Notice of meeting of

Health Overview & Scrutiny Committee

To: Councillors Boyce (Chair), Fraser, Holvey, Kirk, Simpson-Laing, Sunderland and Wiseman (Vice-Chair)

Date: Tuesday, 20 July 2010

Time: 5.00 pm

Venue: The Guildhall, York

A G E N D A

1. **Declarations of Interest** (Pages 3 - 4)
   At this point Members are asked to declare any personal or prejudicial interests they may have in the business on this agenda. A list of general personal interests previously declared are attached.

2. **Public Participation**
   At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **5:00 pm** on **Monday 19 July 2010**.

3. **Update on Recommendations Arising from the Dementia Review (Access to Secondary Care)** (Pages 5 - 22)
   This report presents Members with an update on progress made in relation to implementing the recommendations arising from the 'Dementia Review' (Accessing Secondary Care).

4. LINks Annual Report and Reports Arising from LINks Public Awareness and Consultation Events (Pages 23 - 138)

This report presents Members with a copy of the Local Involvement Networks (LINks) Annual Report and together with reports arising from two LINks Public Awareness and Consultation Events on Dignity and Respect and End of Life Care.

5. Transforming Community Services (Pages 139 - 170)

This report provides Members with the opportunity to comment on a recent NHS North Yorkshire and York board paper, which provides an update regarding how Transforming Community Services is being introduced in North Yorkshire and York.

6. Joint Vision for Older People's Health and Social Care in York (Pages 171 - 184)

This report asks Members for their comments on the draft Joint Vision for Older People's Health and Well Being in York 2010-2015.

7. Work Plan (Pages 185 - 186)

To consider the Committee's work plan for 2010/11.

8. Urgent Business

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

Democracy Officer:
Name: Jayne Carr
Contact Details:

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- Email – jayne.carr@york.gov.uk

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

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

Contact details are set out above

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Agenda Annex

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The purpose of all scrutiny and ad-hoc scrutiny committees appointed by the Council is to:

- Monitor the performance and effectiveness of services;
- Review existing policies and assist in the development of new ones, as necessary; and
- Monitor best value continuous service improvement plans

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Agenda Item 1

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda item I: Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor Fraser	Governor of York Hospitals NHS Foundation Trust; Member of the retired section of Unison; Member of the retired section of UNITE the TGWU ACTS section.
Councillor Kirk	Governor of York Hospitals NHS Foundation Trust;
Councillor Simpson-Laing	Member of Unison An employee of Relate Works for the Disabilities Trust Member of York Healthy City Board.
Councillor Wiseman	Member of York Healthy City Board. Public Member of York Hospitals NHS Foundation Trust

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CITY OF YORK COUNCIL

Health Overview & Scrutiny Committee 20 July 2010

Report of the Head of Civic, Legal & Democratic Services

Update on Recommendations Arising from the Dementia Review (Access to Secondary Care)

Summary

1. This report presents Members with an update on progress made in relation to implementing the recommendations arising from the 'Dementia Review' (Accessing Secondary Care).

Background

2. Between July 2008 and November 2008 the Health Scrutiny Committee undertook a review of the experiences of older people with mental health problems (and their families/carers) who accessed general health services for secondary care in order to identify where improvements may be required.

3. Over a series of meetings, both formal and informal, the Committee heard evidence from a variety of sources to ensure that they built a comprehensive picture of experiences, barriers faced, and possible beneficial improvements to services. As a result of these inquiries the Committee formulated several recommendations.

4. Recommendation 7 of the final report of the Dementia Review requested that all service providers (City of York Council, NHS North Yorkshire & York, Yorkshire Ambulance Service and York Hospitals Trust) report back to the Committee in 6 months time to inform them of the progress made. The original recommendations, the 6 monthly updates as of June 2009, January 2010 and July 2010 are set out in the table contained within Annex A to this report

Consultation

5. Representatives from the following organisations were consulted and have provided updates and information for this report (Annex A refers):

   - Director and Staff in Housing and Adult Social Services Directorate at City of York Council
   - Representatives of NHS North Yorkshire & York
   - Representatives from York Hospitals Foundation Trust

- Representatives from the Yorkshire Ambulance Trust

Options

6. Members can:

   i. Consider whether they wish to sign off any of the recommendations as complete

   ii. Consider whether they wish to receive further updates on progress and if so at what intervals

Analysis

7. The information contained within Annex A to this report outlines progress made to date regarding implementing the recommendations arising from the Dementia Review. Members may wish to consider asking for a further progress update in 6 months time.

Corporate Priorities

8. This report and the information set out within it are directly in line with the Corporate Strategy theme of being a Healthy City – 'we want to be a city where residents enjoy long, healthy and independent lives.'

Implications

9. **Financial** – There are no known financial implications associated with the recommendations within this report. There may be some financial implications for all health service providers in terms of providing funding to develop the Psychiatric Liaison Service and training staff.

10. **Legal** – There are no known legal implications associated with the recommendations within this report.

11. There are no known Human Resources (HR), Equalities or other implications associated with the recommendations within this report.

Risk Management

12. There are no known risks associated with this report.

Recommendations

13. Members are asked to:

   a. Note the report and progress made on implementation of the recommendations arising from the Dementia Review.

   b. Consider whether they wish to sign off as complete any of the recommendations arising from the review

c. Consider whether they wish for further updates and at what intervals.

Reason: In order to carry out their duty to promote the health needs of the people they represent

Contact Details

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Andrew Docherty
Head of Civic, Legal & Democratic Services
Tel: 01904 551004

Report Approved ✓ **Date** 9th July 2010

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

Final Report of the Dementia Review

Annexes

Annex A Update on implementation of recommendations arising from the Dementia Review

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Progress Report on Implementation of the Recommendations Arising From the Dementia Review (Accessing Secondary Care)

Key:
HASS – Housing and Adult Social Services Directorate at City of York Council
PCT – NHS North Yorkshire & York (formerly North Yorkshire & York Primary Care Trust)
YAS – Yorkshire Ambulance Service
YHFT – York Hospitals Foundation Trust

Updates & Progress on Implementation - June 2009 & January 2010			
Recommendation 1 That the York Hospital Trust, in liaison with other appropriate service providers* be urged to develop and implement the Psychiatric Liaison Service. The development of this programme to be a benchmark for training and support for staff working with dementia patients who access secondary care.			
HASS/CYC	**June 2009** Officers from HASS assisted in putting a business case for a psychiatric team at the hospital, which was presented to the Older People's Partnership Board. However the funding for such a service had not been agreed with the PCT and there were ongoing debates about the most effective model	**January 2010 -** Funding should be 'owned' by the PCT	**July 10** – No further update from CYC

PCT	**June 2009** - The PCT has met with York Hospital and discussed the development of a liaison service. The PCT is assessing different models of service with a view to consulting with the relevant key stakeholders including service users and carers on the options available and draft service specification. A business case will then be drawn up for approval by the PCT's Integrated Commissioning Committee.	**January 2010** – The York Dementia Working Group has been established to include all key stakeholders in the implementation of the National Dementia Strategy. This includes the provision of liaison services. A service specification will be circulated for comment by the end of January 2010.	**July 2010** – A paper describing the development of a liaison service in to general hospitals has been put before York Mental Health Modernisation and Partnership Board, York Health Group and York Acute Trust. Data is being collected on current activity to provide more detail on the potential savings for the investment. The intention is to phase in the liaison services across North Yorkshire and York starting in York. However this is dependant on NHS North Yorkshire and York's financial position. We also expect all the acute trusts to demonstrate what other action they are taking to improve the experience of people with dementia and their carers before the liaison service is commissioned.
YHFT	**June 2009** - A proposal for a psychiatric liaison team for older people has been prepared and submitted to the commissioners in the PCT. They have responded by outlining that they are developing a service specification for this service and will issue this once it is complete.	**January 2010** – The situation remains unchanged. The proposal for a liaison team has been shared with the York Dementia Working Group (LIAG) and is supported	**July 2010** The service specification for a mental health liaison team has been circulated and feedback has been provided by elderly medicine
YAS	YAS responses for June 2009, January 2010 & July 2010 are set out at the end of this document		

Recommendation 2 That all service providers be urged to review their arrangements for staff training in relation to recognising and working with those with an underlying condition of dementia. Any such review should include: ➢ Promoting the use of Link nurses and investigating the possibility of nominating Link clinicians within defined staffing groups. ➢ Investigation of the larger gaps in training ➢ The utilisation of the variety of sources for training provision including the Alzheimer's Society and other voluntary sector organisations ➢ Investigation into the pooling of resources between service providers			
HASS/CYC	**June 2009** - Dementia training is part of the requirements for domiciliary staff and has been identified as a priority for care managers this year	**January 2010** – Dementia training has been made available to care managers since Autumn 2009 through a training programme and interest group discussion	**July 10** - No further update
PCT	**June 2009** - This is in line with objective 13 of the Dementia Strategy: An informed and effective workforce. Gaps in training will be considered by each locality as part of the assessment of localities against the strategy. Further use of the third sector, including the Alzheimer's Society, will be considered to provide training and education for both staff and people with dementia and their carers	**January 2010** – The PCT have included training requirements into its service specifications for provider services. The provision of training for all staff is being considered as part of the Dementia Working Group action plan	**July 2010** – The NY&Y Dementia Network set up two sub groups to focus on specific objectives within the dementia strategy. 1) Objective 8: general hospitals. Meeting of acute trusts dementia leads / Older Peoples Champions / Dignity and Respect Champions. The meeting highlighted several areas including training. Agreement that training of staff at all levels is required to the appropriate level and evidence of

	building on work already undertaken. The PCT will review the training requirements of staff for services it commissions to work with people who are at risk of dementia and their carers. This will be considered alongside Transforming Community Services		this is expected. 2) Objective 13 Workforce development. The group are piloting an e-learning package for staff from a variety of organisations. If successful, we are exploring the feasibility of including this within staff mandatory training to ensure all staff working with Adults/ Older people have training on dementia.
YHFT	**June 2009 -** In relation to the third bullet point of this recommendation – elderly services are piloting some training from the Alzheimer's Society on one of the wards and will review this.	**January 2010** – Awareness raising training held for a group of staff within elderly medicine. External training opportunities also being identified and supported	**July 2010** – staff are being encouraged to attend appropriate training.
YAS	YAS responses for June 2009, January 2010 & July 2010 are set out at the end of this document		

Recommendation 3 That secondary care provider clinicians be urged to acknowledge the positive contributions that can be made by a patient's carer to that patient's ongoing programme of treatment (whilst recognising the issues surrounding patient confidentiality). Clinicians are also urged to take the following into consideration: ➢ Where it is recognised that there may be an underlying mental health condition to provide written details of any medication and/or treatment plans to the patient ➢ The issue of carers' information being logged on a patient's notes to be urged as good practice and an ongoing dialogue between medical practices and the York Carer's Forum to be maintained to allow for effective databases to be kept.			
HASS/CYC	**June 2009** – no update	**January 2010** – The Carers' Strategy Group is sponsoring work between carers & York Hospital to develop a 'carer's passport' which will enable better communication and understanding of need.	**July 10** – The Carer's Strategy Group has received reports on the progress of the 'passport', which is being led by the hospital and is progressing
PCT	**June 2009** – no update	**January 2010** – The York Dementia Working Group has highlighted Carers as a priority area. We are looking to provide training / education sessions for carers to help them with practical tips to support those they care for and support themselves We will also work with the hospital to improve support for carers by sharing examples of good practice from other areas.	**July 2010** – The experience of carers was also covered in the meeting with Acute Trust dementia leads. Suggestion that the recommendations within the ADASS report 'Carers as Partners In Hospital Discharge', are implemented. Exploring the feasibility of building it into the contract with Acute Trusts.

YHFT	**June 2009** - Within elderly services a review is underway of written information given to all patients and carers to ensure it meets needs	**January 2010** – Work continues. As policies and procedures and patient information leaflets are reviewed amendments are made to reflect the needs of the patients who have dementia (as well as the needs of their carers). This is especially relevant in relation to flexible visiting times & supporting patients at mealtimes.	**July 2010 -** No new info to add – update remains as before
YAS	YAS responses for June 2009, January 2010 & July 2010 are set out at the end of this document		

Recommendation 4 a. That all service providers be urged to work with the relevant voluntary organisations (Alzheimer's Society, York & District branch of MIND, Age Concern, Older People's Assembly etc) to develop new initiatives and to promote the awareness of dementia (including the provision of an information leaflet for carers) b. That commissioner and service providers discuss the 'This is me' initiative further with the Alzheimer's Society with a view to adopting it within their individual organisations. The Committee wished it to be known that they were very impressed with this particular initiative			
HASS/CYC	**June 2009** - We are not aware of any new information having been produced for carers specific to dementia	**January 2010** – The Voluntary Sector are actively engaged in joint initiatives to develop services and a shared pathway of care for those with memory problems. Our own care homes are already working with the Alzheimer's Society to provide more personalised activities for residents. We will be asking the Independent Care Group to feature the 'This is Me' initiative in one of their newsletters to independent providers this year.	**July 10 -** The Independent Care Group (ICG) has continued to promote a number of initiatives including 'This is Me'. The Council and the ICG have also agreed to use £40k, which could have been considered as a way to offer a very small fee increase for care homes this year, for grants towards dignity, dementia or nutrition initiatives, Invitations for bids will be sought in the next few weeks
PCT	**June 2009** a. The PCT will encourage Providers to work with the voluntary sector through the inclusion of the voluntary sector in the development and implementation of care pathways for dementia/depression as well as the development of service specifications. b. The PCT would be happy to discuss	**January 2010** a. Third sector organisations are included in the York Dementia Working Group and are recognised as providing valuable support to those with dementia and their carers as part of the care pathway. The Map of Medicine for dementia	**July 2010 –** a) Meeting planned with CYC to explore more efficient commissioning of services from the third sector that is focussed on our priorities. The Map of Medicine has included voluntary sector organisations in to the care pathway for Primary Care to

	the 'This is me' initiative with Providers and the Alzheimer's Society and will consider how such initiatives are built into the commissioning of services in the future.	will be piloted in the York/Selby area. This will describe the care pathway and include health, social care and voluntary sector input. b. The PCT would be happy to discuss the 'This is Me' initiative with Providers and the Alzheimer's Society and will consider how such initiatives are built into the commissioning of services in the future.	raise the profile of the services provided by the voluntary sector. b) This links to recommendation 2 and 3 with an expectation that such tools will be used by Acute Trusts to improve the experience of people with dementia.
YHFT	**June 2009** a. Elderly services have set up an older people's liaison group which meets 4 times a year and is well attended by the voluntary organisations. Dementia updates are a standing item on the agenda. b. A meeting has been arranged in early July to discuss the use of the leaflet.	**January 2010** 'This is Me' leaflet pilot. YHFT have piloted the leaflet on a variety of wards. Information on progress is shared with the older people's liaison group as identified above.	**July 2010** - Extra leaflets have been ordered.
YAS	YAS responses for June 2009, January 2010 & July 2010 are set out at the end of this document		

Recommendation 5 That York Hospitals Trust, where possible, be urged to adopt a flexible approach during a dementia patient's stay in hospital, for example flexibility in hospital visiting hours and flexibility at mealtimes to allow carers to assist patients with eating.			
HASS/CYC	**June 2009** – No update	**January 2010** – No update	**July 10** – no update
PCT	**June 2009** – No update	**January 2010** – No update	**July 2010 –** NHS NYY are looking to see evidence of a dementia pathway of care using systems and processes that improve patients stay and the experience of their carers while their cared for is in hospital.
YHFT	**June 2009** - This has been discussed with all Ward Managers and Matrons in elderly services to ensure flexibility whenever possible and to allow carers to participate and help with meals. We are currently getting feedback from patients and carers on 2 wards with regard to experiences of their stay in Hospital in order to improve some of the processes and available information.	**January 2010** – A new Care Pathway has been drafted for patients admitted to elderly wards. This includes involvement of carers wherever possible, especially at mealtimes.	**July 2010** – as above and will be modified by the specialist mental health nurse due to commence post shortly A leaflet has been produced for carers and families of patients with regard to ward 37 – the joint mental health ward
YAS	YAS responses for June 2009, January 2010 & July 2010 are set out at the end of this document		

Recommendation 6 That all relevant parties be urged to resolve the ongoing issues surrounding the implementation of a universal 'Shared Care Record System'			
HASS/CYC	**June 2009** - A person held records pilot has gone ahead but take-up has been limited. The Council has provided funding to the York Health Group to quicken progress on single assessment but this is focused on intermediate care rather than dementia**.**	**January 2010** – Work on a shared pathway of care will include looking at how information can be better shared	**July 10** – No update
PCT	**June 2009** - The PCT are progressing the National IT Programme that will benefit patients and clinicians. Further information is available upon request	**January 2010** – No update	**July 2010** - The PCT are progressing the National IT Programme that will benefit patients and clinicians. Further information is available upon request Greater integration between health and social care staff would enable greater access to people's records – see additional comments.
YHFT	**June 2009** – No update	**January 2010** – YHFT is participating in discussions led through the LIAG	**July 2010 - As** above – an action plan has been produced with recommendations and is now going out for consultation prior to submission to the commissioners.
YAS	YAS responses for June 2009, January 2010 & July 2010 are set out at the end of this document		

Recommendation 7
That all service providers (HASS/CYC, PCT, YAS & YHFT) report back to the Committee in 6 months time to inform them of the progress that has been made.

Comments from YAS

June 2009

YAS has engaged with the Yorkshire and Humber Improvement Partnership to find ways that Primary Care, Social Services, the Police and Ambulance Service may improve partnership working in relation to mental health. This has manifested as three main work streams; conveyance under s 2 the Mental Health Act (1983), s 136 conveyance and assessment/treatment/transportation under the Mental Capacity Act (2005).

- Conveyance under s 2 MHA has been standardised across Yorkshire and the Humber using a template designed in collaboration with a multi-professional working group led by Humber Mental Health.

- Conveyance of patients detained by the Police under s 136 MHA is work in progress and various local protocols and facilities currently exist. However, in partnership with the Police it is hoped to develop a standard level of service to all patients in the region.

- Patients who are deemed to lack capacity are the greatest challenge to frontline ambulance staff and occasionally conflict arises between ambulance service personnel and other health and social care workers. To address this, YAS is undertaking a service-wide education programme, coupled with modification to the standard patient report form (PRF) to include mental capacity assessment. In addition, establishing partnership working through YHIP will ensure improved frontline multi-professional relations.

The latter work stream is of most relevance to the review of dementia in York as patients with dementia ought to be recognised as lacking capacity by our frontline crews and may be directed to alternative pathways of care as they are developed. In addition, there

is an opportunity for YAS to 'flag' the addresses of patients with dementia but, as this may be a significant number, it is likely to be associated with a commissioning need.

January 2010

YAS has now implemented the changes detailed in the report from the last meeting in the summer i.e. ambulance clinicians now carry documentation to allow them to record assessment of mental capacity and a protocol has been developed for treating patients who lack capacity to make decisions for themselves. Work is ongoing with the Yorkshire & Humber Improvement Programme (YHIP) to develop robust multi-agency processes for treatment of patients detained under S136 of the Mental Health Act.

July 2010

Work is progressing with the Yorkshire & Humber Improvement Programme to establish a multi-agency region-wide project looking at all aspects of capacity and Mental Health Act impact. There has been a noticeable improvement in working relationships with Social Services over the past year.

Additional Comments from YHFT (January 2010)

- YHFT will be participating in the RCP National Care Audit of Dementia
- YHFT have agreed terms of reference and membership of a Dementia Strategy Group which will be an internal group and meet quarterly
- Snapshot audit of numbers of patients in elderly beds in November 2009 with a diagnosis of 'dementia'/cognitive impairment – showed 50 patients (total bed base in elderly is 238)

Additional Comments from YHFT (July 2010)

- The Core Audit has been completed and we await national benchmarking results
- The dementia strategy group is now in place with user and carer input

- We have appointed a new specialist mental health nurse, as this post has been vacant since January 2010. Start date yet to be agreed.
- NICE have issued guidance on Quality Standards for dementia and there are 10 quality statements.

Additional Comments from the PCT (June 2009)

Since the completion of the Dementia Review final report in November 2008 the National Dementia Strategy has been released (February 2009). NHS North Yorkshire & York is currently liaising with key stakeholders to assess the current care and treatment of people with dementia and their carers against the seventeen objectives outlined in the strategy. This will result in an action plan for each locality, including York.

Additional Comments from the PCT (January 2010)

The PCT has discussed the development of a North Yorkshire & York Dementia Network with representatives from both City of York Council and North Yorkshire County Council. This Network is aimed at operational staff, service users and carers, voluntary sector and independent sectors to share good practice and develop the standards of care we want to see for our population. One initial meeting has been held and the next is planned for 3rd February. If anyone would like further information on this or would like to be added to the network mailing list please contact Judith Knapton at NHS NYY (judith.knapton@nyypct.mhs.uk or 01423 859622)

Additional Comments from the PCT (July 2010)

Yorkshire and Humber Health Improvement Partnership has held a Peer Review of dementia services in York. One of the areas for improvement highlighted by the team was the lack of integrated services between health and social care. Currently social care staff are not integrated with Community Mental Health Teams.

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Health Overview & Scrutiny Committee **20th July 2010**

Report of the Head of Civic, Legal & Democratic Services

LINks[1] Annual Report & Reports Arising from LINks Public Awareness & Consultation Events

Summary

1. This report presents Members with a copy of the LINks Annual Report and copies of reports arising from two LINks Public Awareness & Consultation Events on the following topics:

   - Dignity & Respect
   - End of Life Care

2. Members are asked to note the reports and provide any comments they may wish to make.

Background

3. The work plan for the York LINk for the previous municipal year (2009/10) was set at its Annual General meeting in March 2009. A series of Public Awareness and Consultation Events (PACE) were organised to undertake the work on the agreed work plan and to gather information and evidence on its chosen themes. Evidence gathered during PACE events is collated and presented in reports, which are sent to the appropriate health services and to the Health Overview & Scrutiny Committee.

4. At a meeting held on 23rd September 2009 the Committee agreed to formally receive future LINks PACE reports by way of them being included in Health Overview & Scrutiny Committee agendas.

5. Two of these reports are attached for Members' consideration today. Annex A is the report on Dignity & Respect and Annex B the End of Life Care Report.

6. In addition to this Annex C sets out the LINks Annual Report for 2009/10 which details work undertaken by the LINk last year. The Partnership Co-ordinator for the York LINk will be in attendance to present the Annual Report. A copy of the 2010/11 LINks work plan is also attached at Annex D for information.

[1] Local Involvement Networks

Consultation

7. The Public Awareness & Consultation Events were carried out in liaison with many people; these are detailed within each of the individual reports (Annexes A & B refer).

Options

8. The reports at Annexes A, B & C and the work plan at Annex D are for information only.

Analysis

9. Whilst Annexes A – D are for information only Members are encouraged to ask questions of the LINk representative and comment on the information received as part of today's agenda. There are no recommendations within either of the PACE reports that directly affect the Committee.

10. LINks were established by the Local Government & Public Involvement in Health Act 2007. Part of the Act (section 227) requires LINks to publish an annual report about their activities during the previous financial year and to send it to various bodies, one being the Local Authority Overview & Scrutiny Committee.

Corporate Strategy 2009/2012

11. This relates to the Healthy City theme of the Corporate Strategy 2009/2012.

Implications

12. There are no known financial, human resources, legal or other implications associated with the recommendations contained within this report.

Risk Management

13. In compliance with the Council's risk management strategy there are no known risks associated with the recommendations within this report.

Recommendations

14. Members are asked to note the reports at Annexes A, B & C of this report and the LINks work plan at Annex D and provide any comments they may wish to make.

Reason: In order to carry out their duty to promote the health needs of the people they represent.

