

#### Notice of a public meeting of

**Health and Wellbeing Board** 

To: Councillors Runciman (Chair), Brooks, Cannon and

Craghill

Julie Hotchkiss Acting Director of Public

Health, City of York Council

Guy Van Dichele Director of Adult Social Care,

City of York Council

Jon Stonehouse Director of Education, Children

and Skills, City of York Council

Tim Madgwick Deputy Chief Constable, North

Yorkshire Police

Luke Barnett Chief Executive, York Centre

for Voluntary Service

Siân Balsom Manager, Healthwatch York

Julie Warren Locality Director (North) NHS

England

Chris Butler Chief Executive, Leeds and

York Partnership NHS

**Foundation Trust** 

Patrick Crowley Chief Executive, York

**Teaching Hospital NHS** 

**Foundation Trust** 

Dr Mark Hayes Chief Clinical Officer, Vale of

York Clinical Commissioning

Group (CCG)

Rachel Potts Chief Operating Officer, Vale

of York Clinical Commissioning

Group (CCG)

Mike Padgham Chair of Independent Care

Group

Date: Wednesday, 15 July 2015

**Time:** 4.30 pm

**Venue:** The Snow Room - Ground Floor, West Offices (G035)

#### AGENDA

#### 1. Introductions

#### **Items for Discussion**

#### 2. Declarations of Interest

(Pages 3 - 4)

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

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

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

3. Minutes

(Pages 5 - 16)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 11 March 2015.

#### 4. Public Participation

It is at this point in the meeting that members of the public who have registered their wish to speak can do so. The deadline for registering is by **Tuesday 14 July 2015** at **5.00 pm**.

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

#### Filming, Recording or Webcasting Meetings

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https://www.york.gov.uk/downloads/file/6453/protocol for webca sting\_filming\_and\_recording\_council\_meetingspdf

#### 5. Patient Story

Users of the HEAL Programme (Health Exercise Activity Lifestyle) will be in attendance to discuss with members of the Health and Wellbeing Board their experiences of COPD (Chronic Obstructive Pulmonary Disease) Physical Activity session at Clifton Moor.

### 6. Children and Young People's Emotional Health and Wellbeing (Pages 17 - 42)

This report sets out the vision and strategy for supporting the emotional and mental health of children and young people in York.

### 7. Update on the Healthy Child Service 0-19 years (Pages 43 - 54)

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

8. Safeguarding Children-Update June 2015 (Pages 55 - 74)
This report updates the Board on key safeguarding activity as agreed in the protocol between the Health and Wellbeing Board (HWBB), its sub group, the Children Trust YorOk Board (YorOK) and the City of York Safeguarding Children Board (CYSCB).

It includes the report to the Board of the Independent Chair of City of York Safeguarding Children Board at Appendix 1.

### 9. Update made on Progress to Health Inequalities (Pages 75 - 92)

This report provides the Board with an update and information made on progress towards the actions on 'Reducing Health Inequalities' as outlined in the 'Improving Health and Wellbeing in York-Our Strategy 2013-16'.

# **10. Update on the Better Care Fund** (Pages 93 - 218) This report asks the Board to note progress made and to continue their support of the implementation and delivery of the Better Care Fund plan.

**11. Performance Update July 2015** (Pages 219 - 228)

This report asks the members of the Health and Wellbeing Board to note the latest available performance figures for the indicators agreed in December 2014.

#### 12. Joint Health and Wellbeing Strategy Refresh

(Pages 229 - 238)

This report asks the Health and Wellbeing Board to approve the process and timescales for the Joint Health and Wellbeing Strategy Refresh.

#### **Items for Information**

### 13. Governance Arrangements for the Health and Wellbeing Board (Pages 239 - 242)

This report provides Board Members with an update and reminder around their current governance arrangements.

