital including intensive home treatment for eating disorder
- A whole pathway approach to eating disorders with earlier robust prevention of naso-gastric tube feeding requirement
- Prevention of admission to hospital
- Support for early discharge and reduction in length of stay by working with community teams to level up service provision
- Developing protocols and improving communication with paediatric/medical units in managing eating disorders in CYP.

2. Develop an integrated referral hub for CYPMHS inpatient referrals

Currently the two inpatient teams in HNY PC (Mill Lodge and Inspire) assess referrals for their respective place based providers. The access assessment process involves ensuring all necessary information is gathered prior to making a decision regarding whether admission is the

appropriate next step and if further assessment is warranted (e.g., CETR information, copies of detention papers etc.) and this is done from existing capacity and can cause delays and frustration for young people, their families and referrers. All referrals are currently discussed in a weekly meeting with both units and decisions made regarding the most appropriate environment for each young person based on the young person's needs, distance to home and capacity of the units. Work is planned to develop an integrated referral hub:

- To provide a central point for all referrals for inpatient admission to be managed and responded to in a timely manner.
- Improve consistency of response and develop a clear understanding of thresholds for admission and appropriate referrals with community partners.
- Reduce the number of inappropriate referrals/admissions.
- Ensure that referred young person's needs are met in the most appropriate environment as close to home as possible.
- Provide ongoing support/guidance to community referrers whilst a young person is awaiting admission.
- Provide discharge planning support and input to the inpatient and community teams to ensure there is a clear and timely discharge plan with appropriate support available post discharge.

NHS England Regional Information Provided on any relevant policy and approaches

- The Healthwatch York Report on Children's Mental Health highlights the significant challenges experienced by many children and young people in trying to access Child and Adolescent Mental Health Services (CAMHS) in York. The strong presence of children and young people's voices throughout the report and the emphasis on lived experience is extremely important and very welcome.
- This report is useful in further reiterating these challenges and the difficulties faced by children and young people. Increasing timely access to high quality, evidence-based mental health services for

children and young people continues to be of the utmost priority regionally and nationally.

- Information has been provided on the national picture below and additional context but it is recognised that many challenges exist and the difficulties faced by children and young people and their parents and carers remain.

National Policy Picture

A number of Long Term Plan Ambitions and recent NHS England communications relate to the themes highlighted within the report. Key elements are shared below with NHS England's continued commitment to increasing access to mental health services for children and young people.

- Key ambitions and policy areas specifically relating to improving access to CYPMH services include:
    - Increasing access to children and young people's mental health services: By 2023/24 at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams.
    - This builds upon the Five Year Forward View for Mental Health commitment that at least 70,000 additional children and young people each year will receive evidence-based treatment – equating to 35% of those with diagnosable mental health conditions using 2004 prevalence data.
    - Mental Health Support Teams in Schools (MHSTs) offer evidence-based interventions and contribute to the attainment of the national 345,000 ambition for access.
- As highlighted in the recent 2023/24 Operational Planning Guidance, NHS England is continuing in its commitment to deliver the Long Term Plan including core commitments to improve children and young people's mental health services supported with funding.

- NHS England's Quality Improvement Taskforce has launched a resource pack that aims to improve understanding of the current care and treatment offer for children and young people with mental health needs, learning disabilities and/or who are autistic, with a specific focus on pathways of care into hospital beds, as well as the experience of inpatient care. The resource pack aims to support professionals to develop their local case for change around pathways of care to increase and improve community provision and reducing unnecessary inpatient admissions and can be found on the FutureNHS Platform.
- As part of the increasing access ambition, the importance of expanding the CYPMH workforce remains. NHS England were pleased to recently announce the publication of the Children and Young People's Mental Health (CYPMH) Workforce Census 2022, which highlights a 5% increase nationally in whole time equivalent (WTE) staff across CYPMH services between 31 March 2021 and 31 March 2022.

Additional Context

We would also suggest that the refreshed Humber and North Yorkshire CYPMH Strategic Plan would be a useful resource to view in order to further understand the ICB's commitments and priorities within this area. Mental Health - Humber and North Yorkshire Health and Care Partnership

Appendices

Appendix 1: TEWV Yes letter

Appendix 2: TEWV list of support options for York sent to parents / children to assist with waiting well

Appendix 3: Cocreation leaflet

Appendix 4: Examples of positive feedback about Children's Mental Health Support Services

Appendix 5: Further useful links

Appendix 1: TEWV Yes letter

Orca House
Child and Adolescent Mental Health
Link Business Park
Osbaldwick Link Road
York
YO10 3JB

Main Reception: 01904 420950
East Team: 01904 420970
West Team: 01904 420980
EDT: 01904 615343
SPA: 01904 615345
Email address: tewv.orcahouse@nhs.net

Ref: FG/
Date:
Parent(s) of

Dear Parent(s)

Name:		**DOB:**	
Address:	**As above**		
PARIS ID:		**NHS No:**	

Further to the recent referral of Child's name, we are writing to inform you that we have now received the completed Autism screening forms and they have been reviewed by our Neurodevelopmental Screening Panel.

Following the information which has been provided, we have agreed to place Child's name on our waiting list for a full specialist Autism assessment.

Unfortunately, there will be a significant wait for this assessment due to the high demand on service.

Once your child reaches the top of the waiting list you will receive a letter inviting you to attend for the diagnostic assessment appointment, and included will be details of what this will entail.

Once the autism assessment has been completed, you will be signposted to further appropriate support in your area and discharged from the CAMHS service, unless there are additional concerns regarding mental health, which are felt to reach the threshold for ongoing CAMHS involvement.

We have enclosed a leaflet which details all the support options available to you whilst you are waiting for the assessment. This support is available both pre and post diagnosis therefore we would recommend familiarising yourself with this whilst your child is awaiting the assessment.

In the meantime, while you are waiting for an appointment to be sent to you, should you have any increased concerns regarding your child please do not hesitate to contact CAMHS directly within office hours – 09104 420950 – or outside of office hours, and if you have increased concerns regarding your child's mental health/risk and feel your query is urgent, please call 08000 516171 to speak to the CAMHS Crisis Team who are available 24 hours a day, 7 days a week.

Alternatively, if you feel your concerns require an urgent response, please go to the Accident and Emergency Department at York Hospital.

Yours sincerely

Dr Fiona Gospel
Consultant Clinical Psychologist,
On behalf of CAMHS Neurodevelopmental Panel

Copy:
GP –

Appendix 2: TEWV list of support options for York sent to parents / children to assist with waiting well

Support options available in York

Please find below a list of support options available to you both pre and post diagnosis whilst you are awaiting your child's assessment of Autism.