Contact Details

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Chief Officer Responsible for the report:
Andrew Docherty
Head of Civic, Legal & Democratic Services
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Report Approved ✓ **Date** 9th July 2010

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A Dignity & Respect PACE Report
Annex B End of Life Care PACE Report
Annex C LINks Annual Report 2009/10
Annex D LINks Work Plan 2010/11

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Dignity and Respect in Health and Social Care Services

April 2010

Supporting your right to the best health and social services in England

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Dignity and Respect in health and social care

One of the times at which people are most in danger of losing their dignity and self-respect is when they need health or social care services. These services are provided when people are at their most vulnerable and so respect for dignity is particularly important.

The Dignity in Care Campaign was originally launched by the Government in November 2006. It aims to end tolerance of services that do not respect people's dignity by:

- Raising awareness and stimulating a national debate around Dignity in Care
- Inspiring and equipping local people to take action
- Rewarding and recognising those who make a difference

The Campaign was originally launched specifically to promote dignity for older people but its focus was extended to all those receiving health and social care services. As part of the Campaign, the Dignity Challenge was issued. Based on consultations with service users, carers and professionals, it lays out the national expectations of what constitutes a service that respects dignity. It focuses on ten different aspects of dignity – the things that matter most to people.

The Dignity Challenge

To pass the Dignity Challenge, health and social care services must:

1. Have **zero tolerance** of all forms of abuse
2. Support people with **respect**
3. Treat each person as an **individual** and offer them a service that suits their own needs
4. Encourage people to be **independent,** give them **choices** and give them **control** over their treatment.
5. **Listen** to the people being cared for and encourage them to **talk** about how they feel
6. Respect people's right to **privacy**
7. Ensure people feel they can **complain** without being worried about the consequences
8. **Engage** with family members and carers
9. Help people to feel **confident** and **positive**
10. Help **prevent** people from feeling lonely or isolated

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National Dignity Ambassador

Sir Michael Parkinson was named as Dignity Ambassador in July 2008. He agreed to help raise the profile of the campaign by bringing it to the attention of the public, saying: "I am honoured to take on this role as Ambassador for the Government's Dignity in Care campaign.

I have always had immense respect for the contribution older people have made to our country. Like many others I have experienced the care system in the past as the son of elderly parents.

Dignity is about being treated as an individual with respect and compassion. I intend to use my role to make a real difference and ensure the issue of dignity moves to the heart of all NHS and care services."

During his time as Dignity Ambassador Sir Michael visited many health and social care settings and met both staff and people using the services. He has written a report about his experiences, which was published in January 2010. The report is on the Department of Health's Care Networks website:

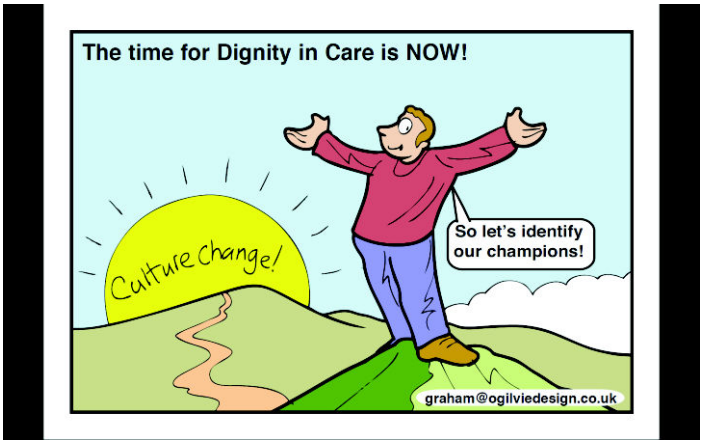
www.dhcarenetworks.org.uk/dignityincare/Ambassador/12345/

Dignity Champions

There is a network of well over 10,000 Dignity Champions set up by the Department of Health. These are people who are committed to taking action to create a care system that has compassion and respect for those using its services. The role of dignity champions varies depending on their knowledge and influence and the type of work they do. Dignity Champions include health and social care managers and frontline staff. They also include doctors, dieticians, porters, care workers in care homes, MPs, councillors, members of local action groups and Local Involvement Networks (LINks). People from voluntary and advocacy organisations, people who use care services, their relatives and carers are also becoming Dignity Champions.

Dignity Champions are willing to:

- stand up and challenge disrespectful behaviour rather than just tolerate it
- act as good role models by treating other people with respect, particularly those who are less able to stand up for themselves
- speak up about Dignity to improve the way that services are organised and delivered
- influence and inform colleagues
- listen to and understand the views and experiences of citizens



Further information about Dignity Champions is available from:

www.dhcarenetworks.org.uk/dignityincare/BecomingADignityChampion

The cartoons used in this report are part of the toolkit of resources which is available for Dignity Champions to use when promoting the Dignity Campaign.

Dignity and Respect on the York LINk work plan

Dignity and Respect was one of the issues on the York LINk work plan for 2009-10. The York LINk Interim Steering Group used a voting system to prioritise the work of the LINk and create the work plan for the year. A debate on the issues that had been referred to the LINk from a variety of sources took place during the 2009 AGM, and members then voted for their preferred issues. To try to include as many members of the community as possible, and have a recorded process that provided evidence for LINk priorities, the voting document was also sent to all registered members prior to the AGM and was available on request from the LINk office. Dignity and Respect was one of issues which was voted onto the work plan.

The Steering Group wanted to find out whether the people of York feel that they are treated with dignity and respect when they receive health and social care services. This includes hospitals, ambulances, clinics, doctors, residential care, day care services, respite care services.

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Dignity and Respect questionnaire and responses

To try to find out about the experiences of people in York around dignity and respect in services, York LINk designed and produced a questionnaire (See appendix 1), based on a respect and dignity checklist produced by The British Nursing and Midwifery Council (NMC).

From October 2009- February 2010 people visiting the York LINk stand at roadshows and other events were invited to fill in the questionnaire. It was also sent out to groups and organisations on the LINk's mailing list and was available to download from the York LINk website. People were asked to comment on a time within the last year when they or someone they know/care for received a health or social care service in York. The services could include hospitals, ambulances, clinics, doctors, dentists, residential care, day care services, respite care services. In total 90 questionnaires were completed and returned.

The questionnaire responses were as follows:

Question	Yes	No	Not sure
Did staff care **about** you as an individual? – not just care **for** you?	72	11	7
Were the staff courteous and respectful?	77	8	5
Did you feel safe and secure when you were there?	79	7	4
Were you, or someone who knew what you would want, involved when decisions were made about your care and treatment?	58	15	17
Were you happy with the treatment you got?	73	8	9
Were you given information about how to make a compliment or complaint?	29	44	17

Question	Not applicable	Yes	No	Not sure
If you were given a meal, did it meet your dietary needs?	53	24	7	7
If necessary, were you given help to eat and drink?	10	69	4	7
Did you get pain relief when you needed it?	33	43	7	7
Were your hygiene and continence needs met?	31	50	6	3

A response from 90 people is only a small percentage of the number of people who have used health and social care services in York during the past year. This small sample cannot be used to draw hard and fast conclusions, but it is a useful 'snapshot'.

The majority of people who responded to the questionnaire gave answers which indicate that their dignity was maintained and they were treated with respect.

11 of the respondents used the questionnaire to provide further details about their experiences of services. These have been added to the list of issues which have been referred to York LINk. This list is used to compile the issues voting form for LINk members to decide the next years work plan.

The responses to 2 of the questions indicate that there are some services which would not pass the Dignity Challenge:

- Two thirds of respondents (61) were not given, or were not sure if they were given, information about how to make a compliment or complaint.
- Just over one third (32) of respondents answered 'no' or 'not sure' to the question about whether they (or someone who knew what they would want) were involved when decisions were made about their care and treatment.

Both of these relate to ineffective communication. York LINk is already aware of a number of issues regarding ineffective communication, and communication is one of the items on the LINk 2010-2011 work plan voting form. Carers rights is also an issue on the work plan voting form.

It is hoped that a Carers 'passport' will be available in the near future which might assist with both of these areas.

Dignity Action Day February 25th 2010

Dignity Action Day was part of the national Dignity campaign. It was designated as a reminder that the dignity of people in the community is not the sole responsibility of health or social care staff.

One of the aims of Dignity Action Day is to ensure that people in care are treated as individuals, are given choice, control and a sense of purpose in their daily lives. Health and social care workers are asked to take action in their place of work to promote dignity. Members of the public are also asked to do what they can to promote dignity for people in their communities.

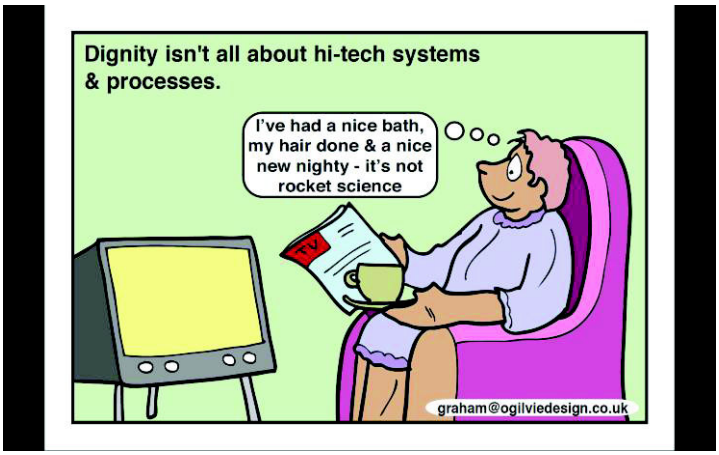
The LINk decided to use Dignity A e awareness of the importance of dignity in care with people in York. A display and stand was set up at Morrisons Supermarket, Foss Islands Road on 22nd February and at St Sampsons Centre for older people on 25th February. At both of these events members of the LINk Steering Group talked to shoppers and visitors about the Dignity Campaign and the role everyone can play in promoting dignity and respect in services.

Conclusions

Dignity and Respect is not an issue which should stand in isolation or be regarded as another 'flash-in-the-pan' initiative. The York LINk Steering group have pledged to make sure it is a fundamental part of all the LINk's future work plan items and will work to make sure that:

- Issues of dignity are embedded in the commissioning of health and social care.
- Health and social care services in York have policies in place to promote dignity and respect and are able to pass the Dignity Challenge.

To demonstrate their commitment to the Dignity Challenge, in April 2010 the York LINk Steering Group decided that all Steering Group members will sign up to become Dignity Champions.



York LINk has noted that awareness about the issue of dignity in health and social care services is increasing and has resulted in some practical actions which will really make a difference. The Design for Patient Dignity programme, led by The Department of Health and the Design Council, has brought together teams of leading UK designers and manufacturers to help solve privacy and dignity issues for patients. The LINk is particularly pleased to see that new hospital gowns, specially designed with dignity in mind, as well as practicality, will be available for hospitals to buy (at the same price as the old style gowns) from next year.

More information about the Dignity in Care Campaign, the Dignity Challenge and Dignity Champions can be found on the Department of Health website at:

www.dignityincare.org.uk

The Royal College of Nursing dignity campaign is described on the RCN's website:

www.rcn.org.uk/newsevents/campaigns/dignity

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Appendix 1 page (i)

York Local Involvement Network (LINk) has been set up to give everyone in York the chance to influence local health and social care services.

We want to hear about your experiences of health and social care services and your ideas for improvements and changes.

The local NHS, the City of York Council and other organisations provide our health and social care services – including doctors, dentists, hospitals, clinics and care homes.

We help local people and groups to influence the local NHS, the City of York Council and the organisations who provide our health and social care services.

One of the issues on the LINk work plan for 2009-2010 is **dignity and respect in health and social care**. We need to know the views of people in York – are you, or someone you know and care for, treated with dignity and respect when you receive health and social care services?

Please take a couple of minutes to complete the attached questionnaire. We want to know about a time within the last year when you or someone you know/care for received a health or social care service in York. This includes hospitals, ambulances, clinics, doctors, dentists, residential care, day care services, respite care services.

Completed questionnaires can be returned free of charge to:

York LINk
FREEPOST
Holgate Villa
22 Holgate Road
York YO24 4AB

Or you can return the questionnaire to the organisation/group who gave it to you. Please contact York LINk office if you would like additional copies of the questionnaire.

If you have any further concerns about the care that you or someone you know has received, please contact York LINk:

Telephone: 01904 621631 **E mail: admin@yorklink.org.uk**

Dignity and Respect in Health and Social Care

Everyone has the right to privacy, dignity and respect when it comes to health and social care. Think about a time within the last year when you or someone you know/care for have received a health or social care service in York. This includes hospitals, ambulances, clinics, doctors, dentists, residential care, day care services, respite care services.

Please answer the following questions:

Did staff care **about** you as an individual? – not just care **for** you?

Yes ☐ No ☐ Not Sure ☐

Were the staff courteous and respectful?

Yes ☐ No ☐ Not Sure ☐

Did you feel safe and secure when you were there?

Yes ☐ No ☐ Not Sure ☐

If you were given a meal, did it meet your dietary needs?

Yes ☐ No ☐ Not Sure ☐ Not applicable ☐

If necessary, were you given help to eat and drink?

Yes ☐ No ☐ Not Sure ☐ Not applicable ☐

Did you get pain relief when you needed it?

Yes ☐ No ☐ Not Sure ☐ Not applicable ☐

Were your hygiene and continence needs met?

Yes ☐ No ☐ Not Sure ☐ Not applicable ☐

Were you, or someone who knew what you would want, involved when decisions were made about your care and treatment?

Yes ☐ No ☐ Not Sure ☐

Were you happy with the treatment you got?

Yes ☐ No ☐ Not Sure ☐

Were you given information about how to make a compliment or complaint?

Yes ☐ No ☐ Not Sure ☐

If you've answered no to any of the questions over the page, please use the space below to tell us about your experience, the name of the service and approximate date.

Your name: .....

Address: .....

.....

.....

Tel No: .....

E mail: .....

If you give us information, we will not divulge your name or contact details to anyone except the Department of Health on their request.

York LINk will add you to our mailing list so you will receive newsletters and information about the work of the LINk. Please tick here if you do **not** wish to be added to our mailing list. ☐

Thank you very much for completing the questionnaire

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York's Local Involvement Network

Holgate Villa
22 Holgate Road
York
YO24 4AB

Tel: 01904 621631/
07971 054829

E mail: admin@yorklink.org.uk
Web: www.yorklink.org.uk

Department of Health

Dignity in Care Campaign

York LINk is a project hosted by North Bank Forum. The North Bank Forum is registered in England and Wales as a Private Company Limited by Guarantee No. 5206464 and a Registered Charity No. 1107013.

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Annex B

Public Awareness & Consultation Event on

End of Life Care services

28 August 2009

Supporting your right to the best health and social services in

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Introduction from York LINK Steering Group

York LINk (Local Involvement Network) was launched in September 2008 to take over the role of the Patient and Public Involvement in Health Forum (PPI Forum) in the York Area. The PPI Forum was a group of volunteers who inspected health services in York on behalf of the public. The main difference between the LINk and the PPI Forum is that the LINk can inquire about social services issues as well as health services.

The money to fund LINks comes from the Department of Health and is divided between every Local Authority in England with responsibility for providing social services. The City of York Council contracted a 'Host' organisation to help develop the LINk. This is so that the LINk is not directly managed by the Council, giving the staff and volunteers freedom to make recommendations about services without being influenced by council decisions. York LINk's host organisation is North Bank Forum (NBF), based in Hull.

At the LINk launch event in September 2008, an Interim Steering Group was formed to agree the constitution and rules for the LINk before the first Annual General Meeting (AGM).

The AGM was held in March 2009 and a Steering Group made up of individual volunteers and volunteers from York organisations was established.

The Interim Steering Group decided to use a voting system to prioritise the work of the LINk and create the work plan for 2009/10. A debate on the issues that had been referred to the LINk from a variety of sources took place during the AGM, and members then voted for their preferred issues. To try to include as many members of the community as possible, and have a recorded process that provided evidence for LINk

priorities, the voting document was also sent to all registered members prior to the AGM and was available on request from the LINk office. The ‘provision of end of life care services’ was one of the issues with the most votes and so was adopted as part of the LINk work plan for 2009/10.

The role of the LINk is to discover what people in the York area think about health and social services and look into any issues that are affecting more than one person. When the issues have been examined, the LINk can make recommendations to organisations to amend or improve their services. When reports are published, they are sent to the organisations concerned together with a letter outlining the recommendations. The organisations then have 20 working days to reply to the LINk.

York LINk Steering Group

March 2010

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Background

The National End of Life Care Strategy

In July 2008 the Department of Health (DoH) published a national End of Life Care Strategy. This is the first such strategy for the UK and it aims to promote consistently high quality of care for all adults at the end of their lives. It acknowledges that, in the past, the profile of end of life care within the NHS and social care services has been relatively low and the quality of care delivered has been very variable.

It is envisaged that implementation of this strategy will make a 'step change' in access to high quality care for all people approaching the end of life. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere.

The strategy stresses the need for Primary Care Trusts (PCTs) to work with local authorities, hospitals, hospices, carers etc to agree and implement ways to promote consistently high quality of care for people as they approach the end of their life.

Key areas addressed by the National Strategy

The National Strategy sets out recommendations and actions in a number of key areas:

- PCTs and local authorities need to work in partnership to consider how to engage with their local communities to raise the profile of end of life care. This will involve liaising with schools, faith groups, funeral directors, care homes, hospices, hospitals, home care services, employers etc and agree ways to speak to people about dying and ask their views on current services.

- An integrated approach to planning, contracting and monitoring of service delivery should be taken across health and social care. Improved services should be commissioned as the contracts for present services come to an end, taking the needs of the community into account.

- Health and social care staff need sufficient training to identify people who are approaching the end of life. Workforce training is needed, so that staff have a greater ability to recognise people who are at risk and the correct care can be implemented.

- Everyone who is identified as approaching the end of their life should have their needs assessed. This assessment must include their wishes and preferences about how they are cared for and where they would want to die

- Everyone approaching the end of life should receive coordinated care from all services at all times of day and night. This could be achieved by providing a single point of access through which all services can be co-ordinated.

- Rapid access to care is essential. PCTs must work with local authorities to ensure that medical, nursing, personal care and carers' support services can be made available in the community 24/7 and can be accessed without delay.

- High quality care should be delivered in all locations. These will include services provided in hospitals, in the community, in care homes, sheltered and extra care housing, hospices and ambulance services.

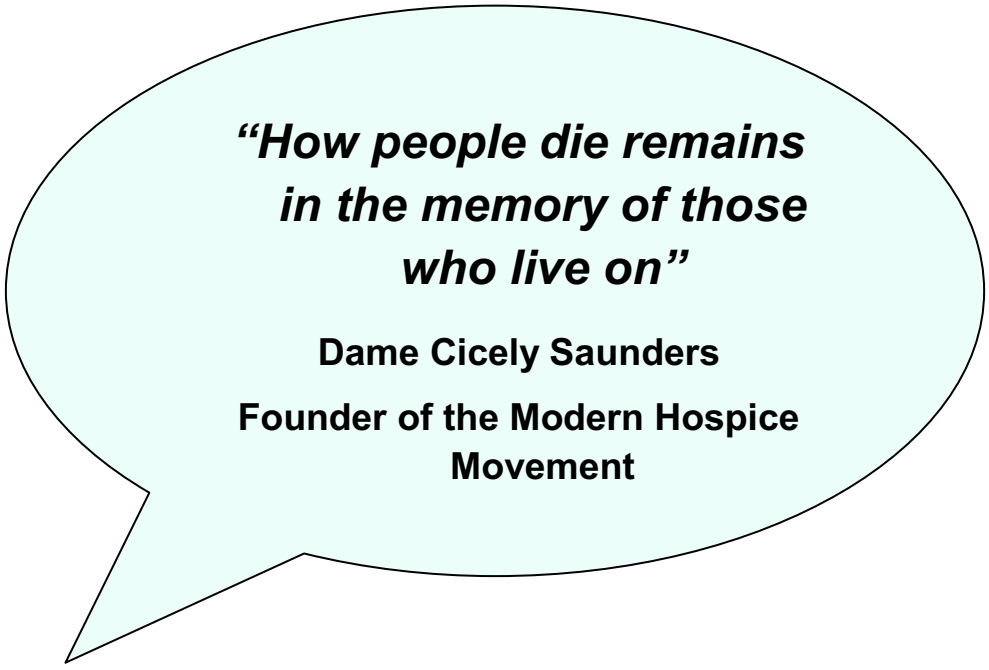
- Increasingly the Liverpool Care Pathway, or an equivalent tool, is being adopted. It was first developed for use with cancer patients but has now been modified for use for people with other conditions. It can be used in hospitals, care homes, hospices and in people's own homes.

- The family and carers of people approaching the end of life have a vital role in the provision of care. They need to be closely involved in decision making, with the recognition that they also have their own needs. Carers already have the right to have their own needs assessed and reviewed and to have a carer's care plan.

- It is critical that health and social care staff at all levels have the necessary knowledge, skills and attitudes needed to care for the dying. Strategic Health Authorities need to consider how training can best be commissioned and provided to ensure that staff have the necessary competencies.

- Measurement of end of life care provision is essential in order to monitor progress. Measurement will largely be through self assessment against quality standards, carried out by the organisations themselves.

- The overall cost of end of life care across health and social care is large and difficult to calculate. The key elements of expenditure are: hospital admissions; hospices and palliative care services; community nursing services; care homes. Increased government resources are committed to implement the strategy - £88m in 2009/10, £198m in 2010/11. Many improvements can be achieved by better use of existing health and social care resources. For example, at least part of the additional costs of providing improved care in the community and in care homes will be offset by reductions in hospital admissions and length of stay.



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The Gold Standards Framework

The Gold Standard Framework (GSF) is an approach which is designed to enable a gold standard of care for all people nearing the end of life. It is concerned with helping people to live well until the end of life and includes care in the final years of life for people with any 'end stage' illness in any setting.

The Department of Health End of Life Care Strategy 2008 says that every organisation involved in providing end of life care will be expected to adopt a co-ordination process, such as the Gold Standards Framework. It is also recommended as best practice by NICE, Royal College of General Practitioners, Royal College of Nurses and other major policy groups.

GSF is extensively used in the UK, by thousands of primary care teams and care homes and increasingly in other settings through cross boundary care and also internationally.

GSF is about:

- Enabling generalists and improving the confidence of generic staff
- Organisational system change - the right care at the right time for the right patient
- Patient led focus on meeting the needs of patients, families and carers
- Care for all those with any end stage condition, non-cancer and cancer
- Pre-planning care in the final year or so of life, proactive rather than reactive care
- Care closer to home - decreasing hospital admissions and deaths
- Cross boundary care and in all settings - care homes, hospitals, hospices etc

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Local background

In North Yorkshire and York, deaths are attributable to three main areas of illness:

- Heart and circulatory disease 41%
- Cancer 26%
- Respiratory disease 12%

Of the remaining 21% some deaths will be sudden or unexpected, such as road accidents. Other deaths relate to a range of long term illnesses such as Neurological Disease or Renal Disease. Other deaths relate to frailty and very old age, without a specified diagnosis.

In York, approximately 1,822 people of all ages die each year. Approximately 56% of all deaths take place in hospital, 19% take place in peoples own homes, 5% take place in hospices and 19% take place in nursing and residential homes (PCT End of Life Review/Healthy Ambitions 2008).

In York, NHS North Yorkshire and York (the PCT) staff were already working with City of York Council Social Services staff to review end of life care services before the National Strategy was published. The work began with issues around cancer services but it was recognised that ‘end of life’ is a much broader area.

The North Yorkshire and York End of Life and Palliative Care Commissioning Strategy 2008-2011 was published in September 2008. An End of Life and Palliative Care work plan has been developed to deliver the strategy.

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York LINk Public Awareness and Consultation Event

In order to discover more about End of Life Care services in York, the LINk Steering Group decided to hold a Public Awareness and Consultation Event (PACE) on End of Life Care services. The event took place on 28th August 2009 (see Appendix 1 for the event programme). Speakers from City of York Council Social Services, NHS North Yorkshire and York and York Hospitals NHS Foundation Trust were asked to give information on the services they provide. To include the support available from the voluntary sector a speaker from MacMillan Cancer Support was also invited. Invitations to the event were sent to individuals, local voluntary and community groups and statutory services.