# 14. Healthwatch York Reports: Patient Led Assessments of the Care Environment (PLACE), Who's Who in Health and Social Care (Pages 243 - 308)

This report asks the Board to receive two new reports from Healthwatch these being;

- Who's Who's in Health and Social Care (at Annex A to the report)
- Consistency and Confidence in Patient Led Assessments of the Care Environment (PLACE) (at Annex B to the report)

#### **15.** Forward Plan (Pages 309 - 312)

Board Members are asked to consider the Board's Forward Plan for 2015/16.

#### 16. Urgent Matters

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

#### **Democracy Officer:**

Name- Judith Betts Telephone No. – 01904 551078 E-mail- judith.betts@york.gov.uk For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

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

Contact details are set out above.

This information can be provided in your own language. 我們也用您們的語言提供這個信息 (Cantonese) এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। (Bengali) Ta informacja może być dostarczona w twoim własnym języku.

Bu bilgiyi kendi dilinizde almanız mümkündür. (Turkish) - پیه معلومات آپ کی اپنی زبان (بولی) میں سی مہیا کی جا سکتی ہیں (Urdu)

**T** (01904) 551550

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

#### Remit

#### York Health and Wellbeing Board will:

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

#### York Health and Wellbeing Board will not:

- Manage work programmes or oversee specific pieces of work acknowledging that operational management needs to be given the freedom to manage.
- Be focused on the delivery of specific health and wellbeing services – the Board will concentrate on the "big picture".
- Scrutinise the detailed performance of services or working groups

   respecting the distinct role of the Health Overview and Scrutiny
   Committee.
- Take responsibility for the outputs and outcomes of specific services – these are best monitored at the level of the specific organisations responsible for them.
- Be the main vehicle for patient voice this will be the responsibility of Health Watch. The Board will however regularly listen to and respect the views of residents, both individuals and communities.



#### **Health & Wellbeing Board Declarations of Interest**

#### Julie Hotchkiss, Acting Director of Public Health

Founding Director of Deep Green Care Community CIC

#### Luke Barnett, Chief Executive, York CVS

York CVS holds the contract for York Healthwatch and the Independent Living Scheme

#### Patrick Crowley, Chief Executive of York Hospital

None to declare

#### Rachel Potts, Chief Operating Officer, Vale of York Clinical Commissioning Group)

None to declare

#### Dr Mark Hayes, Chief Clinical Officer, Vale of York Clinical Commissioning Group

None to declare

#### Chris Butler, Chief Executive of Leeds and York Partnership NHS Foundation **Trust**

None to declare

#### Mike Padgham, Chair Council of Independent Care Group

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

#### Siân Balsom, Manager Healthwatch York

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















### Page 5 Agenda Item 3

City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	11 March 2015
Present	Councillors Cunningham (Chair), Looker, Cuthbertson and Wiseman,
	Luke Barnett (Chief Executive, York Centre for Voluntary Service)
	Michelle Carrington (Chief Nurse, Vale of York Commissioning Group)
	Guy Van Dichele (Director of Adult Social Care CYC)
	Julie Hotchkiss (Acting Director of Public Health - CYC)
	Tim Madgwick (Deputy Chief Constable, North Yorkshire Police)
	Jon Stonehouse (Director of Children's Services - CYC)
In attendance	Lynn Parkinson (Deputy Chief Operating Officer for Leeds and York Partnership NHS Foundation Trust)
Apologies	Sian Balsom (Manager, Healthwatch York)
	Chris Butler (Chief Executive, Leeds and York Partnership NHS Foundation Trust)
	Patrick Crowley (Chief Executive, York Teaching Hospital NHS Foundation Trust)
	Mark Hayes (Chief Clinical Officer, Vale of York Clinical Commissioning Group)
	Mike Padgham (Chair of Independent Care Group)

Rachel Potts (Chief Operating Officer, Vale of York Clinical Commissioning Group)

#### 46. Introductions

Board Members were informed that the Vale of York Clinical Commissioning Group had nominated Michelle Carrington, Chief Nurse, as one of their substitute members on the Health and Wellbeing Board. Board Members were asked to confirm the substitute appointment.

Resolved: That the appointment of Michelle Carrington as a substitute member of the board be confirmed.