1) Courses and information to help you understand your child's difficulties

This is an important first step to help you understand and know how to support your child who is possibly on the Autistic spectrum:

- ✓ **ADAPT course** - See poster for details
- ✓ **Open University** – They provide a free online course to help people understand Autism https://www.open.edu/openlearn/science-maths-technology/understanding-autism/content-section-overview?active-tab=description-tab
- ✓ **York Inspirational Kids** – (see below), they sometimes run training courses and the specialist teaching team for Autism running specific modules every month to learn more about Autism and how to support this.
- ✓ **National Autistic Society** – They offer a wealth of information, videos and articles on their website to help parents and young people learn what is Autism and how to support this.
- ✓ **Family matters** – time out for parents of children with additional needs. Parents can sign up to this course and it will help to support families to understand how to adapt parenting for children with additional needs https://fmy.org.uk/course-we-offer/
- ✓ **Books** can also be an excellent way to learn about Autism, some recommendations include:

"The Autism Discussion Pages" by Bill Nason (you can also follow their social media pages)
"The girl with the curly hair" – she has a range of publications and helps to explain Autism in a very easy to understand way
"How to live with Autism and Asperger Syndrome: Practical strategies for parents and professionals" by Chris Williams and Barry Wright
"The parents guide to managing anxiety in children with autism" by Raelene Dundon – this is an excellent book for helping parents manage anxiety in their ASC child
"How to make and keep friends, tips for kids to overcome 50 common social challenges" by Nadine Briggs and Donna Shea and "How to find your groove (conversation skills and other tips for surviving in the social world) by Laura K.Cornish

2) Link in with York Inspirational kids parent support

This is a parent led service which offers a range of parental support across the city and supports the development of services for disabled children. It brings together all parents and families across the city who care for a child with a disability and provide online peer support along with days out and a Saturday club. They can be accessed by searching "York Inspirational Kids" on Facebook. You can also search "York Ausome kids" which is a subgroup of York Inspirational Kids and aimed at parents/carers of a child with a diagnosis of Autism and "YIKs all about Autism" page which has details of the ASC hub. Information can also be found on the website www.keyworking.co.uk
Specific support which YIK can provide:

- ✓ **Coffee mornings for parents** to help support each other and gain peer advice. This can also be done via the Facebook threads where parents ask questions and other parents provide guidance and advice.
- ✓ YIK work closely with other organisations such the **specialist teaching team for Autism and the Educational psychologists**. They offer telephone and in person drop ins on a monthly basis where

parents can ask advice on how to manage a multitude of behaviours and difficulties. The specialist teaching team also run workshops for parents once a month about specific topics (eg: friendships, coping with holidays). Details can be found on the Facebook page.

- ✓ **The Autism Hub** provides groups for autistic young people to come together and socialise and engage in activities. They are run in person by volunteers and provides a good opportunity for young people to socialise and engage with peers. Groups are run from primary age up to 25 years. More details can be found on the YIK Facebook page.

3) Have a look at the SEND Local offer

All local authorities have a responsibility to outline a plan of how they intend to support young people in their area with additional needs. This plan is often referred to as the "local offer" the York local offer webpages has a wealth of information relating to health, education, social care and support for families. They also have a Facebook page which is helpful to follow ("York Local offer"). It is advisable that you familiarise yourself with this offer of support. You can google "York disability local offer" or go to website: https://www.yor-ok.org.uk/families/Local%20Offer/sendlocaloffer You can also refer yourself to the family information hub if you are struggling with understanding what support can be accessed. You can call 01904 554444 and speak to someone about what to do to get more support and guidance.

Please note, the SEND local offer goes up to the age of 25 so is particularly useful for young people about to transition into adult services.

4) Are you struggling to manage some behaviours which challenge in the home?

We would recommend first completing the courses recommended above around understanding Autism, in particular the ADAPT course and putting

in place the adaptations recommended. We would also recommend linking in with the local offer and familiarising yourself with the support offered by the local authority.

We would also highly recommend linking in with York Inspirational kids and attending the drop in sessions offer by the specialist teaching team for autism and the educational psychologist. We would also recommend attending the monthly training sessions provided by the specialist teaching team. The training session offered by Family Matters may also be helpful in understanding how to parent a child with additional needs (see above in courses). You can also self-refer to the Autism Community Connector and Engagement Team (ACCET) who can help connect you with support in the local area (see poster below)

If you have done all the above but you are still struggling, then it may be helpful to go back to the SENCO and further discuss the difficulties at home. The SENCO then may be able to request a family early help assessment to look at what other support may be helpful for your family.

Alternatively you can self-refer to the early help team for more support by calling the multi-agency safety hub (MASH team) on 01904 551900 or the family information service on 01904 554444

5) Is your young person struggling with sleep and needing more help with this?

Please note: The CAMHS Service cannot provide sleeping medication (such as Melatonin) where sleep is the main difficulty.

Alternatively you can access further support for sleep difficulties from the Sleep Charity. They have a wealth of resources, videos and information leaflets on their website to help you put in place a robust sleeping routine and a dedicated national helpline which can give further advice and guidance: https://thesleepcharity.org.uk/

6) Is your young person struggling with social isolation and loneliness?

Social isolation is very difficult for children on the spectrum as they struggle to fit into more mainstream activities due to their needs. There is however a wealth of opportunities which are adapted for young people with Autism which may provide opportunities for socialisation

- ✓ **The ASC hub** – YIK provide social groups from primary school up to the age of 25 on a weekly basis. The groups are an opportunity to meet other young people who have similar needs and opportunities to socialise, make friends and participate in outings. Please see their Facebook page for more information.
- ✓ **Choose2Youth** – they are an organisation which provides opportunities for training and socialisation for all young people who have a disability in the city. They cater for children between the ages of 9-25 and have a wealth of activities they can join in with: https://choose2.co.uk/
- ✓ Many **mainstream organisations** in the city now provide disability friendly options for engaging with the activities. Ask about sensory friendly hours and additional needs sessions they may provide. For example: Point zero have an autism friendly hour between 5-6pm on a Thursday and many cinemas have autism friendly screenings. More informaiton can be found through the York Inspirational Kids parent thread.
- ✓ **Speak to your SENCO** at school around opportunities for engaging in clubs or further support sessions to develop social skills

7) Is your young person struggling with sensory difficulties which are impacting on day-to-day life?

Sensory difficulties are a part of everyday life for children on the spectrum and can be quite disabling in many ways. Sensory difficulties are often covered in the teaching resources about Autism so there is a

wealth of information which can be accessed (see ADAPT course, national autistic society and book recommendations)

If you are wanting more support, we would recommend accessing the Sensory integration network for more specialist advice. They provide a wealth of courses and information for parents. Click on the website and go to the parents/ carers section at the top. They provide a free course in understand sensory needs in children and how to understand/ support these - https://www.sensoryintegrationeducation.com/collections/courses-for-parents-and-carers2

8) Is your young person struggling at school?

School difficulties are very common in children with Autism. The mainstream environment can be very difficult for some children to cope with and may need extra support to cope with the demands of this environment.