Emma Taylor, End of Life Care Facilitator/ Bereavement Services Manager York Hospitals NHS Foundation Trust

Emma Taylor spoke about both the Liverpool Care Pathway and the Bereavement Suite at York Hospital.

1) The Liverpool Care Pathway

The Liverpool Care Pathway is a document that can be used by all professionals such as nurses, doctors, social workers etc. The document contains templates that doctors, nurses, social workers etc can use to provide the best care possible. This document has been put together from many studies of the evidence available (evidence-based) that has led to the best result possible (best-practice) and has involved the patient's views (patient -centred care).

The Pathway is a tool to help transfer the hospice 'model of care', which promotes patient comfort rather than a cure for their condition, to a hospital setting and will help the staff to have a York Hospital wide structure (pathway) to provide the best care for dying patients and relatives

The role of the End of Life Care Facilitator is to:-

- Lead the development, education and implementation of the Liverpool Care Pathway across York Hospitals NHS Foundation Trust.

- Carry out an audit on the use and the findings of the Pathway.
- Carry out a full review of the Bereavement Care service.
- Develop services to meet preferred priorities of dying patients.

The Pathway is structured in three sections to provide the following:-

1. An 'Initial Assessment' of the patient's needs and the care required
2. An ongoing assessment of needs and care
3. Care for the patient and family after death

When patient care is managed in accordance with the Liverpool Care Pathway, nurses must check patients' physical, psychological, religious or spiritual, and social goals every four hours.

Hospital staff do not need to ask permission from the patient to put them on the Pathway but it is best practice to let them know that staff are helping them as much as possible. Some Doctors still think that a dying patient is a failure of their expertise. This is changing and many now accept that if they have done all they possibly can it is better to help someone to die in comfort than put them through further medical procedures.

How much is the Pathway used in the hospital currently?

- In August 2009 55% of the wards in the Hospital were using a Care of the Dying Pathway - this will be replaced with the Liverpool Care Pathway after staff have received the necessary training.
- There is a roll out development programme for the remaining wards to implement the Liverpool Care Pathway. A large piece of work will be involved prior to the implementation of the Liverpool Care Pathway in the Intensive Care Unit because patients in the unit can have different needs to those on the wards.
- A computer based learning package is being developed for **all** staff including ward clerks, porters and health care assistants as it is recognised that all staff need to have awareness of this area.

- Training on End of Life Care will be incorporated in the hospital staff's mandatory training from April 2010.

An audit of services in York Hospitals NHS Foundation Trust during 2008 found that 55% of all hospital care is about end of life.

Also:-

- 37% of Patients who died were on the Care of the Dying Pathway
- 27% of Patients could have been on the Pathway but weren't
- 36% of Patients were not appropriate for the Pathway

This means that 401 Patients who could have been on the Care of the Dying Pathway were not.

A similar audit carried out in April 2009 after the implementation of the Liverpool Care Pathway in some areas found a small improvement but hopefully this will improve further after all staff have been trained.

Further training is planned for staff who have already been trained on the Liverpool Care Pathway to include documentation and arrangements for sudden or unexpected death.

2) Bereavement Suite at York Hospital

As part of the bereavement care plan to improve services offered to newly bereaved relatives, a new Bereavement Suite is planned for York Hospital. Having been severely delayed, building work is due to commence mid March 2010, with a predicted opening date of August 2010. The project is funded by the Kings Fund Charity and from donations.

Initially the service will be similar to the current service, and will provide an enhanced environment for collection of death certificates, property and valuables. There will be an on-site Registrar of births and deaths, and a room for relatives to be seen by doctors if appropriate. The design also features quiet space outside for bereaved relatives.

Future plans for the suite will involve the use of agencies such as Cruse Bereavement Care and Sands (Stillbirth and Neonatal Death Society) to provide expert counselling and support to the bereaved.

Initially the suite will be open from 8.30am - 4.30pm Monday – Friday.

Annex B

Ruth Wilson, Macmillan Cancer Support Community Network Development Coordinator

The history of Macmillan

In 1911, a young man named Douglas Macmillan watched his father die of cancer. His father's pain and suffering moved Douglas so much that he founded the 'Society for the Prevention and Relief of Cancer'.

Douglas wanted advice and information to be provided to all people with cancer, homes for patients at low or no cost, and voluntary nurses to attend to patients in their own homes.

The Society provided information on recognising, preventing and treating cancer to patients, doctors and members of the public. In 1924 the Society became a Benevolent Society and changed its name to the 'National Society for Cancer Relief'. As recent as 1975 the first Macmillan nurse was funded and the first Macmillan cancer care unit built**.** The nurses were so successful that only three years later in 1978 their number had increased to ten. By 1980 the Society was able to invest £2.5Million to expand the Macmillan teams throughout the UK primarily focusing on an educational programme to train doctors, nurses and students in advanced pain control and cancer care. In 1986 the first Macmillan doctor was funded. The charity is now called the 'Cancer Relief Macmillan Fund'.

At present, Macmillan directly employs 800 people but includes almost 5,000 people as many nurses etc are sponsored and employed via NHS Trusts. The Development Managers are looking at the gaps in services at present so the interest shown by York LINk is very timely.

Macmillan Grants

The Fund provides grants for travel expenses to hospices, holidays to help recuperation after treatment etc for people who otherwise have difficulty affording them. There are also small grants to support people with the practical impact of cancer such as increased fuel bills.

There are also start-up grants of £500 to help set up local support groups. The support groups can then apply for up to £3,000 in development grants to expand the group or pay for awareness sessions etc. Volunteers can also attend Cancer Voices training and then hold awareness sessions in local areas.

Cancer Networks

Macmillan organises Cancer Networks throughout the country. These are based in grouped NHS areas. In the York area there is the Yorkshire Cancer Network which includes the Huddersfield, Bradford, Wakefield, Harrogate, Leeds and York districts.

Macmillan also has local groups and asks them what they think of services. They come together to meet with professionals at the Network meetings to try to jointly improve services.

Nationally, Macmillan has organised a campaign to get free car parking for cancer patients who attend hospitals for treatment.

At present regionally, there are discussions taking place about moving the main provider of cancer treatment out of Leeds into more local areas, possibly York. Consultation on this is via the Yorkshire Cancer Network and further information is available via Colin Sloane, User Partnership Facilitator. Phone: 01423 555786 E mail: colin.sloan@ycn.nhs.uk.

The York Cancer and Palliative Care User Partnership Group can be contacted on 01904 631313 (Maggie Clough) and can provide information and advice for people at the end of their lives or their families.

Annex B

Richard Tassell, Operations Manager, City of York Council Social Services

How does Social Services help?

Most people do not want to die in hospital. The pressure to discharge people from hospital quickly when they are well enough or, if they wish, at the end of their life, is high. There are specific Social Services discharge liaison staff employed to work in the hospital solely to plan discharges. The liaison staff work with Social Services locality managers to ensure a smooth service for people leaving hospital.

Who pays for what service?

Health authorities and councils were requested to agree their respective responsibilities for health and social care services by 1 March 2002. This is an agreement on who pays for social and health care. Councils pay for social care funded via their 'Financial Settlement' from National Government and locally raised rates. Primary Care Trusts pay for health care.

Local agreements on the responsibilities to pay for services have been in place since 1 October 2002. Councils then use Fair Access criteria to determine eligibility for the services for which they are responsible.

Assessing need

Social Services staff assess an individual's needs then prioritise the needs that they are eligible to fund.

The issues and problems that are identified when individuals contact, or are referred to, councils are defined as the "presenting needs".

Those presenting needs for which a council will provide help because they fall within the council's eligibility criteria, are defined as "eligible needs".

When considering needs, councils should not make assumptions about the capacity of family members or close friends to offer support.

City of York Council has agreed to provide End of Life Care to people who require this in their own home as it meets the eligibility criteria used by Social Services.

Fair Access to Services

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The "Eligibility criteria" describe the full range of eligible needs that will be met by councils having taken their resources into account.

The four bands are:

1 Critical

- when life is, or will be, threatened;
- and/or significant health problems have developed or will develop;
- and/or there is, or will be, little or no choice and control over vital aspects of the immediate environment;
- and/or serious abuse or neglect has occurred or will occur;
- and/or there is, or will be, an inability to carry out vital personal care or domestic routines;
- and/or vital involvement in work, education or learning cannot or will not be sustained;
- and/or vital social support systems and relationships cannot or will not be sustained;
- and/or vital family and other social roles and responsibilities cannot or will not be undertaken.

2 Substantial

- when there is, or will be, only partial choice and control over the immediate environment;
- and/or abuse or neglect has occurred or will occur;
- and/or there is, or will be, an inability to carry out the majority of personal care or domestic routines;
- and/or involvement in many aspects of work, education or learning cannot or will not be sustained;
- and/or the majority of social support systems and relationships cannot or will not be sustained;
- and/or the majority of family and other social roles and responsibilities cannot or will not be undertaken.

3 Moderate

- when there is, or will be, an inability to carry out several personal care or domestic routines;
- and/or involvement in several aspects of work, education or learning cannot or will not be sustained;
- and/or several social support systems and relationships cannot or will not be sustained;
- and/or several family and other social roles and responsibilities cannot or will not be undertaken.

4 Low

- when there is, or will be, an inability to carry out one or two personal care or domestic routines;
- and/or involvement in one or two aspects of work, education or learning cannot or will not be sustained;
- and/or one or two social support systems and relationships cannot or will not be sustained;
- and/or one or two family and other social roles and responsibilities cannot or will not be undertaken.

The City of York Council sets the eligibility criteria at ‘moderate’ so anyone requiring services at a higher level will need to pay towards the cost. The criteria covering when life is threatened is ‘critical’.

Annex B

Liz Vickerstaff, Senior Commissioning Manager NHS North Yorkshire & York

NHS North Yorkshire and York's End of Life and Palliative Care Strategy was published in September 2008. This strategy reflects national strategy and was developed by patient groups, service providers, statutory and voluntary organisations from across York and North Yorkshire. It also includes information from the following sources:

- NICE Supportive and Palliative Care 2004
- Healthy Ambitions (Darzi Review)

The Strategy includes the following; also contained in the National Strategy for End of Life Care:

Although every individual may have a different idea about what would, for them, constitute a 'good death', for many this involves:

- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends.

To enable the above, the overall aims of the Strategy are focussed on:-

- Assessment and planning of care (advance care planning). This will be done by discussions between staff and patients as their end of life approaches
- Coordination of care. This will be done by assessing, planning and reviewing care
- Providing specialist care when necessary
- Ensuring quality and dignity in delivery of services
- Providing care for Carers/Bereaved
- Monitoring care/audits surveys to ensure the strategy is working

- Sharing best practice

The aims of NHS North Yorkshire and York are

- That people who are in need of palliative care, or have reached the end of their lives, should receive the best possible care, in the setting of their choice where this is possible, and that when death finally comes, that they are able to die with dignity.
- That carers of those who are receiving palliative care, who are dying or have recently died, should have their needs met throughout the process of caring for their loved one.

The outcomes to be delivered by the strategy are:

- The delivery of person Centred Care – Palliative
- The delivery of person Centred Care – End of Life
- Quality services
- Quality staff performance
- Sustainable services

N.B. Palliative care and end of life care are distinctly different. Palliative care is given to maintain the best quality of life when a cure is not possible – this could be for several years. End of life care is usually in the last weeks of life and involves symptom control, pain relief and meeting spiritual needs.

An End of Life and Palliative Care work plan has been developed to deliver the strategy. The work plan contains the following areas to target:-

- Identify Patients
- Assess documentation
- Coordination of services / policies
- Community/District Nursing and Key worker involvement
- Provision of out of Hours Care

- Provision of specialist Palliative Care
- Ensure access to Equipment and Medication
- Involve Acute Care providers
- Provide treatment in alternative settings
- Provide bereavement care/spiritual care
- Ensure Patient & Carer involvement
- Social Care involvement
- Psychological Care
- Training and Education for staff

The final version of the PCT's strategy was agreed by the board in November 2009, including the above work plan. Following the 'refresh' of the PCT's five year strategic plan, the End of life Care strategy is now part of the delivery of this plan, including the work streams which are now part of the community systems work stream.

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St Leonard's Hospice

In order to find out about hospice services in York, the LINk Steering Group arranged an informal visit to St Leonard's Hospice on 15th December 2009.

The Hospice was founded in 1985 It is a registered charity caring for people with life-threatening illness. Its aim is: 'To provide for the needs of patient, carers and families in a setting which is as homely and informal as possible and from which the patient will benefit with enhanced quality of life and greater physical and mental comfort.'

It offers:

- In-patient care in a purpose-built, 20-bed unit. Patients can receive short-term care, respite or terminal care.
- Day care at the hospice for people living in their own homes. This provides a combination of practical help and relaxation.
- A lymphoedema clinic where outpatients can be seen by specialist staff.
- Bereavement support for families and carers after a patient has died.

The Hospice is currently running a one year pilot Hospice at Home scheme to support people in their own homes. Hospice at Home aims to enable patients with advanced illness to be cared for at home, and to die at home if that is their preference. Care may be provided to prevent admission to, or facilitate discharge from, inpatient care.

Doctors and nurses work with a team of other professionals and are supported by volunteers. Referral to the Hospice is made by the patient's own family doctor or hospital consultant. No charge is made to patients or relatives, the Hospice is financially supported almost entirely by the generosity of the local community.

Central to the Hospice philosophy is the care of every patient as an individual. The philosophy of the Hospice is that patients should be consulted about medical treatment and have their questions answered honestly; they should be treated with dignity and sensitivity; they should be cared for as a whole person, with compassion and understanding.

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Findings the LINk gathered before, during and after the PACE event:

Information was gathered from 20 individual people, and from a variety of publications and websites (see Bibliography for details of publications and websites).

After the first draft of this report was written, a letter about one family's experience was sent to the LINk office. This was in response to a letter in The Press (24 March 2010) from the Vice Chair of the LINk, asking for experiences (good or bad) of end of life care services. Although this letter was received too late to be included in the main report, the LINk decided to include it because it illustrates Dame Cicely Saunders' quote: "How people die remains in the memory of those who live on". It is published in full (with identity details removed) as Appendix 2.

It is acknowledged that due to unforeseen circumstances this report has taken almost a year to complete therefore services may have improved. Nevertheless, this is what the LINk has found.

Key findings	Source
Home care staff do not know always know how to care for people with MND. For example, one patient was given tablets whole rather than crushed	York Against MND
NICE clinical guidelines on Parkinson's Disease state that that the needs in the palliative care stage of Parkinson's disease are not always identified or satisfied. Their recommendations include that people with PD and their carers should be given the opportunity to discuss end of life issues with appropriate healthcare professionals	NICE clinical guidelines

Qualified nurses are available during the day, but not at night. One patient's partner reported that they stayed up most nights to look after the patient	York Against MND
One patient with MND refused to be admitted to York hospital when she was dying, stating that the care she had received previously was appalling and she would rather "suffer than go into the hospital"	York Against MND
One patients last wishes were not taken into account by a locum GP	York LINk member

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Recommendations from York LINk.

1. There is a major mismatch between people's preferences for where they should die and their actual place of death (Department of Health End of Life Care Strategy in England 8 months on by Prof Mike Richards March 2009). Research suggests that the majority of people (between 56 and 74 %) express a preference to die at home. However mortality statistics for 2006 show that 35% of people die at home or in a care home (National Audit Office, End of Life Care, 24 November 2008). However, they may struggle to get services quickly enough to enable this to happen.

    a) 'Fast track' discharge from hospital needs to be available for people wishing to die at home. Hospital and ambulance services need to be able to respond to this.
    b) The 24/7 community nursing service in York needs to provide a rapid response for patients who are nearing the end of their lives. Timely access to advice and medication would mean that people approaching the end of their life are less likely to be unnecessarily admitted to hospital.

2. Hospices are widely agreed to be 'beacons of excellence' in the provision of end of life care. However, in York, there are only 20 beds available at St Leonards Hospice and so can only deal with a minority of patients at the end of their lives.

    a) The Liverpool Care Pathway is being introduced throughout York Hospital and this should be regarded as a starting point to developing 'hospice standard' care (NB St Leonards Hospice do not currently use the Liverpool Care Pathway).
    b) The Hospice should be encouraged to consider what roles it wants to deliver within an integrated local service, responding to local peoples' needs e.g. awareness raising, education and research, co-ordination, specialist outreach services.

3 Patients and carers end of life care needs must be met regardless of who is delivering the service.

a) Co-ordination of resources, and collaborative working across health, social services and the voluntary sector should be a priority. The Marie Curie Cancer Care Delivering Choice Programme demonstrates the effectiveness of establishing a central coordinating facility providing a single point of access through which all services can be co-ordinated. (Recommended in the Department of Health End of Life Care Strategy July 2008).

b) All organisations involved in providing end of life care should adopt a co-ordination process such as the Gold Standards Framework. (Department of Health End of Life Care Strategy – What the End of Life Care Strategy means for patients and carers, July 2008).

4 Improved education and training is needed for all staff involved in End of Life Care, both in health and social care. In addition, for some clinicians and NHS managers a change of culture is necessary so that death is not seen as a failure. Cancer consultants and other cancer services staff in hospitals are now accessing improved communications training which will support this (for cancer service provision). Professionals should not be reluctant to initiate end of life discussions, especially with patients who have long term neurological conditions where the illness may be less predictable than other illnesses such as cancer (NHS Evidence – Supportive and Palliative Care Specialist Collection, National Library for Palliative and Supportive Care, October 2009).

5 Time and an appropriate quiet environment must be available for professionals to have conversations about end of life care planning with patients. (NHS Evidence – Supportive and Palliative Care Specialist Collection, National Library for Palliative and Supportive Care, October 2009)

6 Bereavement care should:

a) Ensure that counselling and support are available 24/7.
b) Provide support for those bereaved through sudden death and include the needs of children (The Department of Health End of Life Care Strategy Rationale Chapter 5 – Support for Carers and Families)

7 Local End of Life Care services must include all sections of the community, including those regarded as 'hard to reach' such as people in prisons and hostels for the homeless, gypsy and traveller communities. The Department of Health End of Life Care Strategy Rationale (Chapter 4 Care in different settings) says that prisons and hostels for the homeless should be included in local plans and examples of good practice identified.

8 End of Life Care services for people with long term neurological conditions can be more difficult to identify and satisfy. Advance care planning is necessary, in an appropriate quiet environment. In some cases a day hospice environment may be beneficial to patients and carers (NHS Evidence – Supportive and Palliative Care Specialist Collection, National Library for Palliative and Supportive Care, October 2009)

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www.goldstandardsframework.nhs.uk

www.macmillan.org.uk

www.nyypct.nhs.uk

www.york.gov.uk

www.stleonardshospice.org.uk

www.mcpcil.org.uk/liverpool-care-pathway

www.nice.org.uk

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Appendix 1

Public Awareness & Consultation Event

End of Life Care Services

Friday 28 August 2009 - City Mills, Skeldergate York

Programme

10.30 – 11.15	The Liverpool Care Pathway in York Hospital, Emma Taylor, End of Life Care Facilitator, York Hospitals NHS Foundation Trust
11.15 – 12.00	Services from Macmillan Cancer Support, Ruth Wilson, Macmillan Community Network Development Coordinator
12.00 – 12.30	Support from City of York Council Social Services, Richard Tassell, Operations Manager, City of York Council Social Services
12.30 – 12.45	Tea / coffee & cake
12.45 – 13.00	NHS North Yorkshire & York and City of York Council Social Services End of Life Care Strategy – Liz Vickerstaff, Senior Commissioning Manager, NHS North Yorkshire & York
13.00 – 13.30	Discussion and recommendations for the future

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Appendix 2

Response from a York resident after a letter from York LINk's vice chair was published in the York Press (24th March 2010) asking for feedback about experiences (good or bad) of end of life care services in York.

" My close relative was in York Hospital for many weeks during 2009 suffering from an internal abscess, septicaemia and MRSA. He was also diabetic. In November the doctor at the hospital said that my relative had reached a 'plateau' and would have to leave hospital and go into a nursing home. We were able to have him admitted to Fulford Nursing Home. They treated him with kindness and did all they could to make him comfortable. Unfortunately he was only there for five days before he was re-admitted to York Hospital suffering from pneumonia. We dearly wished that he had been admitted to Fulford Nursing Home much sooner and at least he would have received comfort and care in the last weeks of his life.

There were untoward incidents in the period that my relative was in York Hospital, but there were also positive aspects to his care. We found that general attitudes towards patients were often uncaring, although some of the nurses did help as much as possible. My relative was aware of what was taking place, but he did not complain very much. Occasionally he became upset and exasperated by the way in which he was treated. Some of the staff were quite rigid in their working methods, e.g. sick and elderly patients had to wait for attention if meals were being served. If staff were doing the final bed change in the evening, they would insist on doing everything in a certain sequence, even if a patient needed attention, the patient had to wait.

The separate room that my relative was in was not very warm, especially as the cold winter weather set in. When I visited I needed to keep my overcoat on. My relative was always supplied from home with warm clothing, including jumpers and pyjamas, but often he was wearing none of these things, but just an incontinence pad and a skimpy, short sleeved cotton top (hospital issue). Consequently he often felt cold. This way of dressing a patient may have been an easy method of dealing with patient care, but it did not make the patient warm and comfortable. The food was often unpalatable and eventually we needed to take food in to persuade him to eat.

His next of kin was treated shabbily when she tried to obtain information about his illness. She struggled with this problem the whole time he was in

hospital until his death. When she spoke to a nurse she was often told that he was 'fine', when this was clearly not the case. The same answer usually came over the telephone. If he had been particularly unwell the previous evening, she tried to phone the ward the next morning. It often took at least six attempts to get through to the ward, and when an answer was finally obtained, it was vague and lacking in information. If she enquired on the ward, the nurse often said she did not know anything or that she had 'just come on duty' or that he 'was not their patient'. No attempt was made to find out what the situation was. A request for an interview with the consultant was granted and although he explained something of my relative's illness he did not mention MRSA.

I do not believe that we were alone in our difficulties with communication. I often heard relatives trying to speak to staff and not receiving satisfactory answers. On Christmas day 2009 we were at the hospital from mid afternoon until 8pm. My relative was not fully conscious, but a nurse came to take his blood sugar reading. We objected to this being done at that stage in my relative's life but the nurse said it was 'protocol' and went ahead and took the sample. Although my relative was on his own in a separate room, no other staff came to see him or talk to us. We did not get any advice about his condition and we did not know what to do. We left him reluctantly. When his next of kin took hold of his hand it was covered in blood. This was the last time we saw him. The hospital phoned the next morning at 6.30am to let us know that he had died at 6.15am. We did not go back to the hospital, we were too upset to do this.

We did not know what to do or where to turn for help and advice in my relative's last illness. We did wonder if it would have been possible for him to be admitted to St Leonards Hospice but we did not know if it was feasible, or how to take steps to find out. I consider that lack of communication is a big problem for patients and relatives. If a proper system of communication was put in place I think that this would help to clear many problems."

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York's Local Involvement Network

Holgate Villa
22 Holgate Road
York
YO24 4AB

Tel: 01904 621631/
07971 054829

E mail: admin@yorklink.org.uk
Web: www.yorklink.org.uk

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Annex C

Annual Report

2009/10

Supporting your right to the best health and social

Annex C

York LINk Annual Report 2009/10

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1. Introduction

I am delighted to introduce York LINk's Annual Report for 2009/2010. During the year, we used several methods to recruit members such as attending local events; editorials, letters and advertisements in 'The Press' newspaper; and advertisements in the 'Your Local Link' magazine and on the local 'First York' buses. We have also raised awareness of the work of the LINk by holding a series of Roadshows. These started with an event in the Guildhall then continued in various areas outside the city centre. Steering Group members and volunteers also attended many other meetings to gain information, and find out what people thought about services. Public Awareness and Consultation Events (PACE) were held for aspects of the LINk work plan (see appendix 1 for a list of these events; a full list of publicity, events and meetings with dates is available from the LINk office on request).