Introductions were carried out.

The Chair stressed the importance of ensuring that Board Members had named substitutes in place.

#### 47. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests in the business on the agenda, other than those listed in their standing declarations. No further interests were declared.

#### 48. Minutes

Resolved: That the minutes of the Health and Wellbeing Board meeting held on 21 January 2015 be signed and approved by the Chair as a correct record.

#### 49. Public Participation

It was reported that there had been no registrations to speak at the meeting under the Council's Public Participation Scheme.

#### 50. Patient Story

A previous user of Mental Health services was in attendance to discuss his past experiences as a patient. He detailed the difficulties that he had experienced in accessing support for his depression and the desperate situation in which he had found himself. The following issues were of particular concern:

- The bureaucracy involved in accessing support, including the referral process. It had not been possible to access help at the point of need and geographical factors had been an issue.
- The Police did not have access to medical records.
- In order to access help it had been necessary to use the emergency services.
- The patient had not felt that he had been listened to or reassured whilst waiting for treatment at the hospital.

Board Members expressed their appreciation of the patient's willingness to share his experiences.

Tim Madgwick, Deputy Chief Constable of North Yorkshire Police, informed the Board that he had been aware of the patient's experiences and, although progress had been made over the last year to address some of the issues, there was still more work to be done. Although children with mental health issues would not be taken into police cells, the situation had not yet been reached whereby it could be guaranteed that alternative provision would be made for all adults with mental health issues.

Board Members agreed that the Street Triage service was carrying out valuable work and were also pleased to note that discussions were taking place regarding the provision of telephone or online support for people with mental health issues. Nevertheless they remained concerned that if a patient presented themselves for assistance in an area outside of where they lived, this was being refused. There were also issues in respect of information sharing that needed to be addressed.

Resolved: That, at one of the Board's Development Days, consideration be given to practical ways of addressing the concerns that had been raised by the patient, including the cross-boundary issues that had been experienced and the implications in respect of

information sharing. These should also be reported back to a future meeting of the Health and Wellbeing Board.

Reason: To ensure that services can learn from patients'

experiences.

### 51. Governance and Assurance Arrangements for the Health Protection Function of City of York Council

Board Members considered a report that detailed the proposed direction of travel for the implementation of the assurance arrangements for health protection for the City of York. It was recommended that this responsibility be exercised by creating a local Health Protection Assurance Board, which would be accountable to the local authority through the Director of Public Health and the Health and Wellbeing Board.

The Acting Director of Public Health and the Interim Consultant in Public Health gave a presentation on the report [a copy of the presentation is attached to the online agenda papers for the meeting].

Concerns were expressed regarding the robustness of the national data that was provided. Often the data received was late and it was not sufficiently detailed to enable it to be broken down to particular groups or communities in order to target strategies and interventions.

- Resolved: (i) That the risks and complexity of the health protection responsibilities of the Director of Public Health, as detailed in the report, be noted.
  - (ii) That the Board supported the creation of a Health Protection Assurance Board in the terms described in the report.
  - (iii) That, as a priority, the Health Protection Assurance Board be requested to consider the issues that had been raised in respect of data including:
    - ascertaining the data that was available
    - consideration as to how this data is being shared

 determining what additional data was required to enable effective targeting of resources

and report their findings to the Health and Wellbeing Board.

Reason: To ensure that health protection responsibilities are

adequately undertaken.

### 52. Annual Report of the Mental Health and Learning Disabilities Partnership Board

Board Members considered a report which presented the Annual Report of the Mental Health and Learning Disabilities Partnership Board (MHLDPB). The Chair of the Partnership Board was in attendance to present the report.

Board Members were informed that considerable work had taken place to ensure that delivery against the "Improving Mental Health and Intervening Early" element of the Joint Health and Wellbeing Strategy had been as co-ordinated as possible.

Details were given of the key principles set out within the recently refreshed strategy, as outlined in Annex A of the report.