If you are worried about schooling and there are significant difficulties, the following can be advised:

a) You can make an appointment to speak with the SENCO and discuss your concerns in more detail

b) If you would like further independent advice, you can contact the SENDIASS service who can provide independent advice and support around education and special needs. They also have a very robust and informative website with a wealth of information which parents can access: https://www.yorksendiass.org.uk/

c) You can also access the specialist teaching team for Autism directly via one of the drop in sessions provided through York Inspirational Kids.

What is the Autism Community Connector and Engagement Team (ACCET)?

The Autism Community Connector and Engagement Team in North Yorkshire and York aims to improve the health; well-being and independence of families with children and young people who are awaiting or have recently received an Autistic diagnosis to strengthen pathways of support. The core principles of the service are:

- To provide free, time limited, targeted, support
- To promote independence and facilitate self-help
- To work alongside families to build their confidence and skills
- To facilitate self-assessments and make referrals where appropriate.
- To complement existing services
- To provide practical advice, information and support

Social Prescribers spend time with families on a one-to-one basis to identify what is important to them, what potential networks of support they have and what their priorities are. They will work with families to achieve positive outcomes that are important to them. There isn't a definitive list of 'things' that the Social Prescriber will do because it is a personalised service and it will vary as to what the individual wants to achieve. Some examples of support are:

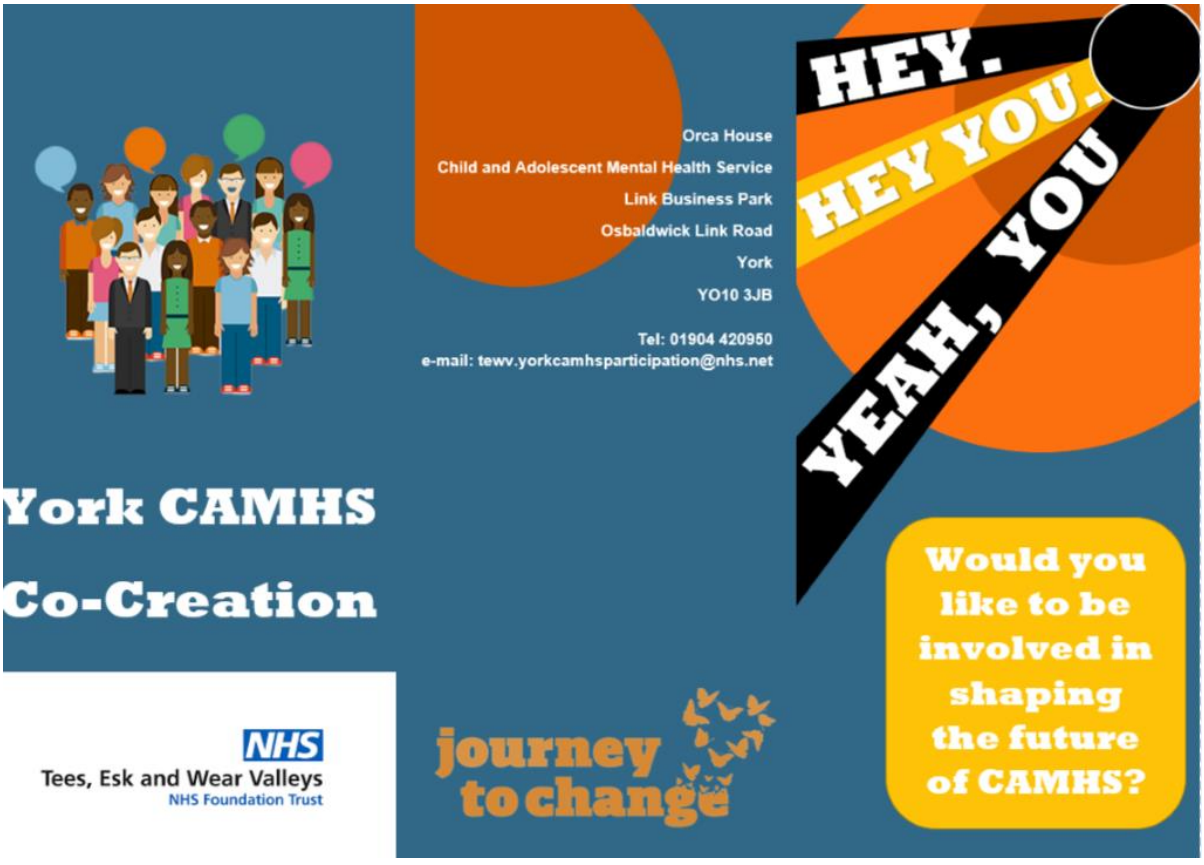
- Support to build self-confidence
- Support with practical advice and skills
- Helping a family to be connected to, linked with or signposted to services and networks in their area.

Who can access support from the Autism Community Connector and Engagement Team? This service is currently available to families who have a child and young people with autism diagnosis or those who are currently going through the diagnostic process. As this service is currently a pilot, it

is available only to families based in Harrogate, Hambleton/Richmondshire and City of York localities.

For further details about the project please contact: Ruth Little ruth.little@northyorks.gov.uk

Appendix 3: Cocreation leaflet



Appendix 4: Examples of positive feedback received about Children's Mental Health Support Services

Feedback regarding the MHSTs in York Schools

"During their time in school, the Wellbeing in Mind Team have provided our children and staff with highly effective support and input via staff training, consultations and 1:1 direct work, workshops and group intervention. The entire team has shown a commitment to improving well-being provision in our school and their knowledge and practical advice has been well-received by everyone. A strong partnership has been formed between school staff and the Team and their direct and indirect input is having a positive effect on children, staff and families"

Nicola Jones, Head Teacher, Clifton Green Primary School

"Direct work; most young people are finding it really helpful... Majority go from intense pastoral support to check-ins and universal support once they have had direct work with you."

"I think that anxiety will still happen at times, but I know now what to do and I know it does get better."

"Pastoral managers in school are more skilled and comfortable in talking about low mood and anxiety with parents".

"We really appreciate the time you spent creating the resources and the time today delivering to staff. The resources for the school website are excellent and again much appreciated."

"I would just like to take this opportunity and thank you for your work with the Wellbeing Anxiety base group you have delivered over the last 10-12 weeks for Year 7 learners".

"The work I did with you helped me get my confidence back in my parenting abilities."

"He is normally quite quiet and a bit reserved, but she really connected with him."

"I like how people don't know me as *that* person in college. I really like it here, I like my course, and my mum and dad are really proud of how I have settled in".

"And thank you so much to you and your lovely colleagues for the care you give and for making me feel at ease. You do a fantastic job"

"Thank you for the update and the plan. This is really useful. I will meet with ..... in the next week or so and talk over it with her so is knows that we are aware of this in school."

Feedback for ASC social prescriber

"There have been lots of challenges so good to know help is on the way and I appreciate everything you have done for us. Thanks."

"Your support has been invaluable when looking for nurseries for X, thank you."