The LINk Steering Group looked at the issues that were voted onto the work plan at the last AGM. They were neurological services; mental health services; end of life care services; dignity and respect in services and the 'personalisation' agenda. We produced two reports in 2009 on neurological services and mental health services and had significant success in achieving the implementation of most of the recommendations. Further information on these publications is available on page 11 and 25 of this report. The development of a Health Passport for people with neurological conditions is a major development that has come from the report and we look forward to reading the results of the pilot scheme taking place shortly in York Hospital. The recommendation to improve training for Home Care staff and the process developed by the LINk to achieve this is another success and has been put forward as an example of how LINks can improve services by the Department of Health, see page 23. However, there have also been challenges as some statutory authorities were unhappy with the process we used to agree the reports. In order to overcome these difficulties we have now agreed a 'Report Writing Protocol' which has been agreed by all statutory partners (see appendix 2) and hope to develop a Strategic Partnership Group with stakeholders such as NHS North Yorkshire and York, York Foundation Hospital Trust and City of York Council Social Services.

We also had the challenge of finding new office space for the LINk as the premises on Shipton Road were no longer available. We moved to premises nearer to the city centre on Holgate Road. This has the benefit that people are now more able to drop in, speak to staff and/or give or receive information. Our next challenge is to look into into the areas that have been voted on for this year's work plan which will be announced at the AGM. We will be concentrating on gaining information and planning events for these areas at the first Steering Group meeting on 5 May 2010.

If you would like to be regularly informed about our work by receiving our newsletter or if you would like to get directly involved (in any way that suits you) please let us know either via letter, phone or email. If your organisation would like to hear more about the LINk, via a presentation or by attendance at one of your events, we would be delighted to hear from you to arrange a date and time.

We are delighted that the Archbishop of York, Dr John Sentamu agreed to be a Patron for the LINk. We are aware that he is a busy person and are grateful to him for his support.

Finally, I would like to thank the LINk Steering Group and the rest of the hard working LINk volunteers who have helped to make a difference to health and social care services on behalf of our community. As the LINk is more established, we hope to as well, if not better, this year.

Andrew Kent
Chair of York LINk

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2. Information about the LINk

The LINk office is now based at Holgate Villa, 22 Holgate Road, York YO24 4AB, 01904 621631 admin@yorklink.org.uk.

The LINk Host organisation is North Bank Forum, 94 Alfred Gelder Street, Hull HU1 2AN, 01482 472458 admin@nbf.org.uk

Membership of the LINk is open to any resident living within the boundary of the City of York Council, over the age of sixteen years old, or any voluntary organisation that is interested in working with the LINk.

The LINk is governed by an elected Steering Group consisting of a maximum of seven Community Representatives who liaise directly with the people of York and a further seven Steering Group members representing various York voluntary groups. The role of a Steering Group member is to make decisions on behalf of the LINk, meet with groups, visit Health and Social care establishments and get to know the needs of people living in York. They also provide information regarding LINk activities to the community, undertake surveys and collate the opinions of residents. Steering Group members are supported by LINk Ward Representatives.

Steering Group meetings now take place on the first Wednesday of each month except January and August. Robin McIlroy was elected to be Chair of the LINk by the Steering Group members on 6 May 2009. However, due to personal circumstances Robin decided to stand down from the position in September. At the Steering Group meeting on 7 October, Andrew Kent was elected as Chair. The LINk agreed to have two vice-chairs therefore Lesley Pratt was elected as Vice-chair along with Kath Briers.
A list of the people who have been Steering Group members since the last AGM with the dates for the people who have joined since the event is available at appendix 3. There have been vacancies, but due to the outstanding work done by the LINk volunteers and extensive local publicity only one vacancy exists this year. Unfortunately we have been unable to find a member to represent the BME community.

As well as those on the Steering Group, the work during the past year has been assisted by a number of Ward Representatives, and other volunteers who have helped when they were able. Without the assistance of the outreach work that has been done by these people, the work the LINk has produced would not have been as rich and we hope that others will volunteer their services as Ward Representatives this year.

A pool of LINK Experts have been trained to undertake the 'Enter and View' role (visit and gather evidence from service providers) for the LINk. These people have also been trained to facilitate discussions and interview people to obtain knowledge of a situation. The first 'Enter & View' visit was to the Wheelchair Centre on 23 March 2010.

The LINK Readers Panel read publications to ensure they can be easily understood by members of the community. Members of the Readers Panel have been busy this year and were asked to comment on the list of documents; this list is available on request from the LINk office. The Steering Group members are pleased that this service has been adopted predominantly by the PCT. However, we are confident that City of York Council and other statutory bodies will eventually see the benefit of lay readers commenting on publications. To enable the work to increase we distributed nomination forms to recruit people to the Readers Panel with notices for the AGM and gained more people interested in the role.

Task and Finish work groups, such as the York Neurology Group, led by a LINk Steering Group member can include any member who has an interest in the subject. This group has been instrumental in improving training for Home Care workers and producing a 'Health Passport' to pilot in York Hospital; more information about this is available on page 24. It is planned to have more work groups as the need arises.

The LINk has adopted Governance documents including a Code of Conduct for members that outline the principles of equality and diversity. To date the LINk has193 individual members, 45 associate members and 323 group members. Many of the voluntary sector groups that are actively involved with the LINk have over 300 members who are regularly kept up to date with developments. We plan to employ a Membership Development Officer during the next year to help recruit more individuals and groups.

3. How we included people

There are 193,300 people living within the boundary of City of York Council. In the 2001 Census, 95% of the York population classified themselves as White British compared to 5% non white. However, new research has discovered that the ethnic population in the city has almost doubled. It is estimated that 70 different languages are spoken and 800 migrant workers are currently employed in the city. The largest BME populations by ward estimated at that time were Heslington, Fishergate and Guildhall. The obvious link to the University of York impacts on the ethnic mix in Heslington ward. There were around 350 Gypsy and Traveller households in the City of York in 2001. In 2007/8 there were 1,720 national insurance registrations for non-UK nationals in York indicating there has been an increase in the number of people who would not classify themselves as White British living in the area.

In the 2001 Census 16% of people in York area said that they had a limiting long-term illness/disability. A breakdown of these figures by age group showed that rates were particularly low in men and women under 65, compared to national figures. The number of older people who received home care services in York in 08/09 was 3,095. However, the population over 65 is predicted to grow by 31% over the next 15 years. This would indicate that by 2020 an additional 1300 people will need services due to having physical disabilities.

In March 2007 there were 1,140 people registered as deaf or hard of hearing in York. Of these 895 were registered as hard of hearing with 115 in the 18-64 year old age band and 130 65-74 and 650 over 75. In the same year 25 people were newly registered as blind or partially sighted.

The health of people in the area is generally better than average however, inequalities exist mainly related to the area in the city where people live. Overall York's levels of deprivation are decreasing. In the 2007, (based on data from 2005) York was ranked 242 out of 354 compared to a position of 219 in 2004. In 2007 there were eight areas in the City estimated to be in the most deprived 20% in the country compared to eleven in 2004. Nevertheless, 60% of the population in York live in areas that are in the best 40% nationally. The number of areas in the most deprived fifth of the country has reduced from 3 to 2 but one area, Westfield, has remained consistently in the most deprived 10% in the country.

It is estimated that one in eight of the population in York is a carer therefore there are 22,000 carers in York. Of these 3,290 could spend up to 50 hours per week caring and 6,675 spend at least 20 hours per week.

The LINk recognises the need to involve people who represent specific communities and has recruited people to represent those who have caring responsibilities, learning disabilities, physical disabilities and long term neurological conditions onto the Steering Group. These representatives are all involved with local groups and liaise with a large number of people e.g. the representative for people with neurological conditions has regular contact with 300 or more people and the Carers representative has regular contact with approximately 300 people. Some of the individuals involved with these groups informed the LINk that they were unable to attend events due to their condition and their Carers stated that they were too busy caring to attend therefore they are obviously hard to reach people.

The LINk also had a vacancy on the Steering Group for someone to represent people from the BME community in York. A representative from this community was a member of the Interim Steering Group for the LINk but unfortunately had to give up the position due to personal circumstances. However, we are hopeful that another representative can be recruited this year.

The LINk has some members in the wards identified as being deprived areas in York. However, it is widely recognised that only parts of these wards are deprived and other areas are affluent therefore numbers alone are unhelpful. In order to reach people within the different wards the LINk has attended several Ward Committee meetings during the year.

The LINk Roadshows that were held in areas outside the City centre were poorly attended therefore it is has been suggested that we try to contact people via information stands in various public places such as supermarkets during the next year.

Presentations were also given to several local voluntary groups and information was gained on the perceived value of services by users as well as informing them about the LINk.

The York LINk newsletter, LINked In, is published bi-monthly and sent to all individuals and groups on our mailing list either by e mail or paper copy. The newsletter is designed and printed by Our Celebration, a local organisation which supports recovery from mental ill health.

A new York LINk website (www.yorklink.org.uk) was developed, and launched in January 2010. The new site will be developed further during the coming year. It aims to provide a resource for LINk members, and a source of health and social care information for the whole community.

4. LINk Involvement with Stakeholders

LINk Representatives are now members of the Healthy City Board and the Inclusive York Forum which are sub-groups of the City of York Local Strategic Partnership (Without Walls). Although it is early days to make a great contribution to the work of these groups the information gained has been helpful and positive relationships are developing.

The LINk is delighted to be asked to externally quality assure the City of York Council's 'Safeguarding' procedures which will start with an extensive information session on the scheme in May 2010.

The LINk was asked to help gain information for the Joint Strategic Needs Assessment for 2010/11 by the Chair of the Healthy City Board who is also the Locality Manager for the York area at NHS North Yorkshire & York. A copy of the questionnaire was distributed to all LINk members with the December edition of the LINked-in newsletter.

The LINk has established a good relationship with the City of York Council Health Overview & Scrutiny Committee. A LINk Steering Group member attends most OSC meetings and has regular meetings with the Chair and Vice-chair.

Work with York Health Group (Practice based Commissioning Group for GP's) began with a presentation from the Chief Executive Officer about the work of the group. The LINk offered assistance to establish Patients Forums in GP surgeries and is delighted that LINk Representatives have been asked to be members of the Patients Forum that will cover the whole of the York area.

A training event for Steering Group members and LINk volunteers to find out more about how NHS North Yorkshire & York work was held earlier in the year. Since then, regular meetings have been held with members of the Patient Involvement Team. LINk Representatives have also met with the Chair and Chief Executive Officer and a healthy working relationship has been established. The Chair also offered to take part in the LINK AGM.

Members of the LINk Steering Group met with the Chief Executive Officer and the Chief Nurse of York Foundation Hospital. A meeting with some Hospital Governors was also held. A LINk Information Day was held in the hospital and plans to pilot a Health Passport document in some Wards have also helped to develop a positive relationship with staff and managers.

LINk Representatives have attended a variety of voluntary and community organisation meetings and events. The relationship between the LINk and voluntary organisations has developed well over the past year and the LINk welcomes a staff member of York Council for Voluntary organisations as a member of the Steering Group for 2010/11.

The proposal to establish a Statutory Stakeholders Group that was debated at the inaugural AGM in 2009 did not develop. Some statutory agencies appeared to be very willing to work with the LINk but others were reticent and needed time to fully appreciate the legislation around listening to the views of members of the public. However, following specific requests from the City of York Council Health Overview & Scrutiny Committee and the York Health Group, quarterly meetings have been agreed for the next year.

5. Training

Members of the LINk Steering Group are either individuals or belong to a variety of organisations. In order that everyone understood the legislation around the working of the LINk, an induction day was held on 23 April which was attended by 10 people. Further inductions for new members were also carried out on an individual basis throughout the year.

A training scheme for the LINk Experts who can be authorised to undertake 'Enter & view' visits was also designed. This training was delivered in 3 stages and followed the national guidelines on 'Enter & View'. Sessions on safeguarding and equality and diversity were also included.

- Seven people attended on 13 May for stage 1. The session was also repeated for people who could not attend on 13 May.
- Stage 2 was held on 8 June
- Stage 3 on 16 June.

LINk Experts were also required to undertake CRB checks and so far a total of 7 people have completed all the training and checks. The first 'Enter & View' visit took place on 23 March; please see report on Enter and View. LINK Experts also visited local nursing homes etc to gain information about how services are delivered.

Other information sessions for Steering Group members and volunteers were delivered throughout the year as follows:

- 19 June – Personalisation Agenda & New Complaints Procedures for healthcare
- 14 July – How the PCT works
- 23 July – Home Call - Mobile Warden Service
- 2 September - York Health Group (Commissioning group for GP's)
- 4 September - Altogether Better project
- 4 November – York Hospital Pharmacy
- 5 December – JSNA
- 13 January 2010 – media training

Annex C

6. What we did during 2009/10

Where did the issues for the LINk work plan come from?

Following extensive publicity, most people gave evidence to the LINk via phone, letter, on our information leaflet or via Interim Steering Group members and volunteers. All evidence that was given by letter or leaflet was followed up by either a phone call or a meeting with the person to gain further insight into the problem. In addition some people gave evidence to Steering Group members at ward committee meetings, the LINK Roadshows that were organised in various areas around York, following presentations that were made to voluntary groups, at Public Awareness and Information Events (PACE) and other public events.
To ensure that as many people as possible had the opportunity to provide evidence for the work plan for 2010/11 a notification was placed in the local media and in the LINked In newsletter, which goes to most voluntary and community groups in York, asking for people to contribute issues.

How did the LINk decide which issues to make enquiries about during the year?

The Steering Group decided that people in the York community should be able to vote on the issues for the work plan. Last year the issues were debated and voted on during the inaugural AGM and the work plan was announced some time after the event. In order to be able let people know as soon as possible the issues that the LINk will be making enquiries into this year the Steering Group agreed that voting should take place prior to the AGM. To facilitate this, after the published cut off date to refer issues, a log of the issues was produced and collated into an 'Issue Voting Form'.

How did people vote on issues for the work plan?

The 'Issue Voting Form' was checked by Steering Group members and posted to all members eligible to vote. It was to be returned to the LINk office by a date prior to the AGM. The forms were then counted and checked by Steering Group members and the ones with the highest number of votes incorporated into the work plan which will be announced at the AGM. The work plan will also be communicated to other members via the LINked In newsletter and posted on the LINk website. To promote transparency, all voting papers will be retained by the LINk until at least the next AGM.

7. York LINk Reports

Neurological services
Various problems experienced by people with neurological conditions were referred to the LINk and the issue gained the highest number of votes for the work plan 2009/10.

Individuals and groups informed the LINk that the beds for patients with neurological conditions that had been based on one ward in York Hospital were now reduced and moved to another location and this was the cause of many of the problems. It was rumoured that the PCT had cut the funding for the beds. LINk Steering Group members questioned NHS North Yorkshire and York about this and were subsequently informed by the PCT Commissioner that the funding had not been cut. The LINk was also informed that people requiring neurological care, in the main, are assisted by community services but may need to be cared for in a medical facility during times of crisis and possibly at the end of their life. Anecdotal information about problems around 'end of life care' related to the reduction of the neurological beds in one area had also been given to the LINk.

The LINk was informed by patients and their carers that when the neurological beds had been based on Ward 38 the staff gained an insight into the different neurological conditions, thus patients stated they received an extremely good service. Neurology is a specialised area, and every person who has a neurological condition has individual symptoms therefore it is very difficult to train every member of staff on all wards on all conditions. Personalised care plans for people with long term conditions, such as neurological conditions, are scheduled to be implemented in 2010. New guidance has also been issued to help NHS and Social Services staff to ensure that people who have long term conditions are more involved in decisions about their illness and treatment, including their treatment in hospital. It is widely recognised that people with long term conditions require a great many health and social services and often find difficulty in accessing the services they need at the correct time due to the variability of their condition. NHS guidance states that a care plan must be agreed between the person with the condition, their family or carer, the NHS and social services staff. This care plan must be accessible for all to read so there is no mistake in what has been agreed (National Service Framework for Long Term Conditions now renamed National Service Framework for Long Term Neurological Conditions).

During the first meeting with York Foundation Hospital Chief Executive and members of the LINk Steering Group it was discovered that three wards had been closed because the hospital had received a reduction in funding from

the PCT. The hospital had applied for Foundation Trust status and one of the conditions is the need to show the organisation is financially sound, meaning the services they intend to provide meet with the amount of funding they will receive. In order to balance the books, a decision was made to reduce the number of wards. Thus the 14 beds specifically for people with neurological conditions that that were based on Ward 38 were reduced to 8 and moved to the Cardiology ward. Some staff were transferred with the patients but many took early retirement or moved to work in another part of the hospital. When the 8 beds on the Cardiology ward are occupied, patients with neurological conditions are allocated a bed within another ward thus patients with neurological conditions are scattered throughout the hospital. Also, staff on the Cardiology ward could not possibly gain the knowledge and experience required to nurse people with long term conditions in a short time so patients experienced an inferior service. When asked, York Hospital Patient Advice Liaison Service (PALS) stated that no complaints had been received either before or after the neurological beds were moved, bringing into question why people complained to the LINk and not PALS.

The LINk was informed that beds for people with neurological conditions would eventually be reallocated to the Stroke Unit. Stroke is classed as a neurological condition therefore the staff should have more of an insight into the nursing skills required on this ward that others. However subsequent information emerged that the Stroke Unit is permanently full and could not accommodate further patients so the future of the neurological beds would come under a ‘Bed Review’ that was being undertaken by the Hospital. There appeared to be much confusion on what was happening with beds provided for people with neurological conditions in the hospital therefore the LINk formally requested to have copies of the minutes of all meetings regarding the ‘Bed Review’ and the time-table for this piece of work. However, a written reply was eventually received stating that the ‘Bed Review’ was being undertaken by a manager in NHS North Yorkshire and York employment. The LINk formally requested information regarding this and discovered that no-one working for NHS North Yorkshire & York was involved.

In order to progress matters and discover more evidence, the LINk Steering Group agreed to hold a Public Awareness and Consultation Event (PACE) on services for people with neurological conditions. Speakers from five neurological charities (MS, PD Society, York Epilepsy branch, Stroke Association and York Against MND) were invited to speak followed by a general discussion on what is good and bad with the services available. Invitations were sent to individuals and groups involved with neurological conditions and statutory services.

Annex C

Information requested

Date	Person	Request
15 June	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	Following conflicting information regarding beds allocated for patients with neurological conditions, request for copies of minutes of meetings where the 'Bed Review' was discussed
		Reply
22 July		NHS North Yorkshire & York are undertaking the 'bed review'

Date	Person	Request
3 Aug	Pat Sloss, NHS North Yorkshire & York	Following the reply from York Hospital, the name of the person undertaking the 'bed review'
		Reply
20 Oct		After an extensive search no one from this organisation is leading a 'bed review' for beds in York Hospital

Using information gained from the PACE on neurological services and evidence provided by members of the public the following recommendations were made to the relevant statutory authorities on 30 September 2009. Replies received from the organisations are also included as follows:

1. York LINk should help to form a 'York Neurology Group' to bring people interested in all neurological conditions together to identify problems, highlight good practice and work with health and social services.

Reply

Date		
20 Oct	LINk	First meeting of York Neurology Group, 14 people indentified as members.
		Regional Officers from national Neurological Charities are building on work done by York Neurology Group and hope to establish a Neurological Alliance in the area. A meeting to discuss this has been booked for 5 July 2010.

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2. York LINk recommends to NHS North Yorkshire & York and York Hospital that a ward designated for people with neurological conditions is made available, with the necessary equipment.

People with most neurological conditions have suffered as a result of the designated ward being closed in York Hospital. There are also other ongoing problems such as the lack of recognition given to Carers which could possibly be resolved by implementing the standards contained in the National Service Framework (NSF) for Long Term Neurological Conditions. Staff on the Cardiology Ward, since the report was completed, have increased their knowledge and experience in how to treat people with neurological conditions but these beds are often full so patients are admitted to any ward. The lack of an informed workforce in other wards appears to be the cause of much of the problems experienced by patients at present such as improper use of chairs.

Replies

Date	Person	
23 Oct	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are looking at the detail and will contact you again'.
26 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'We will ensure we are working closely with acute Trust colleagues in developing neurological services further, including taking forward these recommendations'.
23 Nov	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are continuing to examine your recommendations'.
12 Feb	Patrick Crowley, Chief Executive Officer York Foundation Hospital	'We explained in our letter of 14 August, that we have not closed any services for people with neurological conditions, only the location from which they are delivered. As you will know, providing a designated ward for people with neurological conditions is not a Quality Requirement of the national Service Framework for Long-term Neurological Conditions. We keep the deployment of all beds under review to meet the changing demands on our resources and any opportunity to improve is taken whenever possible'.

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3. The LINk should work with the York Neurology Group, York Hospital staff, Social Services and NHS North Yorkshire & York to establish Local Implementation Teams (LITs) for all the NSF for Long Term Neurological Care standards.

Replies

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'Given other priorities that have been identified for joint working between health and social care it is likely to be difficult to commit to this recommendation at present. I would encourage the group when established to make contact with existing, multi-agency partnership groups that have a common interest in this topic'.
23 Oct	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are looking at the detail and will contact you again'.
26 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'The PCT is in the process of finalising its 5 year Strategic Plan. This plan includes specific priority concerning reviewing and improving care pathways. As a key part of this work it is intended that neurological services will be the subject of a review in line with NSF standards to identify future commissioning priorities and requirements'.
23 Nov	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are continuing to examine your recommendations'.
12 Feb	Patrick Crowley, Chief Executive Officer York Foundation Hospital	'I understand the first meeting of York Neurological Group was on 20 October and that Fiona Ronan, Advanced Nurse Specialist for MS, has twice attended on behalf of the Trust. It has been difficult for a nurse to attend at the time the meeting is held because it coincides with our clinic times. However, Karen Cowley, Matron for Medical Specialities, will try to ensure that we have some representation on the group. We have been able and continue to make progress on the implementation of this

		NSF and I enclose an updates report from Mike Harvey, Directorate Manager Medical Specialities. This report summarises our progress against the Quality Requirements for the NSF, outlines any outstanding issues and makes recommendations as necessary. It is supported by an action plan in Appendix 1, which indicates target dates for the actions required. I hope you will find it helpful and reassuring'.

4. York LINk recommends to GP's via the York Health Group that an information event such as the LINk PACE day is made available for GP's to enhance their knowledge of the various neurological conditions.

Reply

Date	Person	
01/04/10	Dr John Lethem, Chair York Health Group	There is already a neurology interest group with the next meeting being about MS in late April. There is also quarterly Protected learning days for GP's with a rolling programme of educational events and I'm sure Neurology can be considered although I am not in charge of the events. I will past this comment on to the appropriate organiser.

5. York LINk also recommends that GP's provide 'information prescriptions' to all patients when necessary.

Many people experience problems being diagnosed with neurological conditions such as epilepsy and ongoing problems due to GP's lack of in-depth knowledge about the conditions. The Darzi review recommended that people are given 'information prescriptions' when they are diagnosed. These prescriptions should contain information about the condition as well as the contact details of local voluntary groups that people can access for ongoing support if they wish.

Reply

Date	Person	
01/04/10	Dr John Lethem, Chair York Health Group	GP's do often give out information as appropriate, either in printed or electronic form as appropriate. Please look at the website: http://www.patient.co.uk which is used by many GP's nationwide as a reputable source of information for

		patients. Please let us know what you think.

6. York LINk recommends to all concerned that the neurological charities work together to provide a programme of training on neurological conditions and this be made available to all hospital and community based staff and student nurses at York University. Particular in-depth training on Epilepsy should be provided to staff working in the A & E department.

Many problems that people with neurological conditions experience are as a result of staff not being aware of their fluctuating condition. Members of the public believe that nurses and care staff are often not given the initial training required to nurse people with specialised conditions and that many nurses and care workers would be horrified to discover that they had treated people inappropriately. However, Hospital and Social Services managers must recognise that this lack of knowledge does impact on the care given to patients/clients.