Discussion took place around the following priorities:

- The expected increase in the numbers of people affected by dementia, reflecting the increasing ageing population. Tim Madgwick stated that he had recently been appointed as the national lead for the Police in respect of dementia and offered his support. It was noted that the national expectations regarding diagnosis of dementia had not yet been met but that there had been some successful bids for funding to address this issue.
- Support for those on the autism spectrum
- Procurement of Mental Health and Learning Disability Services
- Implementation of the North Yorkshire and York Mental Health Strategy
- The mental health and wellbeing of the student population
- Implementation of the Crisis Care Concordat
- Communication with people with learning disabilities
- Access to the city's facilities by people with learning disabilities

Board Members noted that letters had been sent to all GP practices regarding the completion of Annual Health Checks for those with a learning disability.

Board Members welcomed the development of North York and York Mental Health Strategy and expressed their hope that this would also incorporate children's mental health. They were also pleased to note the proposal to hold a joint development session with the YorOK Board to look at issues including transition.

Resolved: That the contents of the Annual Report from the

Mental Health and Learning Disabilities Partnership

Board be noted.

Reason: To keep the Health and Wellbeing Board appraised

of the work of Mental Health and Learning

Disabilities Board.

#### 53. Engagement and Consultation

Board Members considered a report which presented the Health and Wellbeing Board with information on a selection of engagement events held to date and their findings. It also set out guidance and advice on future engagement and consultation and suggestions for the direction that the Health and Wellbeing Board may wish to take.

Attention was drawn to the four key emerging concerns that were frequently highlighted at consultation events:

- Communication, information sharing and advice (including shared care records)
- Voluntary sector involvement
- Carers
- Mental health

Board Members were asked to consider:

(i) Whether they wished to hold a Joint Health and Wellbeing Board Stakeholder event in May/June 2015 or whether they wished to wait until they were ready to start the engagement and consultation process for the next Joint Health and Wellbeing Strategy 2016-19. It was noted that the new strategy was due to be in place by April 2016.

(ii) Whether they wished to develop a formal action plan for engagement, consultation and communications that encompasses the work of all organisations represented on the Board.

It was suggested that it would be helpful for a portal to be in place to enable partners to share information obtained from engagement events.

Appreciation was expressed for the work that the voluntary sector played in arranging consultation events.

Resolved: (i) That a Joint Health and Wellbeing Board Stakeholder event not be held in May/June 2015.

- (ii) That a formal action plan be developed for engagement, consultation and communications that encompasses the work of all organisations represented on the Board; to be presented to the Health and Wellbeing Board twice a year.
- (iii) That all members of the Board take feedback contained within the report back to their respective organisations.

Reason: To report back on engagement events held to date and to plan for future events.

#### 54. Final Pharmaceutical Needs Assessment

Board Members considered a report that presented the final Pharmaceutical Needs Assessment for adoption by the Board.

Board Members noted that the city was generally well-served in terms of pharmacy provision. The only gap in the current provision would be that services should be more readily accessible to the student (and other) population on the University of York campus. A pharmacy was, however, available within a twenty-minute walk. Board Members noted the doctors' surgery on the campus was not currently permitted to dispense.

Board Members agreed that student health was an issue that they would wish to consider at a future meeting.

Resolved: That the Final Pharmaceutical Needs Assessment

be accepted and adopted.

Reason: There is a legal requirement on the Health and

Wellbeing Board to publish a Pharmaceutical Needs

Assessment.

#### 55. Winterbourne Review Update

Board Members considered an update report following the previous report to the Health and Wellbeing Board on 8 October 2014.

Board Members noted that there were only a very small number of these patients but that work was on target. Because of their complex needs it was sometimes very difficult to predict the outcome when they moved to different settings and hence partners were working together very closely to take forward this agenda.

Resolved: (i) That the report be noted.

- (ii) That members of the Health and Wellbeing Board continue to promote integrated multiagency working on the Winterbourne Agenda.
- (iii) That the Health and Wellbeing Board receive a further update in three months time.