"The resources you have shared have been really useful and my child's behaviour at home has settled down, which is great as it was putting a lot of strain on the family."

Feedback for Autism Hub – All About Autism

"My son never goes anywhere, but said he would give this a go. Wow. He joined in. He actually joined in. I can't believe it. Thank you for your patience with him, he will be back."

"I like this club. It's for kids like me and that's good cos I don't have to talk to anyone."

"I like the animation session. I can't wait to get started properly."

“He never settles well and is extremely anxious, but the staff are amazing with him.”

Feedback for School Well-Being Service

“I want to say thank you. I love my strategy cards. This was my favourite thing to do. I can feel calm and ask for help in the class.”

“I have noticed a change in my pattern of distorted thoughts and can recognise both my positive thoughts and feelings and improve my negative ones.”

“It was nice for someone to talk to about my feelings. Sleeping and eating are a lot more better.”

Feedback for Specialist CAMHS Support

“The support we have received has been brilliant”

“A very good experience, the staff were all very pleasant and reassuring at all times.”

“Check in phone calls and visits were upheld over Christmas period as per plan set out by community team.”

“Really helped us through crisis, didn't just abandon us, [Staff name] is outstanding, everyone very kind and professional.”

Appendix 5: Further useful links

Autistic Girls Network is a registered charity working to support, educate and bring change. They have a number of resources on their website: https://autisticgirlsnetwork.org/

This includes a list of reasonable adjustments possible at school: https://autisticgirlsnetwork.org/wp-content/uploads/2022/09/AGN-Reasonable-Adjustments-Possible-at-School-Standard.pdf

And a student passport template: https://autisticgirlsnetwork.org/Student_Passport_Template.pdf

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YO1 6ET

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Health and Wellbeing Board 15 March 2023

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 Collaborative 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 2022/2023 cover, prevention, ageing well/frailty, mental health and children and young people, all of which align with the 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.

9. There are no other implications.

Recommendations

10. The Health and Wellbeing Board are asked to:

    i. 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 Collaborative 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 ✓ **Date**

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex A – Report of the Chair of the York Health and Care Collaborative March 2023

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Annex A - Report of York Health and Care Collaborative; Update March 2023

1. Introduction

This report provides an update on the work of the York Health and Care Collaborative (YHCC); briefly outlining the scope of each priority workstream.

2. Progress on Priorities;

The responsibility for leading health promotion and prevention activities across the city is with City of York. YHCC provides a forum to share population health intelligence across wide ranging provider and commissioning partners, including York CVS, and identify where a collaborative approach can increase the impact and effectiveness of interventions.

a) **Substance misuse**; drugs and alcohol; an update was provided to YHCC on alcohol misuse, an area where overall York performs poorly on most indicators. When looking at the whole pathway for alcohol, York is not well placed regionally or nationally. There is a high number of admissions that are alcohol related and people attending health care settings with serious injuries related to alcohol is higher in York than in other areas. 84% of people with alcohol related problems are not thought to be receiving the care that they need. An overview of the support services available in York was shared with all attendees at the November YHCC meeting.

   There is a delay in people accessing help with drug and alcohol use as there is a stigma. As a result, it is common that people aren't seen until they reach crisis. NHS Addictions Provider Alliance have run a campaign called 'Stigma Kills' to raise awareness. Details of the campaign were shared with YHCC attendees in November.

   Between 2018 and 2022, almost 50 people died from drug misuse, this is higher than the national average.

CYC are working in partnership with other organisations to bring these figures down and encouraging people to attend safe needle exchanges.

There is an increasing number of people accessing Changing Lives to discuss dependency on prescription drugs (primarily opiate based). The York City PCNs are working collaboratively to reduce the prescribing of dependency inducing medication.

b) **Homelessness**; As reported to the Health and Wellbeing Board in November, YHCC continues to consider the impact of the Cost of Living on the most vulnerable individuals. The group continues to discuss the ways in which access to care is impacted by deprivation.

In November, a representative from Arclight attended YHCC. Arclight is a service that offers health care to homeless people in York and runs as a 2 hour GP clinic once a fortnight and 2 hour nurse sessions on Thursdays. The care offered is different to that offered in other health services as there are often multiple issues to pick up at once. It is necessary to see patients in a range of locations including hostels or even parks.

When considering how homeless people access care differently to others it was highlighted that there is often an issue for (previous) drug users attending secondary care to have their blood taken for tests. They are often passed between individuals until they find someone who is able to successfully draw blood, this often makes people reluctant to attend. As a result of discussions at the meeting, a process has since been put in place for individuals to have their blood taken by an expert in a primary care setting rather than having to attend hospital.

c) **Deprivation;** In York work is being done to support food banks, grant access to free school meals and look at how to offer better heating through winter. There needs to be a better understanding in York around what services are

available and any gaps that currently exist. A representative from YHCC attended the York Financial Inclusion Group in February to present the work that YHCC has done around deprivation and the cost of living, including how staff within health and social care are impacted. In discussion, it was identified that there are a number of common interests between the two groups and that more needed to be done to achieve positive discrimination for financially excluded groups. Work is ongoing to ensure the priorities of YHCC and the Financial Inclusion Group are linked going forwards.

2.1Ageing Well, Frailty and Multimorbidity

a) Ageing Well and Frailty

The YHCC Frailty Steering Group continues to meet regularly, the aim of the group is to understand how to code frailty and ensure that the coding is readily accessible to all health care professionals supporting frail people. Updates from the frailty steering group:

- A second frailty workshop has been scheduled in March 2023 to look at the services available for individuals assigned a Rockwood score 5 or 6. Following the workshop a leaflet will be produced and shared with health care staff to give details on what services can offer and the referral details. A process for identifying and recording gaps in frailty has also been agreed, as a result of the initial workshop.
- The original objectives set by the group were to increase identification of patients with frailty, establish a consistent way of assessing the level of frailty (Rockwood) and promoting the widespread use of frailty scoring amongst health and care providers. The group has now made significant progress against all of the objectives outlined above.
- Going forward the group will be supporting the design and implementation of an Integrated Community Frailty SPA Hub in York.

3. Future work and further development of York Health and Care Collaborative in 2022/2023

3.1Priority Setting

As previously reported, YHCC will be focusing on the 10 priorities outlined by the Health and Wellbeing Board throughout 2023:

- Reducing the gap in healthy life expectancy
- Mental wellbeing
- Smoking
- Alcohol
- Healthy weight
- Inequality groups
- Suicide/self-harm
- Diagnosis gap
- Physical activity
- Social connection

The March YHCC meeting will aim to align the priorities of the Health and Wellbeing Board (HWBB) with the York Health and Care Partnership (YHCP) and determine the role that YHCC will take in helping to deliver the desired health outcomes at place.

Health and Wellbeing Board 15 March 2023
Report of the Manager, Healthwatch York

Healthwatch York Reports: Dementia Support – Listening to People Living with Dementia in York

Summary

1. This report aims to complete reporting of the work undertaken to help shape the dementia strategy through local engagement.