Replies

Date	Person	
23 Oct	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are looking at the detail and will contact you again'.
23 Nov	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are continuing to examine your recommendations'.
12 Feb	Patrick Crowley, Chief Executive Officer York Foundation Hospital	'We identify training requirements for our staff from a variety of sources, including training needs analyses, serious untoward incidents, adverse incident reports, Department of health requirements, national guidance, our Corporate Directors, complaints and the Patient Advice and Liaison Service (PALS). We provide training through a range of methods as necessary, depending on requirements. These methods include statutory and mandatory training sessions, and generalist and specialist training within and outside the Trust. Our training is targeted and tailored to ensure that our staff are appropriately trained in

		accordance with their roles and responsibilities. Training on epilepsy is included in the pre-registration education of doctors and nurses in their induction. Guidelines in treatment of epilepsy are available in the Emergency Department (ED) in electronic and paper formats. Where there are specific skill requirements, our staff receive the necessary training to support them according to the different conditions under which they work'.

7. York LINk recommends to statutory services that a 'Passport' be used for neurological patients in York Hospital, Primary Care and Social Care services.

Replies

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'The Council has looked at introducing 'person held records' already and is in discussion with carers, through the health task group of the Carers Strategy Group, to explore the use of a 'carers health passport'. The concept of a passport may be similar and we would want to understand more what is intended by this concept. Following discussions with York Carers Forum, Social Services staff and PCT Commissioner for Carers services it is proposed to make this a joint project.
23 Oct	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are looking at the detail and will contact you again'.
26 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'The importance of empowering patients to self-care through effective information and an agreed care plan is a key feature of the PCT's strategy for long term conditions and will be developed considerably in the years ahead. The PCT has already commissioned an Enhanced Services for Multiple Sclerosis care through GP practices, which includes developing care plans and effective co-working between primary and secondary care'.

23 Nov	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are continuing to examine your recommendations'.
12 Feb	Patrick Crowley, Chief Executive Officer York Foundation Hospital	'We look forward to continuing our work with the LINk through the York Neurological Group to develop a passport system for neurological patients. Fiona Ronan, Advanced Nurse Specialist for MS, is keen to develop a passport system and we hope to make good progress on it'.

8. York LINk recommends to all statutory services that a 'Carer's Post Bereavement Course' should be jointly funded and made available.

Replies

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'We struggle with the concept of a 'course' in this context. The need for bereavement support for family and carers is identified within the End of Life strategy. Funding for any new services will need to be considered alongside other priorities'.
23 Oct	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are looking at the detail and will contact you again'.
26 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'The importance of bereavement support has been recognised by both City of York Council and the PCT through the local End of Life strategy'.
23 Nov	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are continuing to examine your recommendations'.
12 Feb	Patrick Crowley, Chief Executive Officer York Foundation Hospital	'We are developing our bereavement services for relatives and carers. Currently we offer support and guidance on how to access support which is not typically provided by hospitals, but signpost to other well equipped groups and organisations'.

9. York LINk recommends that lockers for patient medications should be installed in all wards in York Hospital so specifically patients with PD can self-medicate while an in-patient.

Replies

Date	Person	
23 Oct	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are looking at the detail and will contact you again'.
23 Nov	Marilyn Thirlway, Patient Experience Manager, York Foundation Hospital	'We are continuing to examine your recommendations'.
12 Feb	Patrick Crowley, Chief Executive Officer York Foundation Hospital	'I am pleased to say that the Trust has obtained new lockers with a lockable compartment for patients' medications. As part of our medicines management programme we are developing self-medication and one –stop dispensing for all patients assessed as suitable for this. This means that patients who are used to managing their own medicines safely will be able to continue to do this if they are admitted to hospital'.

10. York LINk recommends to NHS North Yorkshire & York that GP's should agree a protocol with pharmacists so patients with epilepsy receive the medications on which they are commenced, whether they are branded or a parallel import.

Reply

Date	Person	
		No response

11. York LINk recommends that a protocol be drawn up between NHS North Yorkshire & York and Social Services to ensure that a fast-track system is in place that meets the needs of people when equipment is required.

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Replies

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'Our understanding is that the provision of equipment within the community is not a problem area. Our performance indicators suggest that we perform well on this. The report gives examples of where hospital patients have needed access to specialist chairs, which would be the responsibility of the Foundation Trust and would be their responsibility'.
26 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'The PCT is currently looking into these issues with a view to ensuring that patient's needs are met'.

On 2 December the LINk Steering Group agreed to arrange an 'Enter & View' visit to Wheelchair Centre in New Year to discover what is going on.

12. York LINk recommends that CYC Social Services department looks at the time taken to obtain Disabled Facilities Grants to ensure that no one is kept waiting.

Reply

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'We know that there are delays in providing Disabled Facilities Grants. This is something we are exploring, but it will very likely require additional investment.'

13. York Link recommends to CYC Social Services that a programme of intense training including aspects of end of life care is in place for all Home Care Workers.

Reply

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'The council would be happy to share information about current training programmes that are made available to home care providers, and to receive input on known needs, for consideration in the development of the next programme'.

14. York LINk recommends to City of York Council Health Overview and Scrutiny Committee that they monitor regular reports on how many members of staff have undergone the differing types of training.

Reply

Date	Person	
5 Oct	Tracy Wallis, City of York Council Health Overview and Scrutiny Officer	'The committee will consider the report back after receiving clarity on the recommendation specifically the type of training required and those who need to be trained'.

15. York LINk should congratulate York Hospital on their acute stroke services.

16. York Link recommends to NHS North Yorkshire & York that they commission rehabilitation services for stroke patients in a more germ-resistant community setting outside a hospital ward.

Reply

Date	Person	
26 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'The development of community-based services and the effective transition of care between primary and secondary care is a recognized priority for the PCT and we are pleased that this is reinforced in the recommendations of this report. The development of community-based rehabilitation services is a priority within the national Stroke Strategy and this is similarly recognised within the PCT's Strategic Plan'.

Annex C

Impact of report

Recommendation to City of York Council Health Overview and Scrutiny Committee that they monitor regular reports on how many members of staff have undergone the differing types of training.

The OSC replied to the LINk asking specifically for further clarity on the type of training required and those needed to be trained. It became apparent that the information required to monitor training for all Home Care staff was not available to OSC members therefore the LINk decided to pursue alternative arrangements.

The LINk discovered that all Home Carers, whether they are employed directly by the Council or by Home Care agencies and non nursing staff employed in residential and nursing homes should receive training to meet National Minimum Standards. The standards are part of the Care Quality Commission assessment and include the Common Induction Standards (CIS) that have been developed by Skills for Care. Further statutory standards specifically for first aid, moving and handling, food hygiene, safeguarding and health and safety must also be undertaken and many workers are encouraged to undertake NVQ Level 2 in Health and Social Care for Home Care Workers. However, these standards do not include training on aspects of care for people with a specific condition.

The LINk carried out a small survey of Home Care providers and Care Homes in the York area and discovered that some, but not all, provide additional training for staff on specific conditions. It appears that the biggest barriers to this are the costs and the difficulty in finding organisations to deliver the training.

The LINk has contact with a large number of local voluntary groups and charities and some have stated that they would be willing to provide training free of charge. The LINk wrote to all Home Care providers, Residential and Nursing Homes in the area asking them if a list of free training providers made available via the LINk office would improve matters. This proposal has received a positive response as most providers wish to improve staff performance so the LINk has collated a list of voluntary organisations willing to provide free training. Although this training may not include a great deal of Anatomy and Physiology about conditions it will be in the main provided by the people who have the condition or their Carer so they will be able to give the Home Carers information that they cannot gain from books or formal training courses.
The actual training will need to be agreed between the agencies and voluntary/charitable groups concerned but a record of the numbers of staff who attend as well as an evaluation of how it will improve Staff's

performance at work will be gathered by the LINk. It is hoped that this information will be helpful in the commissioning process for Home Care services and for public information for those who are undertaking personalisation of their care. The scheme has also been recommended as good practice for other areas by the Department of Health that supports LINks.

Recommendation that a 'Health Passport' be used for neurological patients in York Hospital, Primary Care and Social Care services.

A draft document has been agreed in conjunction with members of York Neurology Group and York Carers Strategy Group. A launch of the Passport supported by the Chief Executive, Chief Nurse and the Chair of the Foundation Trust is planned to take place soon and a pilot scheme is due to commence in the hospital shortly after. An independent evaluation of the usefulness of the document will be undertaken by a student from York St John's University and the results will be published when available.

Recommendation to help establish a York Neurological Alliance

The first meeting for all neurological groups to establish a Neurological Alliance for York and North Yorkshire will be held on 5 July 2010.

Mental Health services

At the time of the LINk inaugural AGM, NHS North Yorkshire & York ran the majority of Mental Health services in York and North Yorkshire. Services in Scarborough are run by a Mental Health Trust based in Teesside and in the Skipton area they are run by a Bradford based Mental Health Trust. This arrangement had developed over a number of years but the role of NHS North Yorkshire & York, in line with Department of Health policy (Transforming Community Services) changed from providing services to finding the best organisation, then contracting for services (commissioning). This meant that it would be difficult to continue to provide mental health services because it would be like contracting with themselves to provide their own goods so a 'transformation' of how mental health services are run was necessary.

NHS North Yorkshire & York established a 'Shadow Board' for the provider services; this is separate to the overall PCT Board. However, ongoing discussions around the type of organisation best placed to provide mental health services, and the types of services required for people with mental health conditions in future was considered. Also considered was the number and type of services that are needed and whether the quality of the present services could be improved.
New standard contracts for health services are governed by strict rules and can last for three years. This may cause problems for smaller voluntary groups who provide services at present and there is a desire to form a Mental Health Consortium to tender for contracts then subcontract with the various smaller groups. The Department of Health (DH) also expects NHS organisations to invest approximately 15% of their overall budget on grants to voluntary and community providers. Although this has not happened in the past due to the financial constraints of NHS North Yorkshire and York it is hoped that this funding would be available in the future.

There is a Mental Health Forum in York run by the local Council for Voluntary Services (York CVS). Members of the Forum presented a list of mental health service needs for the area to the Local Implementation Advisory Group (LIAG) run by NHS North Yorkshire and York. Interestingly, Forum members maintained that the Joint Strategic Needs Assessment devised by the PCT and City of York Council was inadequate to address the problems experienced by people with mental health problems.

Mental health services was voted onto the LINk work plan at the inaugural AGM. In order to discover more about the situation the LINk Steering Group decided to hold a Public Awareness and Consultation Event (PACE) on mental health conditions. Speakers from local charities were asked to give information on the history of mental health services, dementia, the main types

of problems people experience and the services they provide. The Project Manager for the transformation of the mental health services from NHS North Yorkshire and York also agreed to provide an update on progress. Invitations were distributed to individuals and groups involved with services for people with mental health problems and statutory services.

Using information gained from the PACE on mental health services and evidence provided by some voluntary groups the following recommendations were made to the relevant statutory authorities on 30 September 2009. Replies received from the organisations are also included as follows:

1. York LINk recommends that NHS North Yorkshire & York must include lay stakeholders in York (mainly York Mental Health Forum) in the commissioning process for a new provider of mental health service at all stages.

Reply

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'It is essential for us to engage with all stakeholders to ensure that commissioning decisions are informed by a range of perspectives. An invitation will be made to York Mental Health Forum to nominate a representative to join the Mental Health Partnership & Modernisation Board for York which is to be established this autumn'.

2. York Mental Health Forum could consider undertaking a survey to indentify the services required from the new provider.

Reply

Date	Person	
9 Oct	Sue Bradley, York CVS	'As you know the (Mental Health) Forum undertook a survey relatively recently. It was a significant task for our members in terms of extra energy, and they responded in considerable detail. It was undertaken in order to input through York's LIAG which feeds into the commissioning plans being developed by NHS North Yorkshire & York. I think we would suggest that the

		information from this survey will also form a useful basis of developing effective partnership between members of the Forum for mental health and any new provider'.

3. York LINk recommends that NHS North Yorkshire & York and City of York Council Commissioners provide assistance to local voluntary groups and charities on how to prepare bids for tenders to provide services.

Replies

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'CYC has been working with York CVS who offer advice training and support on bidding for tenders. York CVS have been successful in gaining additional funding through the LSP Delivery Fund to continue this capacity building'.
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	We are pleased to report that Melanie Bradley, Assistant Director (Vulnerable People and NHS Funding Continuing Healthcare), has already offered this to North Yorkshire's Third Sector and advised York CVS that we would undertake an engagement exercise prior to any tenders the Third Sector could apply for so that they are fully informed on how to complete the forms and make their applications'.

4. York LINk recommends that services are commissioned in York using the evidence of need by the population of York.

Commissioning for services in York should be carried out mainly using statistics from the York population which could soften the blow of block contracts.

Reply

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'NHS North Yorkshire & York, with York Health Group and City of York Council, aim to commission services based on evidence of need, using available data and

		the expressed needs of the community. It is also important that core services are provided across all areas and that service users can expect the same range and quality of services regardless of postcode'.

5. York LINk recommends that NHS North Yorkshire & York allocates 15% of the budget for the Central Locality area to support local voluntary groups and charities.

If 15% of the overall NHS North Yorkshire and York budget is allocated for the Central Locality (York) and invested in local voluntary groups and charities they will be able to develop more innovative approaches.

Reply

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'Community Health Services, would in principle support service developments from the Third Sector where they are best provided. We would question a fixed percentage allocation of 15%; however, as we consider that commissioning decisions should be based on service user need and investment in effective services, rather than a quota system.

6. York LINk recommends that statutory services commission more learning opportunities for people with mental health problems.

Reply

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'It is not clear whether this is suggesting that there needs to be specific learning opportunities for people with Mental Health problems. Our approach would be to seek to support people to access the learning opportunities available to all, with appropriate support'.
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'Again, we agree in principle. There are already some good examples of investment in learning opportunities in place, such as the partnership with St John's University and North Yorkshire and York Community and Mental Health Services which has resulted in the

		development of a Theatre Course. This and other such initiatives have been well received and in the future we will be exploring further partnership working to enable more learning opportunities for people with mental health problems'.

7. York LINk recommends that NHS North Yorkshire & York and City of York Council consult members of the Mental Health Forum on an ongoing basis to redress this imbalance in the 2010/11 Joint Strategic Needs Assessment.

Replies

Date	Person	
16 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'CYC and NHS North Yorkshire & York currently consult with the Local Implementation Action Group, and have already received, through this group, the issues raised about gaps in services. It is planned that a new Mental Health Partnership and Modernisation Board for York will be established this autumn. This Board will include representatives from the LIAG. The first JSNA recognised that there was a need for more 'voice' and so it is intended that the next refresh will include feedback from users, carers and the voluntary sector'.
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'While it is recognised that the first JSNA identified gaps in evidence, including in the area of mental health, it is disappointing to see it portrayed negatively in this report. The Local Implementation Action Group (LIAG) Chair was actively involved in developing the mental health section of the JSNA and has written to confirm that he does not consider the LINk report's content on the JSNA to be a fair reflection. Nevertheless, NHS North Yorkshire & York and City of York Council recognise that the next version of the JSNA should involve more input from patients, service users, their carers and the general public and will take on board the themes indentified in this and other LINk reports. In the meantime there is

		ongoing engagement of the LIAG in development of services.

8. York LINk should congratulate the many local voluntary groups and charities on the excellent supportive and preventative work that they provide at present.

9. York LINk recommends that NHS North Yorkshire & York commission more preventative services highlighting the dangers of recreational drugs in young people and early intervention services for people who are going through stressful times.

It is worrying that depression and anxiety affects 1 in 6 people at present and is predicted to rise due to the present financial crisis, also, that young people who use cannabis are more prone to develop mental health problems.

Reply

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'We have expanded the Early Intervention in Psychosis service which is based in the Cotford Centre at Bootham Park Hospital. The EIP works with 14-35 year old people and their families who are recovering from a first episode of psychosis. The team is multi-disciplinary, made up of psychiatrists, psychologists, occupational therapists, nurses, social workers and support workers. It is also the responsibility of the Drug and Alcohol Team to ensure that appropriate services are put in place for people who are substance misusers and potential misusers. The DAAT service ensures that commissioning decisions are based on an understanding of local need'.

10. York LINk recommends that NHS North Yorkshire & York investigate providing specific services to support young cannabis users.

Reply

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York	'Please see response above in relation to the DAAT and EIP service. Please note that nationally it is Local Authorities who are the lead for commissioning drug misuse services for young people'.

11. York LINk recommends that York Health Group members (GP's) are made aware of the benefits of asking people about their feelings and providing time to speak about this.

Missed opportunities for introducing early intervention by GPs who may be too busy to speak to people about their feelings must be redressed.

Reply

Date	Person	
01/04/10	John Lethem, Chair York Health Group	I agree, (as a GP) with your point that statistics should be treated with caution and later on about the difficulties GP's have in terms of time available in consultations.

12. York LINk recommends that statutory services implement a campaign to highlight that people with mental health problems are just as capable as other employees and can effectively contribute to businesses.

Replies

Date	Person	
6 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'This will need to be considered as part of the development of our strategy to improve employment opportunities. It may be that a more individualised approach with employers will be more effective than a public campaign. There was a discussion at the last Mental Health Partnership Board about tackling stigma attached to mental health and support for the 'Time to Change' campaign'.

30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York – NHS North Yorkshire & York	'Community and Mental Health Service strongly endorse local initiatives to support people with mental health problems to remain in employment and to regain employment when they have lost it. Work and education are crucial to well-being and people should not be discriminated against because they have experienced mental health problems. We will continue to work with local partners on this issue'.

13. York LINk recommends that statutory services work in partnership to support people recovering from mental health problems to prepare for work and improve their access to employment opportunities.

Reply

Date	Person	
6 Oct	Bill Hodson, Director of Housing & Adult Social Services, City of York Council	'This is a national issue and CYC recognises that more needs to be done to improve employment opportunities and support for many vulnerable groups. We will look to benefit from regional initiatives to take this forward as part of the work on Public Service Agreements 16. The integrated mental health service in York includes a Recovery Service that is active in this area. The opening of the Umbrella Cafe in Bootham Hospital is just one example of new approaches that are being developed in this area'.
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York – NHS North Yorkshire & York	'As the LINk will be aware, this is a national issue and we would agree that more needs to be done to improve employment opportunities for all vulnerable people. The Recovery Service which is part of the integrated mental health service in York is active in this area. As the LINk may be aware the Umbrella cafe at Bootham Park Hospital contributes to this work and is an example of new approaches that are being developed'.

14. York LINk recommends that NHS North Yorkshire & York work with the Independent Domestic Abuse Service to commission appropriate services for children from families with a history of domestic violence

It is encouraging that the onset of mental illness in people below the age of 14 can be prevented in many cases. However, services must be available for the most vulnerable such as children and young people from families with a history of domestic violence.

Reply

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York – NHS North Yorkshire & York	'The governments' draft mental health strategy, New Horizons, addresses this point and many of the others raised in the LINk report. There is also a very active Children's Partnership Board, YorOK Board which looks specifically at issues relating to children and families. NHS North Yorkshire & York are working with partners to support children and families who are victims of domestic abuse'.

15. York LINk should make contact with people in Askham Grange Women's prison to ascertain their views on health and social services.

The social visit or gain information about Askham Grange Prison will be on 4 May 2010.

16. York LINk should establish a York Dementia Group that includes both voluntary and statutory stakeholders to implement the 15 recommendations from the National Dementia Strategy that must be delivered within the next five years.

People fear a lack of control over their lives if they experience dementia in old age which is understandable given the number of people with dementia living in residential or nursing homes. There is much more work to be undertaken in the area of investigating services for people with dementia than was included in the PACE.

Replies

Date	Person	
30 Oct	Jayne Brown, Chief Executive, NHS North Yorkshire & York – NHS North Yorkshire &	'Thank you for the invitation to join the LINks York Dementia Group. I understand that the group is to be established specifically to ensure local implementation

	York	of the National Dementia Strategy. However, it may be helpful for you to be aware that a substantial amount of work has already taken place via the York Dementia Working Group (a sub group of the York LIAG) and we would suggest that the LINk discuss progress on this work with the Chair or with Judith Knapton who is leading on the implementation of the national dementia strategy and a member of the group.

Impact of report

Recommendation to include lay stakeholders in York (mainly York Mental Health Forum) in the commissioning process for a new provider of mental health service at all stages.

The previous Chair of the York CVS Mental Health Forum is now the Chair of the York Mental Health Partnership Board. Consultation on the transformation of services with members of the public will be held via these groups.

Recommendation that services should be commissioned in York using the evidence of need by the population of York.

It has been agreed that the LINk will provide volunteers to take part in the procurement of all new services in York including Mental health services

Recommendation to consult members of the Mental Health Forum on an ongoing basis to redress the imbalance in the 2010/11 Joint Strategic Needs Assessment.

Ongoing discussions are taking place between both bodies. Also, the LINk was asked to help gain information for the Joint Strategic Needs Assessment for 2010/11. A copy of a questionnaire to discover information was distributed to all LINk members with the December edition of the LINked In newsletter.

End of Life Care services

The ‘provision of end of life care services’ was one of the issues with the most votes and so was adopted as part of the LINk work plan for 2009/10.

In July 2008 the Department of Health (DoH) published a national End of Life Care Strategy. This is the first such strategy for the UK and aimed to promote consistently high quality care for all adults at the end of their lives. It acknowledged that, in the past, the profile of end of life care within the NHS and social care services had been relatively low and the quality of care delivered had been variable.

It is envisaged that implementation of this strategy will make a ’step change’ in access to high quality care for all people approaching the end of life. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere.

The strategy stresses the need for Primary Care Trusts (PCTs) to work with local authorities, hospitals, hospices, carers etc to agree and implement ways to promote consistently high quality of care for people as they approach the end of their life.

The Gold Standard Framework (GSF) is an approach which is designed to enable a gold standard of care for all people nearing the end of life. It is concerned with helping people to live well until the end of life and includes care in the final years of life for people with any ‘end stage’ illness in any setting.

The Department of Health End of Life Care Strategy 2008 says that every organisation involved in providing end of life care will be expected to adopt a co-ordination process, such as the Gold Standards Framework. It is also recommended as best practice by NICE, Royal College of General Practitioners, Royal College of Nurses and other major policy groups.

Local background

In North Yorkshire and York, deaths are attributable to three main areas of illness:

- Heart and circulatory disease 41%
- Cancer 26%
- Respiratory disease 12%

Of the remaining 21% some deaths will be sudden or unexpected, such as road accidents. Other deaths relate to a range of long term illnesses such as

Neurological Disease or Renal Disease. Other deaths relate to frailty and very old age, without a specified diagnosis.

In York, approximately 1,822 people of all ages die each year. Approximately 56% of all deaths take place in hospital, 19% take place in peoples own homes, 5% take place in hospices and 19% take place in nursing and residential homes. (PCT End of Life Review/Healthy Ambitions 2008)

In York, NHS North Yorkshire and York staff were already working with City of York Council Social Services staff to review end of life care services before the National Strategy was published. The work began with issues around cancer services but it was recognised that 'end of life' is a much broader area.

The North Yorkshire and York End of Life and Palliative Care Commissioning Strategy 2008-2011 was published in September 2008 and an End of Life and Palliative Care work plan has been developed to deliver the strategy.

In order to discover more about End of Life Care services in York, the LINk Steering Group decided to hold a Public Awareness and Consultation Event (PACE) on End of Life Care services. The event took place on 28th August 2009. Speakers from City of York Council Social Services, NHS North Yorkshire and York and York Foundation Hospital were asked to give information on the services they provide. To include the support available from the voluntary sector a speaker from MacMillan Cancer Support was also invited. Invitations to the event were sent to individuals, local voluntary and community groups and statutory services.

In order to find out about hospice services in York, the LINk Steering Group also arranged an informal visit to St Leonards Hospice on 15th December 2009.

The report on End of Life Care services has been sent to all statutory partners within York for comments before publication as agreed in the LINk report writing protocol. Unfortunately, the 20 day period does not expire until after the York LINk AGM when this annual report is presented. However, a copy of the End of Life Care Report will be available from the LINk office on request as soon as possible after this date.