Reasons: (i) Due to the national importance of the Winterbourne Concordat the contents of this report should be noted by the Health and Wellbeing Board.

- (ii) The national importance of the Winterbourne Concordat.
- (iii) To keep the Board informed of the progress under this agenda.

### 56. Operational Plan 2015/16 for Vale of York Clinical Commissioning Group

Board Members considered a report that provided an overview of the Vale of York Clinical Commissioning Group's Operational Plan for 2015/16 which supported the on-going development of the five year strategic plan.

More detailed information on the plan would be circulated following the meeting and Board Members were asked to forward any comments on the plan to Caroline Alexander – Head of Strategic Planning at NHS Vale of York Clinical Commissioning Group.

Resolved: That the report be noted.

Reason: To keep the Board appraised of the Vale of York

Clinical Commissioning Group's refreshed strategic

plan.

#### 57. York Better Care Fund Update

Board Members considered a report that gave an update on progress with the Better Care Fund approval process and which gave an insight on performance monitoring and performance delivery to date.

Board Members were updated on the progress that had been made in respect of the refreshed plan and were informed that overall the work was going well. The refreshed plan had been taken through the Nationally Consistent Assurance Review process and had been approved with support. This was a significant move forward since the last assessment.

Resolved: That the Board note the report and would continue

to support the implementation and delivery of the

Better Care Fund Plan.

Reason: To ensure that the Board is kept informed on

progress on the Better Care Fund programme.

### 58. Verbal Update on Progress Made On Producing an Alcohol Strategy

A verbal update was given on the progress made on producing an alcohol strategy. Board Members were informed that a project board had been established and was chaired by Phil Cain. The project board had put in place a strategy with the following aims:

- To reduce health related issues from alcohol
- To make the city more safe
- To make people take more responsibility for their drinking and those of others
- Addressing the economic impact on the city

Progress on the production of an alcohol needs assessment had been less rapid but this was due to be completed by July 2015.

Board Members commented on the difficulties faced in reconciling licensing law with the need to address issues in respect of binge drinking in the city. It was suggested the Licensing Policy needed to be reviewed.

Board Members requested that they had the opportunity to have input into the draft Alcohol Strategy as soon as possible and prior to its presentation to the board in July.

Resolved: That the update be noted.

Reason: To ensure that the Health and Wellbeing Board is

kept informed on progress made in producing the

alcohol strategy.

#### 59. Forward Plan

Board Members were asked to consider the Board's Forward Plan for 2015-2016 and were invited to put forward items for inclusion on the plan.

Resolved: That the Board's Forward Plan be approved.

Reason: To ensure that there is a planned programme of

work in place.

#### 60. Urgent Business

The Chair informed Board Members that she had been notified of two items of urgent business:

#### (i) York Hospital Inspection

York Hospital would be inspected by the CQC the following week. Board Members were asked to participate in the process through attendance at an engagement event that was to be held at York St John University, details of which would be circulated.

#### (ii) Vanguard Application

Board Members were informed that although the Vanguard application had not been successful on this occasion, the drive would continue to achieve the targets in the application.

#### Chair

[The meeting started at 4.30 pm and finished at 6.15 pm].





#### **Health and Wellbeing Board**

15<sup>th</sup> July 2015

Report of Eoin Rush - Assistant Director - Childrens Specialist Services - Childrens Services, Education and Skills

## Children and Young People's Emotional and Mental Health Summary

1. This report sets out the vision and strategy for supporting the emotional and mental health of children and young people in York. The strategy is described across eight key priority outcomes and is iterative work through the CAMHS executive group is ongoing to address other areas such as perinatal care. The outcome areas described and the associated planning and commissioning are considered against the recently published Futures in Mind<sup>1</sup> [FIM]. An analysis of local compliance and synergy between the FIM guidance and local strategic plans is proposed to highlight the strengths, gaps and opportunities that will inform a local 'Transformation Plan' required as part of the national FIM programme. The report concludes with some recommendations about the future strategic alignment between the Local Authority, the wider multi agency partnership and Clinical Commissioning Group's commissioning arrangements.<sup>2</sup>

<sup>&</sup>lt;sup>1</sup> **Future in mind** - Promoting, protecting and improving our children and young people's mental health and wellbeing – DOH 2015

<sup>&</sup>lt;sup>2</sup> Note: It is beyond the scope of this paper to provide a commentary on the full extent of national Child Adolescent and Mental Health service [CAMHS] commissioning changes across the health economy. While these issues are, of course, highly pertinent to the shape and detail of the 'clinical' offer to the City, such a discussion might better follow the scene setting and early discussion issues set out here.