Background

2. Healthwatch York works with partners to explore the challenges people are experiencing in the city. A report was previously shared which focused on the experiences of those supporting people living with dementia. This report brings together other work completed.

Main/Key Issues to be considered

3. The dementia strategy is now in place. The main issue is to make sure people can still be involved in the monitoring of progress against the action plan for delivering the strategy.

Consultation

4. This report and the engagement work undertaken was developed working alongside organisations working with people with dementia and their carers. This report was originally intended for publication in Spring 2022 but was delayed to focus on maintaining involvement in the strategy development. Now the strategy has been launched, this report is being published to make sure everyone's contribution is acknowledged.

Options

5. The report is for information only and as such there are no options to consider.

Strategic/Operational Plans

6. A Dementia Strategy for York was launched in Autumn 2022.

Implications

7. 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

8. There are no risks associated with this report.

Recommendations

9. The Health and Wellbeing Board are asked to:

   i. Receive Healthwatch York's report, Dementia Support: Listening to People Living with Dementia in York

   Reason: To keep up to date with the work of Healthwatch York and acknowledge the voices heard during the development of the Dementia Strategy.

Contact Details

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

Report Approved ✓ **Date** 03.03.2023

Wards Affected: All **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex A – https://www.healthwatchyork.co.uk/wp-content/uploads/2023/03/Listening-to-people-with-dementia.pdf

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Listening to people with dementia

March 2023

healthwatch York

Contents

Acknowledgements

Thank you to everyone who took time out to respond to our survey and to all the organisations that have helped to develop this report, including Joseph Rowntree Foundation, Joseph Rowntree Housing Trust, NHS Vale of York Clinical Commissioning Group (CCG), York Minds and Voices, Beetle Bank Farm, York Dementia Collaborative, City of York Council, Age UK York, Dementia Forward and the Alzheimer's Society York and Selby Branch.

Background Information

Dementia facts and figures

Dementia is a term used to describe a variety of symptoms including memory loss, problems with reasoning, perception and communication skills. Different types of dementia include:

- Alzheimer's disease;
- Vascular dementia;
- Dementia with Lewy bodies;
- Frontotemporal dementia.

A progressive condition with no cure at the current time, it is the leading cause of death in England.

In 2022 Public Health England (PHE) estimated that there were 850,000 people with dementia in the UK. This means that 1 in every 14 people aged 65 years and over has dementia. This figure is expected to increase to 1 million by 2025 and is forecast to increase to over 1.6 million by 2040. More than 40,000 people in the UK under the age of 65 are affected by dementia.

It is estimated that a quarter of people in acute hospitals and three quarters of the residents of care homes have dementia, yet 200,000 people with moderate and severe dementia do not get any kind of funded or professional support.

The local picture

There are an estimated 2,812 people over 65 living with dementia in York; one in twenty people over 60, and one in five people over 80 has a form of dementia. Of those 2,812, only 1,554 people have received a diagnosis. The dementia diagnosis rate for York is 55%; the average for England is 62%.

This suggests that some people living in York are not receiving a dementia diagnosis in a timely way;

"York has a larger than national average gap between the expected prevalence of dementia within our population, and the actual number of people diagnosed. Primary care has a challenge to proactively seek and assess people who may be at risk and identify the condition as early as possible to ensure the right people get the right support at the right time."

<Extract from Dementia Together; A 5-year Dementia Strategy for the City of York - September 2022>

A 5-year Dementia Strategy for the City of York was launched in September 2022 by a partnership of local organisations. The strategy seeks to 'transform the approach to dementia in York' the key aims of aims are based on the National Dementia Well Pathway:

- Preventing well; the risk of people developing dementia is minimised;
- Diagnosing well; timely and accurate diagnosis;
- Supporting well; support plan and review within the first year;
- 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.

The strategy includes a programme of targeted support for GP practices to increase the rate of diagnosis, providing access to dementia support workers across the city, and the development of a new Dementia Hub.

York Minds and Voices Dementia Strategy

York also has a user-led dementia strategy for the city – the York Minds and Voices Dementia Strategy, created in November 2020. The key themes from this have been adopted within the city's formal strategy. You can read the strategy in full here:

https://www.dementiavoices.org.uk/wp-content/uploads/2015/04/THE-YORK-minds-and-voices-DEMENTIA-strategy.pdf

Sources:

Office for Health Improvement and Disparities (OHID) Guidance Dementia: applying All Our Health - February 2022
Health and Social Care Committee's 7th Report 2021-22
NHS Digital - Sept 2022 and November 2021
Alzheimer's Society York Profile - 2021
City of York Dementia Strategy 2022 - 2027

Project Background

Why are we looking at dementia?

At Healthwatch York we frequently hear from people with dementia and those who support them about the difficulties finding or getting the right support. In 2020, Healthwatch York received funding from the Joseph Rowntree Foundation (JRF) to develop a project for people living with dementia.

Previous work at Healthwatch York

Since Healthwatch York formed in 2015, we have had the opportunity to hear the views and experiences of people living with dementia by working directly with people affected by the condition and their carers. In 2017, Healthwatch York worked alongside Minds and Voices to run focus groups to understand how York City could be made more dementia friendly. In 2019, as part of the NHS Long term plan project, we ran a focus group for people with dementia and carers to listen to their views on priorities. Between 2018 and 2021, we had contact with 38 members of the public who raised concerns around support for people living with dementia and their carers. Many people told us about their difficulties of getting the right support when dementia needs had become more complex.

During the Covid lockdown in March 2020 we undertook welfare calls in collaboration with York CVS. We spoke to people living with dementia both via a hotline number and through lists provided to us by GPs.

This project aims to build upon what has been learned so far and to continue the conversation with York residents who have dementia, and their carers, friends and families.

Challenges and limitations

We were keen in this project to listen to residents with lived experience, carers and families of people with dementia and the many groups and organisations who support them.

The project took place during a period of uncertainty caused by the Covid-19 pandemic. Though we hoped that face-to-face engagement would become increasingly possible during the later months of the project, it continued to be problematic. Many groups for people living with dementia had not yet re-started. Keeping people safe and not exposing them to any unnecessary risk were paramount. As such, we had to work creatively and flexibly in order to spread the word and reach out to people living with dementia and their carers. However, we are acutely aware these challenges and constraints prevented us from reaching as many people living with dementia as we would have wanted. Thus we were unable to provide the face-to-face engagement so necessary for many individuals to be able to take part.

What did we do?

When the York Dementia Action Alliance spoke to people directly affected by dementia and professionals working to support them, they found five key areas needing improvement. These were:

- Improved accurate and early diagnosis
- To have a post diagnostic pathway of support
- For services to work together better
- The development of carers' support
- A positive campaign for living with dementia

The questions in this survey ask for people's experiences as well as what could be improved in these five areas.