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Dignity and respect in services

One of the times at which people are most in danger of losing their dignity and self-respect is when they need health or social care services. These services are provided when people are at their most vulnerable and so respect for dignity is particularly important.

Dignity and respect in services was voted onto the 2009/10 LINk work Plan. The Steering Group wanted to find out whether the people of York feel that they are treated with dignity and respect when they receive health and social care services. This includes hospitals, ambulances, clinics, doctors, residential care, day care services, respite care services.

To try to find out about the experiences of people the LINk designed and produced a questionnaire based on a respect and dignity checklist produced by The British Nursing and Midwifery Council (NMC).

From October 2009- February 2010 people visiting the York LINk stand at roadshows and other events were invited to fill in the questionnaire. It was also sent out to groups and organisations on the LINk's mailing list and was available to download from the York LINk website. People were asked to comment on a time within the last year when they or someone they know/care for received a health or social care service in York. The services could include hospitals, ambulances, clinics, doctors, dentists, residential care, day care services, respite care services. In total 90 questionnaires were completed and returned.

The LINk also decided to use Dignity Action Day to raise awareness of the importance of dignity in care with people in York. A display and stand was set up at Morrison's Supermarket, Foss Islands Road on 22nd February and at St Sampson's Centre for older people on 25th February. At both of these events members of the LINk Steering Group talked to shoppers and visitors about the Dignity Campaign and the role everyone can play in promoting dignity and respect in services.

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The questionnaire responses were as follows:

Question	Yes	No	Not sure
Did staff care **about** you as an individual? – not just care **for** you?	72	11	7
Were the staff courteous and respectful?	77	8	5
Did you feel safe and secure when you were there?	79	7	4
Were you, or someone who knew what you would want, involved when decisions were made about your care and treatment?	58	15	17
Were you happy with the treatment you got?	73	8	9
Were you given information about how to make a compliment or complaint?	29	44	17

Question	Not applicable	Yes	No	Not sure
If you were given a meal, did it meet your dietary needs?	53	24	7	7
If necessary, were you given help to eat and drink?	10	69	4	7
Did you get pain relief when you needed it?	33	43	7	7
Were your hygiene and continence needs met?	31	50	6	3

A response from 90 people is only a small percentage of the number of people who have used health and social care services in York during the past year. This small sample cannot be used to draw hard and fast conclusions, but it is a useful ‘snapshot’.

The majority of people who responded to the questionnaire gave answers which indicate that their dignity was maintained and they were treated with respect.

11 of the respondents used the questionnaire to provide further details about their experiences of services. These have been added to the list of issues which have been referred to York LINk. This list is used to compile the issues voting form for LINk members to decide the next years work plan.

The responses to 2 of the questions indicate that there are some services which would not pass the Dignity Challenge:

- Two thirds of respondents (61) were not given, or were not sure if they were given, information about how to make a compliment or complaint.
- Just over one third (32) of respondents answered ‘no’ or ‘not sure’ to the question about whether they (or someone who knew what they would want) were involved when decisions were made about their care and treatment.

Both of these relate to ineffective communication. York LINk is already aware of a number of issues regarding ineffective communication. Carers rights is also an issue on the work plan voting form, and it is hoped a Carers Passport will be introduced in the near future.

Dignity and Respect is not an issue which should stand in isolation or be regarded as another ‘flash-in-the-pan’ initiative. The York LINk Steering group have pledged to make sure it is a fundamental part of all the LINk’s future work plan items and will work to make sure that:

- Issues of dignity are embedded in the commissioning of health and social care.
- Health and social care services in York have policies in place to promote dignity and respect and are able to pass the Dignity Challenge.

To demonstrate their commitment to the Dignity Challenge, in April 2010 the York LINk Steering Group decided that all Steering Group members will sign up to become Dignity Champions.

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8. Further requests for information

Following receipt of a promotional brochure from Yorkshire Ambulance Service.

Date	Person	
7 May	Sara Fatchett, Yorkshire Ambulance Service	Request for contact details for Manager for York area.
		Reply
		None to date

Following Homeless Forum meeting where a lack of Health Visitors was discussed.

Date	Person	
7 June	Pat Sloss, NHS North Yorkshire & York	Request for information regarding the numbers of Health Visitors and where they are based
		Reply
10 June		One HV based at Monkgate for homeless people – need a business case to employ more
2 July		5.52 HVs work in SE York, 7.64 HVs work in West York & 7.56 HVs based in NE York

Following receipt of DH document on how LINks should work with Foundation hospitals.

Date	Person	
2 July	Penny Goff, Membership Manager, York Foundation Hospital	Request for discussions on proposal of LINk member to be Hospital Governor and a Governor to be on LINk Steering Group
		Reply
2 July		Email on 2 July stating this is not appropriate but LINk Steering Group members could put themselves forward to be elected as Public Governors

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Following information changes by PCT to Lower Back Pain treatment.

Date	Person	
24 March 2010	Graham Purdy/Pat Sloss NHS North Yorkshire & York	Request for copies of the 'impact assessment' for the change and copies of the other sources of evidence (other than NICE Guidelines) used to make the decision to withdraw the spinal injections.
		Reply
		No response by the time the Annual Report was printed

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9. Enter & View

The following LINk members have successfully completed a programme of Learning Workshops and have undergone a satisfactory Criminal Records Bureau check. They have familiarised themselves with, and agreed to abide by, the national Code of Conduct relating to Local Involvement Networks' visits to enter and view services.

- Carolyn Murphy
- Andrew Kent
- Jackie Chapman
- Richard Smith
- Kath Briers
- Lesley Pratt
- Fiona Walker

In the Neurological Services report the LINk recommended that a protocol should be drawn up between NHS North Yorkshire & York and Social Services to ensure that a fast-track system is in place that meets the needs of people when equipment is required.

Problems reported to the LINk mainly related to wheelchairs. The response from NHS North Yorkshire & York was 'the PCT is currently looking into these issues with a view to ensuring that patient's needs are met'.

The LINk Steering Group however, agreed to arrange an 'Enter & View' visit to Wheelchair Centre to discover more about the situation.

On 23 March 2010, Lesley Pratt and Kath Briers undertook the first 'Enter & View' visit on behalf of York LINk and produced the following report which was sent to the Weelchair Centre on 12 April 2010:

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York LINk Enter and View Report	
Enter and View visit to:	York Wheelchair Centre Bluebeck House, Bluebeck Drive Shipton Road York YO30 5SF
Date:	23rd March 2010
Authorised Enter and View visitors:	Lesley Pratt Kathleen Briers
The Enter and View visitors would like to thank Jane Thurlow and her staff for their courtesy and cooperation during the visit.	
Background	York wheelchair centre covers the York and Selby area and is funded by North Yorkshire and York NHS Trust. The premises are well equipped and suitable for the work of the wheelchair centre. Parking is available on site, and there is a bus service near by. The centre has 4,500 clients and receives around 1500 referrals per year for motorised and standard wheelchairs. 65% of the centre's clients are aged 65+, 7% are children. Centre staff visit special schools in the area where children have buggies or wheelchairs. The centre is currently fully staffed with 19 staff (including part time). The staff includes physiotherapists and occupational therapists, in-house repair staff, and 2 mobile (off site) repair staff. 2 vans are available for mobile repair work. Facilities at the centre include: • 2 assessment rooms • Workshops • Storerooms • Large reception/waiting area Tea and coffee is available for clients in the waiting area. There are various pamphlets available including a folder showing what accessories are available e.g. wheelchair gloves,

	rain covers. The centre cannot recommend specific suppliers.
Summary	The LINk visitors were made very welcome and were able to view all areas of the centre. They were able to talk to members of staff and clients, although there were only 2 clients at the centre on the day of the visit. One client was undergoing a training session for using a motorised wheelchair - there is a comprehensive training programme for this. The centre is well situated for the training as there is access to a good range of pavements and roads nearby. Each referral (which has to be endorsed by a Health or Social Care professional) is screened by the wheelchair centre and, if required, clients are individually assessed. Each assessment takes about one hour, but flexibility is key as each client has specific needs and the wheelchair is tailored as required. Some assessments therefore take more than one hour. Referrals are considered to be urgent for the following reasons: • Wheelchair required for discharge from hospital • Indication on the referral that the person is in the end stage of a terminal illness Indication of acute, clinical problem that will deteriorate rapidly if equipment is not supplied quickly e.g. pressure sores, high risk of falls. Wheelchair service prescription criteria and agreed policy guidelines say that 'standard attendant push wheelchairs for urgent referrals will be issued as a priority within 5 working days'. The wheelchair centre staff state that they are currently able to meet this target. For urgent referrals with more complex issues, the guidelines do not give a timescale. The average time between the referral and the issue of the wheelchair to the client varies according to the complexity of the need. If a chair has to be ordered, it can take 4-6 weeks after the clinic appointment, depending on the supplier. If this is

	the case, the Centre may offer a basic chair as an interim partial solution. The wheelchair centre buys in equipment from a variety of suppliers throughout the EU and worldwide. A very good stock of wheelchairs and spare parts is kept on site. There is a policy of re-using and re-cycling wheelchairs wherever possible. Some wheelchairs are sent to be re-used in third world countries via a charitable organisation. It is the clients' responsibility to get to and from the wheelchair centre. The Enter and View visitors were advised that some clients experienced problems when using the ambulance service for transport as they were not given a time for the journey home and this could mean that clients are kept waiting for a long time at the centre. On the day of the visit one client had arrived by ambulance but had no idea what time she would be picked up and taken home. There is not currently a wheelchair user/focus group but the Enter and View visitors were advised that one was in the process of being re-introduced. The wheelchair service offers a voucher scheme, which enables clients to enhance the equipment they receive from the wheelchair centre. Clients are able to access models of a higher specification than the standard NHS wheelchair, by paying a top-up towards the cost of the chair. The Enter and View visitors were advised that not many clients took up this option as it meant that they would be responsible for the repairs to the wheelchair. The wheelchair service is not an emergency service. During weekdays when the Repairs Service is operating, response to an urgent repair request is usually the same or next day. From April 1st 2010, anyone with an emergency breakdown after 4pm or at weekends or Bank Holidays can call the PCT's Fast Response Team. They will assess the situation and if

	necessary provide support to enable the person to perform basic functions until their wheelchair can be repaired.
York Link Recommendations	1. Some wheelchair centre clients experience problems with transport to and from the centre. Although travel arrangements are the clients' own responsibility, the wheelchair centre could provide an information leaflet for clients with details of all the options available. This should include details about bus passes and taxi tokens, contact details for disabled taxis and Dial & Ride buses. York LINk would be able to help in the production of this – we have a Readers Panel which reviews health and social care publications. 2. The voucher scheme should be more widely publicised at the wheelchair centre, using posters, leaflets etc. More clients might make use of the scheme if they were aware of the benefits it could bring. York LINk would be happy to help with the design/production of a poster. 3. Re-introducing a wheelchair user group should be a priority for the centre. In addition to dealing with issues relating directly to the wheelchair centre, the group could feed back any issues which relate to other organisations, such as the Yorkshire Ambulance Service or the City of York Council, to York LINk as appropriate. 4. A client/patient pathway needs to be clearly outlined and communicated. This should include a client/patients charter which sets out standards and response times for all types of wheelchair and all client categories. Where precise response times cannot be given e.g. when a wheelchair is being delivered from a supplier, or needs to be customised, the client should be informed of an estimated delivery date, and regularly updated throughout the waiting period. 5. Alongside the development of the client/patient

	pathway, the wheelchair centre should be audited to ISO quality standards. This would ensure that the centre is able to make the most efficient use of its resources and help make sure that the needs and expectations of the clients are met. 6. Although the wheelchair centre is not an emergency service, clients should be provided with contact numbers to be used in case of an emergency breakdown. This information could be attached to the wheelchair so that it is always available, e.g. as a sticker. 7. There is a gap in repair service provision at weekends, Bank Holidays and after 4pm. In the event of a wheelchair breakdown, the Fast Response Team would be able to support the person but they would not be able to repair the wheelchair. There should be provision made for an out of hours repair service.
Conclusion	The wheelchair centre is well run with enthusiastic staff, who work well together. The centre is a very welcoming environment and with a few small adjustments could provide an excellent service.

1. Recommendation that the wheelchair centre could provide an information leaflet for clients with details of all the options available. This should include details about bus passes and taxi tokens, contact details for disabled taxis and Dial & Ride buses.

Some of the LINk Steering Group offered to help produce a leaflet on transport and members of the Readers panel could read the final document and give advice on whether the public would understand the contents.

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'We do have a leaflet but it is not very comprehensive and needs updating, so yes, we would appreciate the help of your Readers Panel.'

2. Recommendation that the voucher scheme should be more widely publicised at the wheelchair centre, using posters, leaflets etc. More clients might make use of the scheme if they were aware of the benefits it could bring.

The LINk offered assistance to produce a poster advertising the voucher scheme

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'Discussion of the scheme features in every clinical assessment, so everyone who is being prescribed a wheelchair knows that they have a choice. As we said at the visit, we have very little take up as the range of wheelchairs we prescribe is quite wide and covers most clients' needs and wants. Not all NHS chairs are heavy and red! By taking up the voucher scheme the client has the responsibility for all repairs, and most prefer the security of access to our repairs service. The scheme costs the NHS clients more. This is because we pay the cost of the prescribed chair plus 3% to cover repairs costs (even if they never have to spend this). Also, the client pays the retail cost for their chair, rather than the discounted cost available to the Wheelchair Service. So the main difference from what we prescribe, having cost us an extra 3% and them possibly £100 or more. So we feel the benefits are marginal and therefore not worth publicising more widely.

3. The recommendation to re-introducing a wheelchair user group as a priority for the centre.

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'We absolutely agree that we need a user group and are currently working towards setting one up. This group may well want to feedback to York LINk if appropriate.

4. Recommendation that a client/patient pathway needs to be clearly outlined and communicated which includes a client/patients charter which sets out standards and response times for all types of wheelchair and all client categories.

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'We are currently taking part in a service development project that is looking at the reporting and improving of wait times and pathways. It may be that this will result in the creation of a leaflet foe our clients. In any case we do try to keep our clients informed of how long they are likely to wait at each stage in the process.

5. The recommendation to develop a client/patient pathway using ISO quality standards.

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'We are not aware of any other NHS wheelchair service being audited to ISO quality standards, and would need much more information on the implications and benefits before we could decide whether this would be a desirable move.

6. Recommendation to provided contact numbers to be used in case of an emergency breakdown which could be attached to the wheelchair as a sticker.

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'Every wheelchair we have on issue has a yellow sticker showing the phone number of the Wheelchair Centre. The ansaphone gives the repairs number, and every user is given the repairs number in their welcome pack when they are issued with the chair.

7. Recommendation that provision for an out of hours repair service is made.

Reply

Date	Person	
15 April	Jane Thurlow, Team leader, York Wheelchair Centre, NHS North Yorkshire & York	'Until the end of March 2010 we did offer a service, but the take-up was very low, and most people were able and willing to wait instil a repairs engineers could call the next day. This was an expensive service to provide as under NHS conditions of service we had to pay the staff a % uplift on their basic salary. We therefore decided to stop this rarely used service and instead offer the option of clients contacting the PCT's Fast Response Team if they felt they could not cope. This team can provide essential support if necessary out of hours.

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10. Summaries

Requests for information

Total number of requests	6
Number related to health	6
Number related to social care	0
Number received within 20 days	1

Enter & View visits

Total number of visits	1
Number related to health	1 joint
Number related to social care	1 joint
Number that were announced	1
Number that were unannounced	0

Recommendations from reports

Total number of reports	2
Total number of recommendations to York Foundation Trust	6
Number replied with required timescale	0
Number recommendations to NHS North Yorkshire & York	18
Number replied with required timescale	18
Total number of recommendations to City of York Social Services	11
Number replied with required timescale	11
Total number of recommendations to City of York Health OSC	1
Number replied with required timescale	1
Total number of recommendations to York GP's via York Health Group	5
Number replied with required timescale	0
Number of recommendations that have led to changes in services	6

Annex C

11. Financial statement

Amount allocated to City of York Council by the Department of Health	**£108,330**
Amount retained by City of York Council for administration	£ 3,330
Amount allocated to LINk NBF (Host) by City of York Council	**£105,000**
Amount carried over from 2008/9	£ 25,305
Total LINk budget	**£130.305**
Total spent by NBF	£ 86,471
Total spent by LINk	£ 13,931
Total spend	£100,402
Under-spend	**£ 29,903**

Income and Expenditure Analysis 2009-2010

Host	**Budget**	**Expenditure**	**Variance**
Staff Salaries/NI	£ 50,367	£ 50,645	-£ 278
Accommodation	£ 7,221	£ 6,106	£ 1,115
Staff Expenses	£ 3,000	£ 2,053	£ 947
Overheads	£ 26,511	£ 27,667	-£ 1,156
Total	**£ 87,099**	**£ 86,471**	**£ 628**

LINk	**Budget**	**Expenditure**	**Variance**
Participant's Expenses	£ 1,000	£ 818	£ 182
Marketing	£ 5,000	£ 4,673	£ 327
LINK Activity	£ 37,206	£ 8,440	£ 28,766
Total	**£ 43,206**	**£ 13,931**	**£ 29,275**

Grand Total	**£ 130,305**	**£ 100,402**	**£ 29,903**

Notes:

Host overheads include: Salaries, Administration, Communications, CRB Checks, Office Supplies and Facilities.

LINK Activity Costs include: Hospitality, Meeting/Conference Facilities, Postage and Reprographics.

Budget Allocation not spent (£29,903) is to be carried forward to 2010- 2011 to fund LINk activity.

Annex C

Appendix 1.

List of public events organised by the LINk

Event	Date
Public Awareness & Consultation Event on Neurological Services	25 June ‘09
Public Awareness & Consultation Event on Mental Health Services	20 July ‘09
Public Awareness & Consultation Event on End of Life Care services	28 August ‘09
LINk awareness raising roadshow, Guildhall	1 October ‘09
LINk awareness raising roadshow, New Earswick	14 October ‘09
Joint consultation event (Big Care Debate) with York CVS & York Carers Forum	30 October ‘09
LINk awareness raising roadshow, Haxby	11 November ‘09
LINk awareness raising roadshow, Dunnington	19 November ‘09
LINk awareness raising roadshow, Poppleton	8 December ‘09
LINk awareness raising roadshow, Acomb	13 January ‘10

Annex C

Appendix 2.

LINk Report Writing Protocol

Following an inquiry of issues, York LINk will publish a report containing the findings and any recommendations to improve or develop services.

It is important to try to make sure that everyone in the community has a chance to contribute towards the evidence given to the LINk and statutory services have the chance to verify that the LINk has the correct factual information about the services necessary to provide constructive recommendations.

This will be achieved though the following steps:-

Prior to adopting an issue for inquiry

1. Information on how to refer ‘issues’ for the work plan will be published in the LINk newsletter and posted on the website at least two months prior to the Annual General Meeting (AGM).
2. When all issues have been gathered they will be collated into an ‘issues voting form’ that will be sent to all members. Members will be asked to complete and return the form at least two weeks before the date of the LINk AGM.
3. The result of the voting will be assessed by at least two members of the Steering Group and the issues collecting the highest number of votes will be adopted to form the LINk the work plan for the following year.
4. The work plan will be announced at the AGM and communicated to other members via the next LINk newsletter and posted on the LINk website.

5. All voting papers will be retained by the LINk until at least the next AGM.

Collecting information

1. Following the AGM the LINk Steering Group will agree dates to begin enquiries into the various issues during the year.

2. Notification of the start of an inquiry will be published via a letter in the 'letters page' or an editorial in the 'Press' newspaper. This will appear at least two weeks prior to the agreed date for an enquiry and will request further information on the relevant issue.

3. The LINk will request information from statutory services, arrange 'enter and view' visits or Public Awareness and Information Events (PACE) to gain further information prior to writing a report.

4. The LINk will cross reference all evidence and information gained from the above actions to the Care Quality Commission Essential Standards of Quality and Safety; all information will be retained and made available to the Care Quality Commission Assessors on request.

Writing a LINk report

1. When Steering Group members are satisfied that all information has been collected a report of the findings will be written in draft form and sent to presenters at PACE events etc as required, for verification.

2. A meeting will be arranged with at least two Steering Group members who will go through the information in the report and agree recommendations that meet the Care Quality Commission Essential Standards.

3. The recommendations including the numbers of people who provided evidence will be written into the draft report which will then be sent to statutory services for initial comment and verification of factual accuracy - within a timescale of twenty working days.

4. The draft report will then be sent to all Steering Group members for final agreement / approval at the following Steering Group meeting. Any responses from statutory services to the draft report will be discussed at that meeting.

Publishing a LINk report

1. When a draft report has been agreed at a LINk Steering Group meeting it will be published within a period of two weeks.
2. The published report and a letter outlining the recommendations will be sent by the LINk to the relevant statutory authority requesting a response within 20 days or a reason why this is unavailable.
3. The expected response should include details of how the relevant statutory authority intends to take forward the recommendations made, or provide an explanation as to why this will not be feasible.
4. A notice will be put in the ‘Press’ newspaper and the LINk newsletter and posted on the website to inform members and the public that the published report is available via the website, and on request from the LINk office.
5. A copy of the published report will also be sent to all public libraries and as many public gathering places as possible in York with a request to put it on display.
6. A letter will be sent to everyone who provided evidence asking them to inform the LINk office if they would like a copy of the published report.

This protocol has been agreed by the LINk Steering Group and statutory authorities.

Signed: .....Date.....

Annex C

Appendix 3.

Community Reps	
1. Kathleen Briers	Individual
2. Robin McIlroy	Ex PPI Forum
3. Carolyn Murphy	Ex PPI Forum
4. Jane Perger	Individual
5. Lesley Pratt	Ex PPI Forum
6. Jackie Chapman	Individual from May 09
7. Vacant	
Voluntary Reps	
1. Andrew Kent	People with Neurological conditions
2. Katie Smith	Carers
3. Fiona Walker	People with Learning Difficulties
4. Chris Edmondson from Nov 09	People with Disabilities
5. Sian Balsom from March 10	York CVS
6. Vacant	Older People
7. Vacant	BME

Annex C

York Local Involvement Network
Holgate Villa
22 Holgate Road
York
YO24 4AB
Tel: 01904 621631
Fax: 0845 3130271
email: admin@yorklink.org.uk
website: www.yorklink.org.uk

North Bank Forum
2nd Floor
94 Alfred Gelder Street
Hull
HU1 2AN
01482472458
admin@nbforum.
www.nbforum.org.uk

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York LINk Work Plan 2010 - 11

Meeting dates	Work Programme
July	1. 7 July - Steering Group meeting – 6pm Priory Street Centre 2. 8 July – Statutory Stakeholders meeting 3. 13 July – Hospital Discharge PACE
August	1. 3 Aug – Training for Home Carers, City Mills - neurological conditions
September	1. 1 Sept - Steering Group meeting – 10am Holgate Villa 2. 8 Sept – Carers Rights PACE 3. Final Report from Hospital Discharge PACE
October	1. 6 Oct - Steering Group meeting– 10am Holgate Villa
November	1. 3 Nov – Steering Group meeting - 10am Holgate Villa 2. Final Report from Carers Rights PACE
December	1. 1 Dec - Steering Group meeting - 10am Holgate Villa

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CITY OF YORK COUNCIL

Health Overview & Scrutiny Committee **20th July 2010**

Report of the Head of Civic, Legal & Democratic Services

Transforming Community Services

Summary

1. This report provides Members with the opportunity to comment on a recent NHS North Yorkshire & York board paper, which provides an update regarding how Transforming Community Services is being introduced in North Yorkshire & York. This is attached at Annex A to this report.

2. It also provides Members with further background information on Transforming Community Services for information and details are at Annexes B, C & D to this report.