#### Introduction

2. In York and across the partnership of childrens services providers there is a well established culture where childrens emotional and mental health is 'everyone's business'.

Over the past ten years the effect of this culture and approach can be seen through a variety of service initiatives across a wide range of partners. Significantly this work is embedded across most of the universal and more specialist settings. This characteristic of our City is perhaps best illustrated through some of the enduring and innovative approaches that have been developed. Examples include:

- 172 Emotional Literacy Support Assistants [ELSA] (specially trained Teaching Assistants) deployed across 60 school settings.
- A multi agency 'Forensic Panel' which has received national recognition for its work to triage and signpost young people who pose a risk to others to appropriate specialist assessment.
- FIRST initiative achieving a significant reduction in the number of young people with complex needs requiring specialist out of city provision.
- A Specialist Teaching Service has effectively supported the continued education and achievement of those young people requiring Tier 4 CAMHS.
- An Autism Strategy delivering clear assessment and support pathways across agencies for children and young people.
- A well supported multi agency *Child and Adolescent Mental Health Services [CAMHS] executive group*<sup>3</sup> that co-ordinate and steers local commissioning and service development to ensure a joined up offer to children and young people in the City.

These examples are not presented to convey in any sense a complete picture but instead to underline the very significant capacity for active and effective collaboration across all providers in the City.

<sup>&</sup>lt;sup>3</sup> The CAMHS Executive group comprises representation from across the statutory and third sector community of childrens service providers

Moreover, they illustrate the existence of a planning and delivery infrastructure capable of considerable innovation in service delivery and design. This infrastructure maximises the value and impact of existing resources. It also helps to highlight where these are not sufficient and ensures any commissioning decisions are well informed.

#### Main/Key Issues to be considered

3. A Shared Understanding of Need and Opportunity

The partnership of childrens service providers through the multi agency CAMHS Executive group have, during a period of national review and reflection over the past two years forged ahead with the development of a high level strategy.<sup>4</sup>

Presented at [Appendix A] this iterative 'storyboard' document attempts to ground in a local context the high level priorities for the City.

It attempts to do this by combining an acknowledgement of the commitment and capacity described above, capturing the 'what works' based on local experience and evaluation and seeks to strengthen and perpetuate the partnership working that has helped to lay such strong foundations for future work (and in fact for Futures in Mind planning going forward).

This 'storyboard' concludes by describing key expected outcomes for children and young people in the City.

Evidence of the continued impact of this approach can be seen through the current development of innovative services across the City, and including;

i. The development of a 'Team around a School Cluster Model' to support children and young people with emotional and mental health issues. This innovative pilot project creates two new specialist 'in school' emotional and mental health roles that will co-ordinate a wider professional group of professionals with emotional and mental health knowledge and skills, advise and train school staff, provide

<sup>&</sup>lt;sup>4</sup> Responding to the Emotional and Mental Health Needs of Children and Young People in York – Vision and Priority Outcomes 15/17

some direct interventions and be a link to the more specialist mental health services. These two new posts have now been recruited and will be in place by September 2015. The work of this pilot will be formally evaluated jointly by the Educational Psychology service and colleagues from Public Health.