We attended a group run for people living with dementia at Beetle Bank Farm to listen to the views of members. Some members talked to us about having a diagnosis; others preferred to talk about having memory problems. The group members are all involved in working at the farm, taking part in various tasks which support its running, including caring for the animals or various farming and gardening projects.

We worked closely with the group and the group's organiser prior to attending to make sure our approach was accessible and appropriate for members. The group organiser helped us to adapt our project, and their help and insight was vital to create an effective way for individuals in this group to share their thoughts or experiences with us in a relaxed and positive way.

We had a few conversation topics which were shared with members before we attended. On the day, we listened to members of the group talk to us about their work on the farm and the different ways they felt it supported their health and wellbeing. We also heard about some good and bad experiences of support from health and social care services.

Some people preferred to talk whilst they were busy doing an activity so we listened whilst helping out with some of the tasks of the day. Others liked to talk within a larger group and shared some thoughts and experiences with each other over tea and coffee during the breaks.

After the group, we gathered all the feedback under a few key headings and sent it back to the group to make sure we hadn't missed anything. The group told us that they had been pleased with the process and said:

"*Thank you very much for offering the info. It's helpful that people are here listening to me and not laughing at me.*"

We are very thankful to the group and its organiser for the time and support they gave us for this project.

Our Findings

We have grouped people's feedback into five key areas:

The importance of being with other people

Participants told us that being part of a small group helped to build their confidence through talking and being with others. They told us about the importance of having a laugh and a joke and being around good people.

Meeting people dealing with similar situations allowed people to see how they coped and that in turn supported them to cope better. Participants said that they wanted to talk to people about their issues with others who could understand, not people who just ask a lot of questions.

People were able to share their knowledge and interests with each other and many members of the group had extensive knowledge about gardening and plants which they were able to draw on and share with others.

Being in the group also allowed some members that personal time which then helped with relationships and stresses at home or with family.

Some reflections on difficulties

Participants shared how they sometimes had difficulty getting sentences out. They described how their thoughts could be difficult to deal with. One person referred to it as though their "mind sometimes feels like it's exploding."

People shared the difficulties around this making you feel aggressive at times and how it can often end up being directed at loved ones. One person talked about how sometimes they just had to go into "survival mode" and had to find a strategy to deal with things.

The group felt that having someone to talk to about their issues would be helpful.

Some group members tend to tell people that they have dementia and others told us; "*I say memory problems, I don't say the word*".

Using activity to support wellbeing

Members of the group shared with us the positive effects that taking part in the group and its activities had on their wellbeing. People spoke about it providing the opportunity to have time away by yourself and time to be yourself. Some described it as being good to be able to take a break from others/family at times. One person described it as: "*somewhere to be me: I just want to be me.*"

The group provided opportunities for people to do things that interested them. Some spent time with animals which they found enjoyable and relaxing. "*Touching is a lovely side of being with animals.*"

Gardening was also an interest to many. "*Things that we can see growing and can give us pleasure.*"

Members of the group enjoyed being outside and told us they went out in any weather. They spoke about the feeling of achievement from the jobs done.

Having the right support/services at the right time

At some points members of the group reflected on support they had experienced in health and social care. They told us about the importance of having services that were able to respond quickly to any change and were able to provide the right support.

They spoke about support from their GP surgeries and felt that the ability to get in touch with them is impossible at times: "*It is no good when they call you back 2 days later or something. You need to talk to someone 'in the moment'. Once they call you back so much later you might have forgotten. You need a quick response.*" Participants spoke about how it was a different GP all the time and so difficult to build any relationship.

Equipment services such as 'Be Independent' were said to have been very useful in some cases. People felt that equipment which could alert any dangers to local services or loved ones offered them some peace of mind and reduced their anxiety.

Some participants felt it was useful to have supportive services and other groups of interest nearby, especially if they were easy to reach and were easy to get to, also having other people to facilitate involvement was important.

For this group in particular, the members enjoyed the variety of activities they could be involved in, how they could take part and how much or little they could attend. Some people preferred to come for the whole day and others preferred half days. They stressed the importance of independence and how *"you need a bit of time on your own so you can get your brain thinking."*

Impact of Covid

Many members had lost some connections to other groups and social activities they had been involved in before the pandemic. Many felt a loss of confidence which came from not being able to attend their regular groups and the disruption of not being able to get to the activities that they had usually attended.

Other Engagement Work in the City

Sheila Fletcher, NHS Vale of York Clinical Commissioning Group ran a series of workshops in December 2021/January 2022 at a variety of locations including Deans Garden Centre Carers Group, St Clements Hall Dementia Cafe, Minds and Voices and Beetle Bank Farm. Key themes included:

Timely diagnosis

A real mixture of experiences with some people having 'very quick referral and assessment' and others experiencing a long wait before their GP

referred them. One person waited four years and was misdiagnosed several times until a brain scan confirmed young onset Alzheimer's. One patient had a family GP with understanding of the patient's past history and immediately recognised dementia; this patient had a very quick referral and assessment. Another patient's GP referred to the condition as 'just old age'.

Access to good health care

Again there were mixed responses from people trying to access health care, but many reported a lack of routine annual physical health monitoring, and a lack of coordination between health care professionals:

- Complications when admitted and discharged from hospital;
- Delirium meant delay to diagnosis;
- Memory assessment suspended when patient admitted to hospital;
- Multiple long-term conditions managed OK, but dementia overlooked;
- Mobility issues prevented people participating;
- Health checks for Long Term Conditions don't always consider dementia diagnosis;
- Feedback generally indicated people were left to fend for themselves after their initial diagnosis.
- Overall feedback that there were gaps in coordination between social workers and care. People reported often going to their GP as first point of contact and often not getting information from a social worker on care assessments or home care/support
- Feedback about gaps in coordination on discharge from hospital and a long wait for practical support at home.

Feeling listened to

There was some positive feedback about individual GPs but overall people had to make multiple phone calls. Online access was not felt to be helpful or 'user friendly', and many preferred a telephone call when they were able to get through:

- Regular call from friendly GP staff would help';
- Dementia Forward ‘a lifeline’;
- Some people objected to word ‘dementia’;
- Some people found the diagnostic process confusing. Four people didn't even realise they were being given a diagnosis;
- One person gave positive feedback about the Police and Yorkshire Ambulance Service for understanding and care of people with dementia.

Able to plan for the future

Some people reported having ‘no formal support: people generally had to source information themselves’, ‘just given leaflets and left to fend for themselves.’

Feeling connected to others

People wanted opportunities for banter, activities, trips, outings, physical and verbal contact, singing groups, musical connections and food. Helpful links included: voluntary and community and not-for-profit sector, faith provision, word of mouth, courses, peer support and learning from others. Also, opportunities to participate in research bring hope.

Participants emphasised the importance of local shops, libraries and bus drivers understanding the needs of people with dementia.