Background

3. NHS North Yorkshire & York currently has two distinct functions – firstly it is the main commissioner of healthcare services from hospital trusts and secondly, via its provider arm (Community & Mental Health Services (CMHS)), it provides a wide range of community health care services, including:

- District nurses, community rehabilitation, fast response teams
- Specialist nursing (e.g., diabetes, cancer, palliative care)
- Children's and family services (health visiting, school nursing, community paediatrics, specialist nursing and speech therapy)
- Sexual health and family planning services
- Community equipment and wheelchair services
- Safeguarding children, smoking cessation
- Podiatry
- Salaried dental services
- Prison healthcare
- Minor injuries units and walk in services
- GP out of hours services

4. CMHS also provides mental health services across most of North Yorkshire, including York.

5. In January 2009 the Department of Health issued national guidance, 'Transforming Community Services: Enabling new patterns of provision' under which Primary Care Trusts (PCTs) are required to have determined the future

organisational model for separating their provider and commissioning functions by October 2010. The Executive Summary is included at Annex B to this report.

6. In February 2010 the Department of Health published 'the assurance and approvals process for PCT provided community services' which sets out the criteria Strategic Health Authorities had to use to assess PCT's proposals for new organisational structures. These criteria are set out in Annex C to this report.

7. In addition to this, and as a result of the changed political environment there have been changes to the operating framework for the NHS in England 2010/11. Revisions to this document included 'Future Direction and next steps on transforming community services' and the relevant extract is at Annex D to this report.

8. The Deputy Chief Executive (Director of Localities) from NHS North Yorkshire & York will be in attendance at the meeting to present the update (Annex A refers) and answer any questions that Members might have.

Consultation

9. As work has progressed, Members have received several updates at previous meetings in relation to Transforming Community Services.

Options

10. Members are asked to:

    i. Comment on the updates received at today's meeting.

    ii. Consider and comment on the impact 'Transforming Community Services' will have on the residents of York

11. Members also have the option of receiving further updates from NHS North Yorkshire & York as their work progresses.

Analysis

12. Members should consider the effect that the proposals set out above and in the updates today will have on the residents of York and advise NHS North Yorkshire & York of any concerns that they might have or comments that they would like to make.

13. Members are advised to ask for a further update from NHS North Yorkshire & York once further progress has been made.

Corporate Strategy 2009/2012

14. This report relates to the Healthy City theme of the Corporate Strategy 2009/2012.

Implications

15. There are no known financial, legal or human resources implications associated with the recommendations within this report. However; 'Transforming Community Services' may well have an impact on the way some services are delivered to York residents in the future.

Risk Management

16. In compliance with the Council's risk management strategy there are no risks associated with the recommendations within this report.

Recommendations

17. Members are asked to:

    i. Note the report and updates given at today's meeting and provide any comments they may have to NHS North Yorkshire & York

    ii. Consider when they would like to receive a further update from NHS North Yorkshire & York

    Reason: In order to carry out their duty to promote the health needs of the people they represent

Contact Details

Author:
Tracy Wallis
Scrutiny Officer
Scrutiny Services
Tel: 01904 551714

Chief Officer Responsible for the report:
Andrew Docherty
Head of Civic, Democratic & Legal Services
Tel: 01904 551004

Report Approved ✓ **Date** 9th July 2010

Specialist Implications Officer(s) None
Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
Attached

Annexes

Annex A PCT Board Paper dated 22nd June 2010
Annex B Executive Summary: Transforming Community Services: Enabling New Patterns of Provision
Annex C Extract: Transforming Community Services: The Assurance and Approvals Process for PCT-Provided Community Services
Annex D Extract From the Revision to the Operating Framework for the NHS in England 2010/11

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Annex A

Item Number:

NHS NORTH YORKSHIRE AND YORK **BOARD MEETING**	NHS *North Yorkshire and York*

Meeting Date: 22nd June 2010

Report's Sponsoring Director:	**Report Author:**
Sue Metcalfe, Deputy Chief Executive (Director of Localities)	**Annabel Johnson, Assistant Director**

1. Title of Paper: Transforming Community & Mental Health Services – Provider Form Project Update

2. Strategic Goals supported by this paper:

Goal 4 - Clinically and financially sustainable healthcare system. The decision about provider form for CMHS will contribute to creating a sustainable healthcare system.

Goal 4 - Highest quality care in the right setting. In considering provider form we aim to provide high quality care in the appropriate setting.

Goal 6 - Strong partnerships focused on the individual. Through discussion about provider form for CMHS we aim to build stronger partnership arrangements to enable improved focussed on the individual.

3. Executive Summary

Following the publication of the operating framework in December 2009 PCTs were required to have determined the future organisational model for PCT provided services by October 2010 at the very latest. The Board has previously agreed that: CMHS will hosted by NHS NYY until March 2011, that the model for PCT provided services will be determined by October 2010 and that a plan will be in place to enable implementation to commence post October 2010. This paper provides an update to the Board of the progress made on provider form, which is a significant project within the strategic initiative 'an improved community system'.

4. Introduction

See above

5. Issue/options

Not applicable

Annex A

6. Risks relating to issue/options

Governance arrangements are in place to ensure that all risks are managed and currently all risks are being managed without the need for further escalation

7. Finance / resource implications

Not applicable

8. Statutory/regulatory/legal implications

These implications are being addressed through the governance arrangements in place.

9. Working with stakeholders/communications plan

Stakeholder analysis and a communications plan have been finalised and agreed and are now being implemented.

Staff engagement is critical to this project and comprehensive plans are in place to ensure this is achieved

10. Recommendations / Action Required

The Board is asked to note and support the progress of this Programme.

11. Assurance

The Board will receive monthly updates regarding progress of this project.

For further information please contact:

Name Annabel Johnson

Title Assistant Director - Strategy

Phone number 01904 694720

Annex A

NHS NORTH YORKSHIRE AND YORK

Board Meeting: 22nd June 2010

Report Title: Transforming Community & Mental Health Services – Provider Form Project Update

1. Introduction

1.1 Following the publication of the operating framework in December 2009 PCTs were required to have determined the future organisational model for PCT provided services by October 2010 at the very latest. The Board has previously agreed that; CMHS will hosted by NHS NYY until March 2011, that the model for PCT provided services will be determined by October 2010 and that a plan will be in place in to enable implementation in post October 2010. The Board has already discounted a range of provider models recorded in a letter to the Strategic Health Authority (SHA).

2. Project Governance

2.1 The governance structure is now well embedded which ensures that this project is part of the 'improved community system' strategic initiative outlined in the strategic plan. The decision making body for this project is NHS NYY Board.

3. Progress on Community Services – Groupings of Services

3.1 The **Locality System Boards** (LSBs) have met a number of times with key stakeholders. The following organisations have been invited to either attend the meetings or be involved in the process in a way that suits them (e.g. other large stakeholder groups):

- Local Acute provider(s)
- Mental Health Provider
- CMHS
- Practice Based Commissioning consortia
- District Council(s)
- County Council / City Council (Adult & Children's Services)
- CVS
- LINkS
- Large local stakeholder groups

If those listed have not been able to attend meetings (in particular LINkS) the PCT has offered to meet with them separately to ensure their views are acknowledged. This has enabled discussion about the current configuration of community services, including presentations from CMHS which has informed their recommendations about appropriate groupings of services as we move into the managed

process. LSBs were asked to consider whether services should be provided on a locality basis or Pan NYY.

3.2 The **Community Programme Board** has also met a number of times and the membership has been extended to include representation from North Yorkshire County Council and City of York Council.

At the meeting in June the Board considered the views of the councils, LSBs, commissioning subject matter experts and CMHS about the groupings of services. It should be noted that NYCC were consistent in their approach that a county wide solution would be preferable from their perspective. However there were varying views across the localities which were highlighted at the LSBs.

Extensive staff engagement has also been undertaken through a variety of mechanisms to ensure that all staff have been and will be able to voice their views. The views of a third of the workforce have been captured through these mechanisms. Key points to note from views collated so far are that:

- integration with an acute or mental health trust are the preferred options and
- retaining NHS terms and conditions is important as is remaining an NHS employee
- the ability to influence quality patient care, improve outcomes and experience for patients is seen as important as is continuity of care
- there is still some confusion over the process and rationale for transforming community and mental health services and therefore some cynicism
- current information needs are being met, but there is a recognition that the intranet is not being accessed by all staff

At the Programme Board it was noted that when considering the groupings of services approximately 80% of the initial recommendations from the various sources were the same. The areas where there was a difference of opinion were debated and collective agreement was reached for example: podiatry and speech and language therapy.

3.3 As the managed process continues the groupings of services will determine the ‘lots’ of services that will be available to providers. It is important to ensure that these ‘lots’ contribute to enhancing patient care and are therefore focussed around patient pathways and do not lead to unnecessary fragmentation of services. A flexible approach will also need to be adopted to ensure that we enable the market to respond appropriately, for example providers will be able to ‘bid’ to provide services in more than one locality. It was also noted that in some instances a one year solution may be required, whilst the service

is reviewed and possibly re-commissioned in another way. The programme board made the following recommendations:

Services that could be provided/managed on a locality basis:

- Older people and vulnerable adults services (district nursing, community matrons, falls assessment, case management, fast response teams, community rehabilitation, community hospitals)
- Specialist nursing services (tissue viability, heart failure, cardiac rehabilitation, diabetes, respiratory, continence and palliative care, cancer and lymphoedema services)
- Children's and family services (health visiting, school nursing, community paediatrics, specialist nursing and speech and language therapy) with a clear aim that there must be integrated approaches to working to ensure coterminosity with local authority boundaries and alignment with primary care
- Sexual health and family planning services – with close alignment to children and families
- Extended scope services (MSK, physiotherapy, chronic pain and fatigue, nutrition and dietetics, speech and language therapy)

Services that could be managed on a pan NYY basis (with locality delivery)

- Community equipment and wheelchair services
- TB liaison and infection prevention and control
- Safeguarding children
- Smoking cessation
- Salaried dental services
- Podiatry
- Prison healthcare (Askham Grange and Northallerton)
- Minor injury units and walk in services
- GP OOH services

3.4 **The Managed Process**

Having taken advice from the Competition and Co-operation panel, the SHA, the Commercial Procurement Collaborative (CPC) and a range of other PCTs it was agreed by NYY PCT Board that the PCT should follow an open and transparent managed process. The following process is currently underway:

- Advert in Yorkshire Post on 1st and 3rd June inviting expressions of interest from providers. Providers were able to access a memorandum of information and complete a pre-qualification questionnaire.
- A launch event took place on 11th June which was attended by 11 providers including local acute trusts and some GP consortia. A presentation was given by the Deputy Chief Executive and Managing

Director outlining the commissioning priorities for community services and the current configuration of services.

- The closing date for expressions of interest and completion of a pre-qualification questionnaire is 18th June.
- The membership and Terms of Reference for the assessment panel have been agreed and are attached at Appendix One.
- The short listing assessment panel takes place on 25th June. Successful providers will be notified week commencing 28th June and supplied with a provider information pack. They will be asked to produce a strategic outline case and a presentation for consideration in early July. This will also be the beginning of the dialogue phase where managed discussions will take place with short listed organisations.
- Providers will submit their strategic outline cases on 6th July and they will give presentations to the PCT assessment panel on 9th July.
- The panel will re-convene on 14th July to make initial recommendations about preferred providers. These recommendations will be presented at the 27th July Board meeting.
- Once preferred providers are agreed a process of validation and dialogue with PBC and PCT commissioners will take place throughout August and September to enable board agreement and sign off to take place at the 26th October Board meeting.

4. Progress on Mental Health

The mental health transfer group has met and agreed Terms of Reference for the mental health project. Chairs of the relevant PBC groups have been contacted and invited to attend the mental health transfer meetings, be involved in the development of new service specifications and in the overall procurement exercise.

Lead commissioners at NHS NYY have met with CPC to clarify the arrangement of the project management and procurement support from CPC to NHS NYY during the mental health transfer; it is understood the procurement exercise will take approximately 2 years from start to completion (which includes staff TUPE to new organisation). The timescales for delivery will be finalised once the project specification has been agreed with CPC. A meeting has been arranged in July with Bradford District Care Trust to discuss the possibility of the Craven locality mental health services being included in the mental health procurement exercise.

5. Recommendation

The Board is asked to approve the groupings of services and support the progress of this Programme.

Annex A

Appendix One

Transforming Community Services – Assessment Panel

Terms of Reference

Purpose

The overall purpose of the Transforming Community Services (TCS) Assessment panel is to:

- Shortlist potential providers from Initial Expressions of Interest received by the PCT
- Assess short listed providers for community services against a set of agreed criteria and make decisions based on that agreed criteria.
- From short listed providers make recommendations to NHS North Yorkshire and York Board of suitable provider models of delivery.

The assessment panel will adhere to the Department of Health TCS assessment criteria, which have been consistently highlighted throughout the process and will also utilise the information provided by the Locality Boards, CMHS Provider team, speciality managers and staff.

The assessment panel will also adhere to the timetable agreed with Y&H SHA with an October completion date for Community Service agreed models, meaning that the process will be a Managed Process and not a full tender.

The overall aim is to ensure the delivery of modern, high quality and sustainable community services which are responsive to individual needs of service users, whilst offering best value for money.

Accountability

The Assessment Panel will make recommendations and report to the Board of NHS North Yorkshire and York.

Risks and Issues

The Assessment Panel will be responsible for identifying, mitigating and reporting any risks to the successful delivery of the TCS project.

Membership

Full Panel members with decision making rights

Jayne Brown, CEO (Chair)

Annex A

Sue Metcalfe, Deputy CEO
Dr Vicky Pleydell, Clinical Executive
Dr John Letham, PBC rep
Geoff Donnelly, NED
Debbie Newton, Deputy Director Finance
Gary Hardman, Director of Quality, Lead Nurse

Observers with speaking rights (no decision making rights)

Janet Probert, Managing Director CMHS
Dave Hendy, Staff Side Rep
Local Authority Representative NYCC, (if not bidding)
Local Authority Representative CYC, (if not bidding)

Supporting Staff

Annabel Johnson, Asst Director Strategy
Robyn Carter, Asst Director CMHS
Kate Tattershall, Project Manager

Simon Cox, Locality Director, East
Amanda Brown, Locality Director, Central
Alex Morton-Roberts, Locality Director, York
Amanda Bloor, Locality Director, West.

Amanda Wilcock – Associate Director Human Resources.

Business Conduct

11 June 2010 - Information event for interested providers
By 18 June – PCT to receive expressions of interest.

The Panel will meet on:

- 25 June 2010 to short list providers
- 9 July 2010 to assess Strategic Outline Case and Presentations
- 14 July 2010 to finalise recommendations to PCT Board

Annex B

Department of Health

EXECUTIVE SUMMARY

Transforming Community Services:

Enabling new patterns of provision

NHS

Annex B

DH INFORMATION READER BOX

Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning/	Finance
Clinical	Social Care/Partnership Working

Document purpose	Best Practice Guidance
Gateway Reference	10850
Title	Transforming Community Services: Enabling New Patterns of Provision
Author	Transforming Community Services team, DH
Publication date	13 Jan 2009
Target audience	PCT CEs, SHA CEs, PCT Chairs
Circulation list	NHS Trust CEs, Care Trust CEs, Foundation Trust CEs, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs, Trade Unions
Description	This enabling guidance is intended to help PCT providers of community services to move their relationship with their commissioners to a purely contractual one, consider what type(s) of organisations would best meet the future needs of patients and local communities, and how change can be managed to support the transformation of services to patients.
Cross ref	Transforming Community Services: Resource Pack for Commissioners of Community Services
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact Details	Helen Dixon New Models of Care Department of Health 6th Floor, New King's Beam House Upper Ground, London SE1 9BW
For recipient's use	

First published 13 January 2009

Produced by the Department of Health

Transforming Community Services:

Enabling new patterns of provision

Contents

Executive Summary

High Quality Care for All has set a clear overall vision – to make quality the organising principle for the NHS. It defines quality as spanning three areas: patient safety, patient experience and the effectiveness of care. These three things taken together will make a quality service. This will require transformational change – by clinicians and other front-line staff, by the organisations providing community services and by commissioners.

Our vision for primary and community care[1] made a public commitment to creating modern, responsive community services of a consistently high standard. We believe that this is what patients and communities need and deserve, and what staff want to deliver.

This is why we have placed quality and enabling transformational change at the core of the Transforming Community Services programme. We have already begun to co-produce with the NHS a Quality Framework for community services. This is being designed to reflect the particular circumstances and challenges of community services. An equally high priority is enabling transformational clinical practice – disseminating best practice and investing in developing clinical and leadership skills.

In parallel, we need to transform the commissioning of community services. We are doing this through World Class Commissioning, and by providing commissioners with the tools they need to drive service improvement – a new standard contract, guidance on costing and pricing, information and metrics.

But to secure modern, high quality community services we also need to ensure that the organisations providing them are fit for purpose. We need modern organisations, which enable and empower front-line staff to innovate and free up their time to care for patients. Organisations which empower all clinicians to shape the future of community services, and provide them with the support and resources they need to be world class practitioners. Organisations which have a robust business infrastructure, capable of contracting with commissioners and effective business planning. Such organisations also need to be sustainable and flexible – capable of evolving to meet an increasingly challenging environment of rising patient expectations, more demanding PCT and practice-based commissioners (wanting higher service quality, more effective targeting of resources to need, and better value), and increasing patient choice.

The aim of this enabling document is to help providers of community services to meet these challenges by considering what type(s) of organisations would best meet the needs of patients and local communities (informed by a thorough needs analysis), and how such change can be managed well to support the transformation of services to patients. This includes following good workforce practice, and timely and sustained engagement with key local stakeholders. Retaining skilled and well-motivated teams of clinical and non-clinical staff during a period of change will be

[1] *NHS Next Stage Review: Our vision for primary and community care*, Department of Health, July 2008

a critical factor in maintaining and improving the quality of provision of services to patients. Early engagement with staff and their trade unions will be central to the success of a strategic approach to transforming community services.

There is no national 'blueprint'. Decisions will be taken locally by PCT Boards as the responsible statutory authorities, with processes and decision-making assured by Strategic Health Authorities. To help support local decision-making, a set of guiding principles should underpin this transformational change. These include:

> the interests of patients and carers must be paramount;

> quality is the organising principle – organisations must enable the provision of safe, effective, personalised care. This will require the capacity and capability for transformational service change;

> a pre-requisite for PCTs is a clear commissioning strategy, with improving quality and reducing inequalities at its core;

> proposals must also be able to deliver value for money for tax-payers;

> decisions about how services are provided should be led and made locally, with robust consultation processes;

> recognition that services differ in their characteristics and the people they serve, and therefore that different solutions may suit different services, even within the same locality;

> the early and continued involvement of staff, trade unions and stakeholders before any decisions are made;

> high standards of human resource management should be followed;

> assurance, approval and authorisation processes must be clear, robust and transparent;

> proposals must enable integrated care including with Local Authority services where appropriate, World Class Commissioning and patient choice;

> proposals must fit with the Department's published *Principles and Rules for Cooperation and Competition*;

> options are equality impact assessed;

> provision of safeguards for service continuity, assets[2] and staff pensions.

[2] Control of current PCT property should be protected in the interests of taxpayers and to ensure that commissioners have sufficient leverage to drive change and improve quality. As a rule, property will not be transferred to providers and PCTs will be encouraged to develop strategic partnerships that make the best use of estate.

One of the reasons for producing this guidance is the current highly variable pace of organisational change to services directly-provided by PCTs. Decisions should be led locally, but it is in everyone's interest that change is managed coherently, to high standards, and reflects the consistent application of common guiding principles and criteria. As part of good leadership and to reduce uncertainty, all PCT boards should start to engage their staff, unions, communities and stakeholders about the likely future direction for the provision of their community services.

The requirement to *'create an internal separation of their operational provider services, agree SLAs, based on the same business and financial rules as applied to all other providers'* was included in the NHS Operating Framework for 2008/09. Therefore **by April 2009 all PCT direct provider organisations should have moved into a contractual relationship with their PCT commissioning function, using the national contract for community services in 2009/10**. This means ensuring sufficient separation of roles within the PCT to avoid direct conflicts of interests.

It is anticipated that, **by October 2009**, PCT commissioners, working closely with their practice-based commissioners, will have developed a detailed plan for transforming community services, including how they intend to enhance patient choice, for agreement with their SHA. To the same timescale, PCT provider services should review (in consultation with local staff and trade unions) and assure themselves that they have the best governance arrangements to sustain high quality community services that best suit local need and circumstances, and whether to declare an interest in establishing new governance arrangements, such as a social enterprise or Community Foundation Trust.

There is a range of potential options for providing community services, from PCT provider services (which will continue to be an option where well-led, well-managed and more business-like), through Community Foundation Trusts, social enterprises for which there is a right to request, integration with other NHS organisations, and PCTs contracting with integrated care organisations, or non-NHS bodies. Different forms may suit different services and hybrid organisations derived from more standard original models may well emerge as systems evolve. *There is no prescribed ideal form and it is a matter for local determination.*

Key points for Chief Executives

> the drivers are for modern, innovative community services that have direct benefits for patients, are responsive to local need, and promote seamless care through increased opportunities for integration of health and social care services;

> there is a clear timetable for PCT provided services to move into a contractual relationship with their PCT commissioning arm, and to develop plans for transforming community services and options for future organisational forms. PCTs can move more quickly provided certain requirements are met;

- ensure clarity about the future ownership of assets;
- ensure robust arrangements are in place for staff engagement and trade union consultation throughout the process;
- the processes outlined enable a PCT to commissioning fairly, whilst developing its in-house provider to become business ready, exercise a right to request, and have "first call" in the initial stages;
- the leadership, capability and capacity of the provider sub committee needs to be of a sufficiently high calibre to take forward new patterns confidently and competently, with appropriate development programmes to enable this;
- services and business continuity must be maintained during these management changes so that patient care is not compromised;
- the SHA has a clear role in assuring the process leading to the PCT Board decision of new patterns of community service provision.

Key points for PCT Boards

- the evidence of benefits to patients and value for the taxpayer of options must be clearly demonstrated;
- decisions will be taken locally by PCT Boards as the responsible statutory authorities, with processes and decision-making assured by Strategic Health Authorities;
- the process is underpinned with robust governance arrangements;
- the role and responsibilities of Non-Executive Directors (NEDS) are discharged in a manner which allows them to fulfil the terms of their appointment to the corporate PCT Board;
- the inevitable split of the Board is managed in such a way to expose and manage conflicts of interest in an open, transparent manner;
- the interests of the workforce are appropriately addressed and safeguarded during the period of preparation and implementation;
- the timeframe and remuneration for the creation of new Boards as a consequence of the separation and provider market development is clarified.