- ii. A focused review of self harm amongst children and young people. This issue, a matter of great concern, is being examined in partnership with colleagues from York Teaching Hospital and the wider CAMHS Executive Group and will feed into the 'deep dive' investigations commissioned by this Board.
- iii. A collaborative emotional and mental health conference across the Higher York community of Further Education providers. This work and proposed conference recognises the value in joining up the emotional and mental health support service arrangements for children and young people throughout their learning journey.
- iv. The development of 'in school' resources to help teachers and school staff address issues of anxiety and low level emotional and mental health issues.
- v. A Health and Happiness survey of over 6000 children in York to produce some comparative data for use in further planning and targeting of services.

These arrangements and initiatives described above give confidence that here in York; there is a robust partnership infrastructure in place across the wider community of childrens services. These arrangements can help to ensure that York can take advantage of the new opportunities that will emerge through the Future in Mind government initiative.

This is very well illustrated in the current joint CYC/CCG bid for additional funds to further develop the school cluster pilots described above.

#### **Some Challenges**

4. It is fair to report that overall York's current strategy and associated multi-agency service development aligns well with the key

principles and expectations set out in Future in Mind. A high level comparative analysis of the current strategy against the Future in Mind recommendations largely confirms the direction of travel in the City in terms of governance, infrastructure, approach and models of delivery.

One test of this assertion will perhaps be the City of York and the Vale of York Clinical Commissiong Group's ability to deliver a shared Transformation Plan that reflects and strengthens the local progress described above.

Such collaboration must ensure that commissioning decisions are sharply focused on the widest understanding of local need, where possible strengthens what already works, supports a bottom up innovative approach to service design and delivery and which seeks to maximise the power of the multi agency partnership approach so well established in York. There are risks in steering this work;

- i. the need to navigate individual agency drivers, legal imperatives and differing service delivery footprints.
- ii. the changing landscape, the arrival in October 2015 of a new health CAMHS provider and a new service specification against which this provider is required to deliver.
- iii. a financial climate which can cause individual agencies to retreat to what might be considered their core purpose putting at risk the partnership approaches most likely to improve the emotional and mental health outcomes for our children and young people
- iv. the potential for disjointed governance arrangements which could see a pattern of duplication, misaligned service development, confusion and weakened bidding for new monies released through the Future in Mind initiative.

Of course, these risks apply across the country and are not unique to York. In fact, progress in York to date gives real cause for optimism. However, it would be wrong to promote any sense of complacency and therefore this paper proposes [at 6. Below] some high level recommendations that might secure the current good progress by further mitigating some of the attendant risks highlighted above.

#### Consultation

5. The storyboard presented at Annex A was compiled in partnership with all of those agencies represented on the CAMHS Executive group. The production of this document was iterative with partners having the opportunity to contribute directly and to comment on the overall document as it developed.

This document has been presented to the YorOK, Childrens Trust Board, the Community of school leaders, City of York Council Management Team and with the regional CAMHS and shared with the national taskforce.

The voice of children and young people has been at the heart of this work, through the Youth Council, the Children in Care Council [Show Me That I Matter] and through wider school engagement.

A shared approach to the wider consultation on the emerging Transformation Plan will be critical to presenting a cohesive picture and set of questions to the wider childrens partnership. Some work between colleagues in the PCU and the Local Authority to shape this consultation is already underway.

#### Recommendations

- The following recommendations are proposed to secure the continued good progress of the local strategy to improve the emotional and mental health outcomes for children and young people in York.
  - The multi agency CAMHS Executive Group is endorsed as a key reference point for the commissioning and development of comprehensive CAMHS services for the City of York.
  - ii. There is a clearly delineated City of York analysis and proposal set out in the wider VOY CCG Transformation Plan.
  - iii. This plan should seek to maximise the potential of the strong multi agency partnership to address gaps and strengthen further the preventative early intervention approach already well established in the City.

- iv. Contract monitoring arrangements for the delivery of the new CAMHS specification by Tees, Esk, and Wear Valleys NHS Foundation Trust should include some direct representation from the CAMHS Executive Group (in addition to direct health commissioners).
- v. A task and finish group is established to consider revised governance arrangements across the VOY/CCG and CYC in relation to the future delivery of multi agency CAMHS. Such an arrangement should reflect the rapidly changing policy landscape and to ensure that the current high level of engagement from across the community of wider childrens services (including schools) is sustained.
- vi. A further report on the progress of this work is presented to a future meeting of this Board.