People felt more positive about dementia when they can participate and that personal care needs shouldn't be a barrier, for example, improving incontinence supplies.

Some people don't feel connected anymore to their local communities and the impact of covid has been profound;

- Carers' isolation: 'at the end of their tether';
- Impact on physical health: ‘couldn’t see GP’;
- Fear of covid; ‘what if carer succumbs?’;
- 'Don't go out anyway so covid made no difference';

- A sense of feeling abandoned;
- No opportunities for stimulation resulting in cognitive decline.

Suggestions for improvements

- Better information about young onset, especially the middle to late stages (which are often the stages people don't want to talk about) including issues around behaviour and incontinence;
- A clear and simple pathway through end of life care;
- An annual review including carers;
- Improved coordination between GPs, social workers and hospital;
- Education and awareness all round to create dementia friendly communities;
- More opportunities for peer support;
- More opportunities for social connections and activities especially music and singing;
- Opportunities for age-appropriate activities;
- Respite for carers;
- Idea of a centre for care provision: a hub providing personal care, respite for carers and age appropriate.

Case Studies

Case studies: **Young onset dementia**
All names have been anonymised Period: May 2021 - April 2022

Paul was 58 years old and living with his wife Julie in their home in York when they referred Paul to Beetle Bank Social Farm in May 2021. Paul had been diagnosed with young onset vascular dementia in 2018 and was mildly impaired cognitively. He was physically able but was also living with multiple medical conditions including mental health difficulties.

Paul and Julie got in touch with our service to help find something for Paul to keep his mind active and to continue to do things he enjoys. Further outcomes they identified were to help support Paul's physical wellbeing and his mental health. Julie was also living with mental health difficulties so it was hoped that Julie would also benefit if Paul received support.

Paul has been a manual worker much of his life and held various jobs where lifting and labouring were part of his role. He also served in the army for many years. Since leaving the army Paul has spent a lot of his working and leisure time outside and is a keen gardener at home, growing his own fruit and vegetables there. With the social farm being a predominately outdoor-based service providing access to many of Paul's abilities and interests, it seemed an appropriate referral for Paul.

Paul and Julie could not afford the full fees and transport costs to attend Beetle Bank Social Farm and would not have been able to join us without a subsidy. Paul did not meet the criteria for social care funding or for a health budget. Fortunately, a grant from Social Prescribing was available and a trial period was agreed with the potential to access the service with a 50% subsidy and full transport costs for six months. Social prescribing is a way for local agencies to

refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. Social Prescribers connect people to community groups and statutory services for practical and emotional support*. They could afford to pay the remainder of the fees.

Because the symptoms of his dementia were mild, he was able to take on a planning role in his involvement at the farm. He has decided what he'd like to do and has helped to develop his experiences at the service from the outset. For example, Paul took ownership of an area of land next to our cabin at the farm which he organised and maintained. We purchased him a lawn mower with some available funds after he requested this and Paul now mows the lawn regularly. Paul has also brought various plants and tools of his own which he wants to share with the service and other service users. For example, he brought in rhubarb and pepper plants to plant and look after. Paul engages socially with others in the service and each week helps in farm maintenance roles of which he is knowledgeable and able. This placement enables Paul to maintain a valued and useful role and in turn helps the farmer maintain her farm at no extra cost to her. Paul was able to access another grant to keep his subsidy going for 6 further months.

Paul has expressed how much he likes the service and how well suited it is to him: "It's brilliant, I feel alive when I'm here". Paul has been enabled to stimulate and maintain his cognitive functioning by planning what he does at Beetle Bank Social Farm. He has also managed his emotional wellbeing and spoken about the impact dementia has had on him on numerous occasions. Paul also spoke about another unexpected outcome and commented how it enables him to handle his dementia: "It gets me out of the house and gives me a chance to meet people. Also gives me a chance to learn how to cope with my illness by observing other people". Julie has also been able to access regular respite for nearly a year.

Paul is planning to apply for a Personal Independence Payment (PIP) and if successful could use this to pay towards his place at Beetle Bank Social Farm after the subsidy period ends. Beetle Bank Social Farm are also applying for grants to enable continued subsidies but there is no guarantee we will access this funding. Therefore Paul's place is at risk of not being funded.

Written by Justin Mazzotta Dementia Practitioner at Beetle Bank Social Farm April 2022

*For more information about social prescribing in York please see https://www.yorkcvs.org.uk/social-prescribing-in-york/

Case studies: **Retired farmer**
All names have been anonymised. Period: March 2018 - May 2019

Derick, a retired livestock farmer aged 78, was referred to Beetle Bank Social Farm by the Community Mental Health Team in March 2018. Derick and his wife Linda lived together in their private house in a rural setting on the outskirts of York. Derick and Linda had been in conflict much of the time at home and the Community Mental Health Team were aiming to help alleviate tensions by enabling meaningful activity for Derick and regular respite for Linda. Derick was mildly impaired by his dementia.

Derick had been a livestock farmer his whole working life. Farming was a way of life for him and he had not had much time for other occupations or hobbies outside of this. Derick was very knowledgeable and interested in farm animals so a referral to Beetle Bank Social Farm was particularly suited to him because of the traditional farm animals on site where the service operates.

Derick was able to use his own financial savings to fund his placement. Attending the service Derick quickly settled and bonded with staff and

other service users there. He expressed a desire to be involved in the care of the animals at the farm and activities around animal care became a regular feature of the service. For example, he would feed the sheep and cows and other animals as well as muck them out. We would also frequently support the farm owner by helping her with maintenance jobs, also something familiar and meaningful to Derick. Derick was able to utilise his knowledge of animals when at the service and put this skill of his to good use; for example, he would observe the animals carefully and let staff know if there were any health issues which needed looking into. The service facilitator would then pass this information onto the farm owner to follow up on.