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Annex C

EXTRACT FROM

Transforming Community Services

The assurance and approvals process for PCT-provided community services

Annex C

DH INFORMATION

Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning/	Finance
Clinical	Social Care/Partnership working

Document Purpose	Best Practice Guidance
Gateway Reference:	13306
Title	Transforming Community Services: The assurance and approvals process for PCT-provided community services
Author	Transforming Community Services team, DH
Publication Date	5 February 2010
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs
Circulation List	Voluntary Organisations/NDPBs, Trade Unions
Description	This guidance supports PCTS and SHAs in an assurance and approvals process for community provider organisational forms. It includes a set of national tests against which proposals for new organisational forms will be assured.
Cross Reference	Transforming Community Services: Enabling New Patterns of provision
Superseded Documents	N/A
Action Required	PCTs to take into account national assurance and approvals process, including assurance tests set out within this guidance.
Timing	**By 31 March 2010**
Contact Details	Transforming Community Services Department of Health 6th Floor, New King's Beam House Upper Ground London SE1 9BW www.dh.gov.uk/tcs transformingcommunityservices@dh.gsi.gov.uk
For Recipient's Use	

First published February 2010

Produced by COI for the Department of Health

www.dh.gov.uk/publications

	No	Test	Areas to be assured by PCT and SHA
Quality Improvement	**1**	**Improving Outcomes** Will it meet patient needs and deliver improved local health outcomes as identified in the PCT strategic commissioning plan and Local Area Agreement (LAA), and significantly better patient experience (including Choice)?	• The fit with the PCT Commissioning Strategy and priority outcomes as identified in World Class Commissioning, including joint commissioning plans • That there are robust plans which show how patient experience for all groups will be significantly improved, and assess the impact on inequalities.
	2	**Improving Quality** Will it deliver significant improvements in quality of service and outcomes delivered?	• That there are identified improvements in quality of service outcomes to be delivered • That there is a clear plan and capability to shift from acute to out of hospital care • That the improvements in quality will be sustained
	3	**Service Integration** Will it deliver significant improvements in service integration and quality of health and social care?	• The proposals demonstrate at patient and pathway level how service integration will be enhanced to improve care • Show how the proposal supports primary, community, secondary, children's services and social care partners to increase prevention through more integrated approaches

	No	Test	Areas to be assured by PCT and SHA
Quality Improvement	**4**	**Stakeholder Engagement** Has it got the engagement and support of key stakeholder groups?	• The extent of engagement to date with all key stakeholders including staff, SPF, patients, the public, OSCs, LINKs and local service partners and their relevant partnership Boards • The extent of support from key stakeholders including staff, SPF, patients, the public, OSCs, LINKs and local service partners and their relevant partnership Boards • Specific plans for workforce engagement to deliver transformed services • Specific plans which demonstrate how the proposals will bind in the support of primary and social care and children's services • Evidence of robust planning involving all key stakeholders for: – future engagement and involvement – any necessary consultation
Increased Efficiency of Solution	**5**	**Efficiency Improvements** Will it deliver substantial improvements in the technical and allocative efficiency of the services being delivered?	• The proposals will help deliver the efficiency improvements set out in the NHS Operating Framework 2010/2011 • The proposals explain how, and the extent to which, they will deliver technical efficiencies in 2010/2011 and 2011/2012 • The proposals set out how allocative efficiencies will be delivered in 2011/2012 and thereafter • Identified reductions in fixed costs including management and transaction costs
	6	**Infrastructure Utilisation** Will it maximise utilisation of own (and any integration partners) estate and infrastructure?	• The proposals will identify steps to increase utilisation and efficiency of back office estate and other infrastructure. They will identify scope to share use of assets more efficiently with other partners including local authorities • How will the proposal improve the utilisation of all NHS owned or used estate and infrastructure? • The proposals will identify any surplus assets and infrastructure that will be released by the proposals

	No	Test	Areas to be assured by PCT and SHA
Sustainability of Solution	**7**	**Sustainability** Will it be clinically and financially sustainable?[10]	• Show how proposals will be sustainable in the long and short term, clinically, financially and in terms of infrastructure • Show how the proposals will give PCTs with LA and PBC partners the leverage in the local health economy to deliver – strategic commissioning plans – continued service transformation and realignment – continuing contestability and service innovation • Show how the proposals will ensure that the local health economy has and retains a sufficiently skilled workforce to lead, develop and deliver new service models
	8	**Whole System Fit** Will it fit into and enable delivery of wider health economy service transformation and shifts in care?	• Demonstrate how solutions will deliver whole health economy effectiveness and efficiency • Show how the proposals will fit into current and future patterns of acute and out of hospital provision • Show how the proposals will contribute to delivering significant wider health system improvements in allocative efficiency • Have any potential adverse impacts of the proposals elsewhere in the local or wider health economy been identified and are there proposals for the management of those impacts?

10 If any proposal for continued direct provision is being considered, then the host PCTs would have to demonstrate very strong commissioning skills, including performance in WCC assessments equal to the thresholds set in the NHS Operating Framework 2010/2011. If those performance levels were not sustained then the DH and SHAs would reserve the right to review any continued direct provision.

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Annex D

EXTRACT FROM

Revision to the Operating Framework for the NHS in England 2010/11

Department of Health

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Action
Gateway Reference	14374
Title	Revision to The Operating Framework for the NHS in England 2010/11
Author	DH/NHS Finance, Performance & Operations
Publication Date	21 Jun 2010
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communications Leads, Directors of Performance
Circulation List	Voluntary Organisations/NDPBs
Description	The Operating Framework for 2010/11 published on 16 December set the agenda for the year. This document sets out the areas subject to immediate change for the NHS during 2010/11, as the first steps towards a health service which puts patients at the heart of decision-making, which focuses on quality and outcomes not processes and with more devolved responsibilities.
Cross Ref	The Operating Framework for the NHS in England 2010/11
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	David Flory NHS Finance, Performance & Operations Directorate Department of Health Richmond House 79 Whitehall London SW1A 2NS
For Recipient's Use	

Annex D

Future direction and next steps on transforming community services

18. Separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011, even if this means transferring services to other organisations while sustainable medium-term arrangements are identified and secured. PCTs should therefore continue to develop and review proposals for the divestment of their directly-provided community services, but in doing so ensure that:

    - they have been tested with GP commissioners and local authorities;
    - final proposals are consistent with the aims of the forthcoming NHS Strategy in strengthening the delivery of public health services and health services for children;
    - they consider the implications for choice and competition;
    - they consider a wide range of options, including the development and early delivery of Community Foundation Trusts and Social Enterprises, providing employee leadership and ownership;
    - there has been effective engagement of staff and their representatives when considering options;
    - previous proposals for continued direct provision are reviewed and alternative options developed which secure separation; and
    - proposals should be capable of being implemented, or substantial progress made towards implementation, by April 2011.

19. Guidance on the approval process and timescale will follow publication of the forthcoming NHS Strategy. This may include an additional option of a staff membership Foundation Trust model for community services, where viable. Existing approved applicants for Community Foundation Trusts, however, should continue to prepare for the first step of being established as NHS Trusts.

20. Looking forward, we shall develop proposals for a phased move towards an ‘Any Willing Provider’ model for community services, addressing barriers to entry to greater participation by the independent and voluntary sector.

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CITY OF YORK COUNCIL

Health Overview & Scrutiny Committee **20th July 2010**

Report of the Head of Civic, Legal & Democratic Services

Joint Vision for Older People's Health & Social Care in York

Summary

1. This report asks Members for their comments on the draft Joint Vision for Older People's Health and Well Being in York 2010-2015. The report will be presented to the Executive Member for Health & Adult Social Services at a decision session on 27th July 2010.

Background

2. At a meeting of the Health Overview & Scrutiny Committee on 7th July 2010 Members asked for this document to be presented to them prior to the Executive Member making a decision on 27th July 2010.

3. The overarching vision for older people in York, to be achieved over the next five years, is one where a higher proportion of older people remain within the community, have fewer hospital and care home admissions and are able to enjoy greater independence. At the same time the deteriorating financial climate combined with the growth in the numbers of older people, will inevitably mean meeting greater demand with fewer resources. This makes it essential to transform the services that health and social care fund, to reduce demand through successful and targeted health and social care interventions and to avoid duplication and waste.

4. If the vision is to be achieved then the Primary Care Trust (PCT) and the local authority need to work ever more closely with each other and with voluntary organisations and other third sector bodies, in order to agree common targets for improving the health and well-being of local people and communities. This will require an improved understanding of need, and the ability to better define service requirements and use of resources.

5. The draft Joint Vision for Older People's Health & Well Being in York 2010-2015 is attached at Annex A to this report and the Interim Assistant Director for Commissioning & Partnerships will be in attendance to present the report and answer any questions that members may have.

Consultation

6. The vision was developed in consultation with health commissioners. Key stakeholders were invited to two workshops and the vision has been considered by the Older People's Partnership Board.

Options

7. Members are asked to comment on the vision attached at Annex A to this report.

Analysis

8. Members' comments will be passed to the Executive Member for Health & Adult Social Services and be taken into consideration prior to a decision being made in relation to the document at Annex A to this report.

Corporate Strategy 2009/2012

9. This report relates to the 'Healthy City' theme of the Corporate Strategy 2009/2012.

Implications

10. There are no known financial, human resources, legal or other implications associated with the recommendations within this report.

Risk Management

11. In compliance with the Council's risk management strategy there are no known risks associated with the recommendations within this report.

Recommendations

12. Members are asked to:

    i. Note the contents of this report and its associated annex

    ii. Make comment on Annex A to this report in order that the Executive Member may take these into consideration.

REASON: In order to carry out their duty to promote the health needs of the people they represent.

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Report Approved ✓ **Date** 9th July 2010

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A Draft Joint Vision for Older People's Health & Social Care in York

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Annex A

DRAFT

The vision for older people's health and well being in York 2010-2015

1 Introduction

1.1 The overarching vision for older people in York, to be achieved over the next five years, is one where **a higher proportion of older people remain within the community, having fewer hospital and care home admissions and are able to enjoy: greater independence; a wider choice of accommodation options; and greater social engagement.**

1.2 During the same time period, the deteriorating financial climate combined with the growth in the numbers of older people, will inevitably mean meeting greater demand with fewer resources.

1.3 This makes it essential to transform the services that health and social care fund, to reduce demand through successful and targeted health and social care interventions and to avoid duplication and waste.

1.4 If the vision is to be achieved then the PCT and the local authority need to work ever more closely with each other and with voluntary organisations and other third sector bodies, in order to agree common targets for improving the health and well-being of local people and communities. This will require an improved understanding of need, and the ability to better define service requirements and use of resources.

1.5 Five strategic outcomes have been developed through which the vision can be achieved. These are; that more older people will:

- **Be demonstrably treated with dignity and respect.**
- **Have greater involvement in family and community life.**
- **Be able to achieve greater independence.**
- **Report that they are able to maintain good health.**
- **Remain within a home of their own.**

1.6 It is not intended that this statement covers every aspect of health and social care, neither should it replicate the range of statements and strategies that already exist. Instead, the intention is to define overarching outcomes which can be applied across health and social care provision and where those outcomes can only be achieved by health and social care working together.

1.7 For each of the outcomes there are a range of evidence based 'outputs' and processes described, by which the outcomes should be achieved.

The outcomes are also accompanied by a set of principles which can be applied not only to the outputs but to any health and social care activity.

1.8 Each of the outcomes are based either on existing policy goals within the local authority or the PCT or on research / audit evidence of need, and where their achievement can be measured by a set of local indicators. The final section on implementation begins to explore some of these issues.

2 Principles

Below are outlined a set of principles designed to underpin the vision for older people in York. They are intended to be used by staff and managers in order to guide them in a range of situations regarding older people not just in delivering the specific outcomes linked to the vision statement. In this light all professionals are responsible for delivering all the outcomes, not just those that might be seen as belonging to one particular professional group.

2.1 Together we will ensure that our services are available to all irrespective of gender, race, disability, age, religion or sexual orientation and to pay particular attention to groups or sections of society where improvements in health and life expectancy and quality of life and sense of wellbeing are not keeping pace with the rest of the population.

2.2 Our services will reflect the needs and preferences of the people who use our services, of their families and their carers.

2.3 We are jointly committed to providing best value for taxpayers' money and the most effective and fair use of finite resources. We should always ask ourselves 'why shouldn't we work together' rather than 'should we do this together'.

2.4 We will give the people who use our services, their carers and the public the opportunity to influence and scrutinise our performance and priorities; and people, public and staff will be involved in relevant decisions.

2.5 We will expect all our staff, and staff in the services we commission, to deliver quality care and support. Wherever it makes sense we will deliver services through integrated teams, and support staff to work together to create simple access to the care and support our customers need.

2.6 We will work together to ensure that skill development and workforce planning promote quality and encourage integrated working between health and care services.

Outcomes and outputs that flow from the vision

3 Outcome 1 – All older people are demonstrably treated with dignity and respect

3.1 Services should only be purchased from agencies and organisations that have a written and verifiable policy with regard to dignity[1].

3.2 People with dementia should receive help and support from staff knowledgeable about their condition whether in a social care or a health care setting[2].

3.3 Carers of older people, particularly where they are caring for someone with dementia, should be offered an agreed package of support. This should be flexible enough to cope with unexpected changes in circumstances, from the point of diagnosis onwards,[3] as well as information about the relevant condition.

3.4 There should be an improved inter-agency response to first contact. For example; whoever responds to the first contact with an older person, should be skilled enough to find out the whole story. Sufficient time should also be allowed for that person to tell their story in their way and at their pace.

3.5 In care settings where there is a key worker the older person should always be offered a choice of who that key worker is. The same should be true when any member of care staff is asked to carry out intimate personal care.

3.6 Where older people have a terminal condition it is important that they die in a place of their choosing and that services work together to help achieve this[4]. Where people indicate they wish to make 'living wills' staff should support and encourage this. Peoples wishes with regard to faith and beliefs should also be recorded and respected.

[1] *Need to make sure this is included in the new home care contract and should be raised at the provider's forum.*
[2] *Development of the Dementia psychiatric liaison service. Shared pathway of care. Carers passport about that person.*
[3] *See York Strategy for Carers 2009-2011 and Dementia Review, Nov 2008.*
[4] *See End of Life Strategy (under development) and Recommendation 5, End of Life, Delivering Healthy Ambitions*

4 Outcome 2 – More older people have greater involvement in family and community life

4.1 All older people should have the opportunity, regardless of incapacity to engage in relevant activities, whether living in their own homes in health care setting or in a care home[5]. Older peoples own contribution to the community through employment and work as volunteers should be recognised and encouraged.

4.2 Good up to date information about the range of services and opportunities should be available to all older people. There should be an offer of positive assistance to those who need it, so that they can take up community provision rather than people simply being signposted to alternative services.

4.3 The local authority and health agencies need to work together to understand where there are risks and barriers to older people participating in community life, eg, snow clearance, access to transport, presence of banks and post offices, etc. Leisure services should ensure that there is proportionality in the activities they offer to ensure they are relevant to and accessible by older people.

4.4 Funding partners need to explore investing in a programme of community leadership. Local existing leaders of voluntary effort should be encouraged and resourced to identify and deliver greater community support for older people[6].

4.5 The impact of living alone in older life, whether as a result of divorce, death, separation , or never having been in a partnership will need to be a consideration in reaching and finding people and in offering support.

4.6 All policies of the local authority and the PCT should recognise that by 2030 25% of the population of the City will be aged over 65. This should be reflected in the type of services and facilities that are available.

[5] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009*

[6] *See The Westfield Project led by economic development*

5 Outcome 3 – More older people are able to maximise their independence

5.1 Older people should always be consulted about any service to be provided and their wishes and views ascertained. Where desired, the option of a personal social care budget should be offered that is sufficient to meet peoples assessed needs. There should be encouragement for older people to self manage health conditions, rather than allowing a potential crisis to occur[7].

5.2 There should be a greater emphasis on collecting the views of service users, carers and those who do not use health or care services but could benefit for doing so. For example, there should be a range of ways to collect feedback, including internet based forums for service users and carers to express consumer views about the care and health services that they receive. Such collections should avoid duplication across agencies and wherever possible should be combined.

5.3 There should be an increased use of technology focussed on alleviating specific risks to service users. The range of technological services available should be explained to service users and carers. Use of technology should be planned and of demonstrable benefit[8].

5.4 Older people should be encouraged and enabled to self manage their health conditions.

5.5 Health and care assessments should have an emphasis on what people can do as well as what they cannot and should record activities that people used to participate in and why they no longer do so[9]. There should be a statement about the degree of independence and choice the older person would like to achieve.

5.6 Longer term and intensive care and support should be planned and provided only after looking at 'reablement' opportunities, and at technology based supports, which could increase independence and reduce reliance on care services

[7] *Recommendation 1 & 9, Long term conditions, Delivering Healthy Ambitions*
[8] *Electronic Home Care Monitoring, Blue Print for Adult Social Care Sept 2009*
[9] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009*

6 Outcome 4 - More older people report that they are able to maintain good health

6.1 Health and care services should proactively identify those at risk of hospital admissions and then act to reduce the risks. Alternatives to hospital admission should be available for those who can be cared for outside an acute hospital setting. This will include good care at home as well as care in community based units. These options should be available to avoid admission and to speed up discharge

6.2 An older person should only be discharged from hospital when it is both timely and safe for this to occur. Greater attention should be paid to older people's confidence to manage on their own as well as their physical capabilities.

6.3 Where an older person has suffered a stroke then there should be improved restoration of functionality and a diminution in the number of older people who have further strokes or TIAs. The levels of permanent impairment to individuals should be reduced[10].

6.4 Where older people have had a fall that has required a health service intervention, then they should receive a targeted falls prevention service. This is particularly appropriate for older people who have had a fall in a care homes[11].

6.5 There should be a 20% increase in the detection of continence problem in older people with an equivalent diminution in the proportion of older people with a continence problem who are catheterised or use pads to 'manage' the problem[12].

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[10] *York hospital under achieved in terms of its 2008/09 meeting of the stroke standard with only 28% of stroke patients in 2008-09 spending time on a specialist stroke unit. Nationally a third of all patients admitted to hospital for a stroke have previously had an earlier stroke or a TIA. 11% go on to a care home 2% within two weeks.*

[11] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009 and York Health Group Commissioning Intentions 2009/2010 – 2010/2011. Nationally. 80% of hip fractures are to women. Average age is 83. The 2007 RCP Audit showed that 22% of all hip fractures occur in care homes. 27% of older people who have had a hip fracture go on to have a continence problem brought about from their hospital admission although in 60% of those cases no referral is made to a continence service. 11%of patients have an unplanned re-admission to hospital within 12 weeks of their fall. There is a strong connection between the falls and depression, with a 30% increased risk of hip fracture for older women if they are suffering from depression.*

[12] *People with continence problems often suffer for years before they reveal their problem. Just over half of hospital sites and only a third of mental health sites offer structured training in continence care. Documentation of continence assessment and management has been described nationally as "wholly inadequate". 90% of PCTs have a written policy saying continence products (pads) are supplied on the basis of clinical need*

6.6 There is a need for improved services focusing on depression in older people particularly where the person has experienced the bereavement of a long term life partner[13].

6.7 All older people should have access to regular dental care regardless of where they live and their ability to access a dental surgery unaided[14].

6.8 Where older people have difficulty in cutting, or are unable to cut, their toenails, access to an appropriate service that can help with this should be made.[15]

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yet 73% limit the number of pads to four a day. The average age of those known to the PCT with a continence problem was 80.

[13] *The majority of older persons who commit suicide are widowed although only a small proportion of the oldest old have experienced the recent loss of a partner. However in absolute terms the oldest old men experience the highest increase in suicide risk immediately after the loss of a spouse.*
A comprehensive Dutch study in 2008 showed there was a link between a history of depression and Alzheimer's. Amongst those who have experienced the death of a spouse in old age 30-60% meet major depression criteria at one month, 24-30% at two months and 25% at three months. The most effective interventions at alleviating social isolation are group activities at a social and educational level. Individual interventions are less effective but work best where the giver of support is matched in terms of age and interests with those of the recipient.

[14] *Older people suffer a wide number of likely additional dental problems yet conversely are less likely to receive treatment. For example; The Adult Dental Health Survey 2008 for Portsmouth reviewed dental care of older people in care homes. Found that 465 had no teeth 73% had dentures, 24% suffered oral pain, 29% not seen a dentists in ten years, 25% felt they needed dental treatment tomorrow.The additional problems include those that stem from the type of medication being taken impacting on the capacity to swallow and the likelihood of introducing dental decay, through a diminution in effective soft tissue holding teeth in place and softer diets, which require minimal chewing and thereby reduces stimulation of muscle tone and the condition of the oral tissues. As a consequence, sugar is retained in the mouth for a longer period of time which promotes dental caries.*

[15] *Help the Aged reported in 2005 that over two thirds of older people have foot problems and there is some evidence that the proportion may be higher as many people are too embarrassed to seek help. The longer term impact of denying treatment to those considered to have a low risk is yet to be established although Malkin et al suggested that 25% of people needing foot care are not receiving it.*

7 Outcome 5– More older people remain within a home of their own.

7.1 There should be a continued development of a programme of extra care housing particularly providing a stimulus to the independent sector to develop provision for older owner occupiers. There is a need to develop ECH on a community basis rather than a just a housing basis, ie that people can receive the range of extra care services within particular given neighbourhoods[16].

7.2 There needs to be much greater clarity about who the Local Authority would fund in residential care and why[17].

7.3 Older people need to be assured that when it comes to hospital discharge they will have the opportunity to fully explore the choices and the implications of those choices that are available to them.

7.4 Where aids and adaptations do not exacerbate people's dependency then there should be a greater funding emphasis on providing property adaptations. Funding partners should also be aware of the costs and benefits of the adaptation programme and the impact of delays in delivering adaptations[18].

7.5 Over and above access to health and care provision older people's confidence to remain in the community is based on their ability to maintain their property, play a part in their neighbourhoods and to feel safe. The local authority will work with a range of agencies across the City to ensure that these ambitions can be achieved and that older peoples feelings of safety and security are regularly monitored.

[16] *This is similar to the Dutch model of integrated neighbourhoods called 'Woonzorgzones'. These are now being planned in about 30 neighbourhoods and villages all over the Netherlands. The woonzorgzones are geographical areas that offer round-the-clock care and a certain percentage of adapted housing within 200 m walking distance of integrated service.*

[17] *The EPH review should respond to this (likely that care home provision will be seen as for those needing high physical care needs and dementia where people are at risk).*

[18] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009*

8 Aspects of implementation

8.1 There should be improved measurement of service success by outcomes rather than outputs. In achieving this the test should be who can provide the best outcome at the best possible price rather than professional groups being allowed to 'colonise' areas of service provision, ie, we are the only group who can deal with dementia, continence stroke etc[19].

8.2 There should be a greater capacity to monitor and measure why hospital admissions and care home admissions occur and those results fed back into the commissioning process. From this there will be an increased capacity to target key populations most at risk.

8.3 In order to consolidate skills and knowledge, reduce costs and give service users a more consistent experience, consideration should be given to the balance of services necessary to achieve the outcomes required within the funding available.[20]

8.4 There should be less repeat assessments by different professional groups and organisations and greater service user satisfaction with the assessment process. Where assessments are completed by 'front door' services they should be accompanied by good risk analysis.

8.5 There should be a greater transferability of skills across health and social care.

8.6 There should be an assumption that the delivery of a paid for care and health service should be a last resort. Therefore, health and care should look to provide greater support to family, friends and communities to support older people rather than fund a paid service. Consequently, there should be a shift in expenditure away from funding whole services to one of investment, wherever possible in supporting and extending an existing activity. A greater test of investment should be applied, ie, if this amount of money is spent what is the desired return from that expenditure and is this cost effective.

8.7 Where consultation exercises are undertaken the norm should be that they are jointly undertaken between health services and the local authority unless there is a good reason for not doing so.

[19] *Recommendation 2, Planned Care Delivering Healthy Ambitions.*
[20] *Improving Clarity and Efficiency of the End to End Customer Process, Blue Print for Adult Social Care Sept 2009.*

Health Overview & Scrutiny Committee Work Plan 2010/11

Meeting Date	Work Programme
7th July 2010	1. 2009/10 Year End Outturn Report 2. Update on NHS North Yorkshire & York's Universal Services Review (post maternity) 3. Update on Dental Provision in York 4. Work Plan Report 5. LINks Stakeholder Group Report
20th July 2010	1. Update on Recommendations Arising from the Dementia Review 2. Presentation on Transforming Community Services 3. Presentation from LINks regarding their Annual Report & work plan for the forthcoming year (2010/11) & LINks Public Awareness & Consultation (PACE) reports on End of Life Care and Dignity & Respect 4. Draft Joint Vision for Older People's Health & Social Care in York
22nd September 2010	1. Quarter 1 Monitoring Report & Report or Attendance of the Executive Member 2. Annual Report from relevant Local Strategic Partners 3. Final Report of the Childhood Obesity Task Group 4. Six-monthly Update from Yorkshire Ambulance Service 5. Proposed Scrutiny Topic – Care for Mothers and their Children (Aged 0-6 months)
1st December 2010	1. Quarter 2 Monitoring Report 2. 6 Monthly Update from York Hospitals Foundation Trust
19th January 2011	
2 March 2011	1. Quarter 3 Monitoring Report & Annual Report from the LSP Chairs 2. Six Monthly Update from NHS North Yorkshire & York 3. Update on Dental Services in York

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