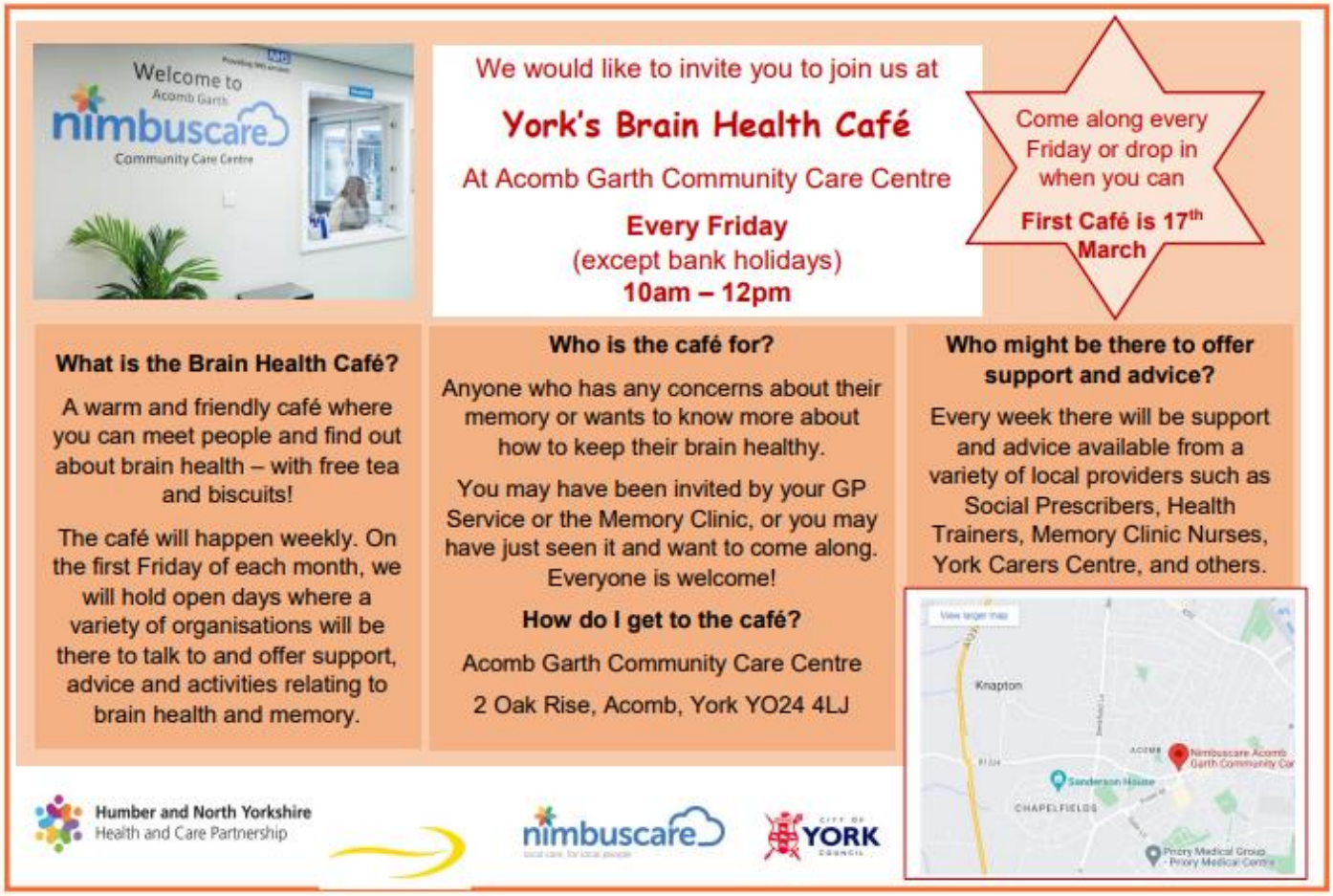
Derick would also gain social and emotional support at the service by being enabled to reminisce about his past with staff, volunteers and other service users. There were positive experiences in his life which staff and volunteers were able to reinforce and help Derick to maintain a positive self-image. Reminiscing was therefore a preserved ability and interest of Derick's which was tapped into during the service sessions.

Derick was able to engage in meaningful activity whilst attending a social farm. Many of the animals there were traditional farm animals and familiar to him, enabling meaningful activity and purpose. Derick was also able to hold onto a status of someone knowledgeable and important whilst attending the social farm. It's worth noting it would have been difficult to find other suitable placements for him since farming was such a large part of his life. Linda was able to access regular respite each week for over a year until Derick became seriously unwell and left the service.

Written by Justin Mazzotta Dementia Practitioner at Beetle Bank Social Farm September 2019

Commissioned Local Support

York's Brain Health Café



Dementia Forward – a wraparound dementia support service

Help Line

Open 9-4 Monday to Friday trained workers can provide emotional and practical support and can link people into other services.

Dementia Support Advisors - Dementia Forward are commissioned by City of York Council and the Integrated Care Board to provide a wraparound dementia support service. The help line is the portal to teams of Dementia Support Advisors who support families from pre diagnosis to end of life with advice, information, education and wellbeing activities.

"It is comforting to know that there is someone to ask along the way, as the disease progresses, who has the knowledge and experience and understands"

Dementia Care Coordinators - In addition Dementia Forward have Dementia care Coordinators working with GPs in primary care to support people to get a diagnosis. The team are run by Dementia Forward's specialist Dementia Nurse. This work supports the need to address the low diagnosis rates in York but also to support people while they are on waiting lists.

"Thank you so much for sending all the information and for the chat. I can't tell you how much good it did just being able to talk to someone who understood. I will be speaking to the doctor today and with the information you have given me I will be able to put a plan in place."

Wellbeing cafes and Hub Clubs - In York Dementia Forward run 2 wellbeing cafes every week and 3 Hub clubs.
Hub Clubs provide a day of meaningful activity for the person diagnosed while the carer has a day of respite from their caring role. The days are run by trained staff and volunteers and activities vary from knitting and crafts to pool and table tennis.

"You understand better than most what we have to deal with. Being able to drop my wife off at the hub club this morning and sit here with my feet up, feeling confident that she is being properly looked after is brilliant."

Young onset dementia – Dementia Forward acknowledges the differences when a person is experiencing the symptoms of dementia under that age of 65. They run a specialist service for people with a young onset dementia diagnosis. As well as tailored advice and information they are able to provide family and friends education and can support employers of people who are still working age and living with the condition.

There is a weekly outward bound young onset day service and a weekly hub club specifically for people in this cohort.

"Instead of sitting in front of the television most of the day, Chris has been taken to a range of interesting places. The visits have helped her improve her use of language and enhanced her confidence. As a family it is a relief and support to know that our sister is being stimulated and supported in this way."

To access any of these services simply call the Dementia Forward Help line 03300 578592 or visit the website www.dementiaforward.org.uk

For more information about the support available in York, please see the Healthwatch York guide "What's out there for people with dementia, their families and carers" here: https://www.healthwatchyork.co.uk/wp-content/uploads/2022/07/HWY_DementiaGuide_June2022_low.pdf

York's Dementia Strategy

The City of York dementia strategy, 'Dementia Together', was launched in September 2022. The Strategy has been shaped by engagement with people in York, and those organisations who provide support to people with dementia and their family and, or carers. This includes the work shared in this report.

Dementia Together highlights the challenges and opportunities for the city in terms of preventing dementia (where possible), diagnosing it well, helping people to live and be supported well with the condition, and ultimately supporting people to die well.

The strategy is available in full here:
https://www.livewellyork.co.uk/media/oupdklz4/dementia-strategy-2022-2027-web.pdf
and as a plan on a page here:
https://www.livewellyork.co.uk/media/4irjjtqu/dementia-strategy-plan-on-a-page-web-accessible.pdf.

An easy-read format is being produced.

People who want to be kept informed and / or involved in work to deliver the strategy can register their interest by emailing ASCTransformationTeam@york.gov.uk, or for people who prefer to talk to someone, please call Helen Rowan on 07747 568107.

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