#### **Analysis**

The recommendations above, taken together, are intended to further strengthen the opportunities for the widest partnership engagement in the design and delivery of emotional and mental health services. This approach will support the development of a continuum of help from across the universal settings, through the childrens trust early help arrangements through to the specialist mental health services.

The benefit of such an approach is well evidenced here in York and reiterated through the FIM guidance.

If agreed, these recommendations will help to provide a fully integrated commissioning approach. Such a model will support the early identification of emotional and mental health issues, provides a non-stigmatising and proportionate response and will help to prevent the avoidable escalation and onward referral to more specialist services of many children and young people.

#### **Implications**

8 A review of the recommendations at 6. Above gives rise to the following implications:

#### Financial

There are no direct financial costs linked with the recommendations above. However, the collective commissioning power achievable through the strengthened partnership model described is significant.

#### Human Resources (HR)

There are no direct HR implications arising from the recommendations in this report

#### Equalities

The recommendations help to promote wide engagement in the design and delivery of services across every community in York.

#### Legal

There are no direct legal implications

#### Crime and Disorder

The work of the multi agency forensic panel makes a significant contribution to the development of a multi agency care pathway for children and young people who harm.

#### Information Technology (IT)

There are no direct IT implications

#### Property

There are no specific property implications

#### **Contact Details**

Author: Eoin Rush Assistant Director – Childrens Specialist Services

Childrens Services Education and Skills City of York Council

Tel No. 01904 554212

**Wards Affected:** 

AII



For further information please contact the author of the report Background Papers: None

**Future in mind -** Promoting, protecting and improving our children and young people's mental health and wellbeing

#### **Annexes**

A - Responding to the Emotional and Mental Health Needs of Children and Young People in York – Vision and Priority Outcomes 15/17

#### **Glossary**

CAMHS- Child and Adolescent Mental Health Services

CYC- City of York Council

DOH- Department of Health

ELSA- Emotional Literacy Support Assistants

FIRST- Family Intervention Rapid Service Team

FIM- Future in Mind

NYCC- North Yorkshire County Council

PCU- Partnership Commissioning Unit

VOYCCG- Vale of York Clinical Commissioning Group

YOT- Youth Offending Team



Annex A

City of York - Child and Adolescent Mental Health Executive

Children and Young People's Emotional and Mental Health in the City

Vision and Priority Outcomes 2015 / 17

#### 1. Introduction

This Story Board describes our vision for the emotional and mental wellbeing of all children and young people in our City. It presents the priorities, strategies and initiatives, developed over the last three years, to ensure best practice and deliver the best outcomes.

This document is intended to set the context and shape the work plan for the multi agency CAMHS executive group for the period 2015 / 17. The outcomes set out at Section 12 below are derived from consultation with partners across the childrens trust workforce.

This Story Board recognizes that a multi-agency approach to commissioning is required and consequently the outcomes are also presented to inform and support the CCG's current specialist CAMHS retendering process.<sup>1</sup>

#### 2. Local Picture of Need

Nationally the prevalence of mental disorder varies by age and sex. Boys are more likely (11.4%) to have experienced or be experiencing a mental health problem than girls (7.8%). Children aged 11 to 16 years olds are also more likely (11.5%) than 5 to 10 year olds (7.7%) to experience mental health problems. Using these rates, the estimated prevalence of mental health disorder by age group and sex in York is 1360 for boys aged 5-16, and for girls aged 5 -16 it is 895². (Source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004).)

<sup>1</sup> Yorkshire and the Humber Strategic Clinical Networks – Draft Specification

<sup>&</sup>lt;sup>2</sup> Source: Office for National Statistics mid-year population estimates for 2012. Green, H. et al (2004).)

Annex A

There will be a greater number of children and young people who experience distress and poor emotional health and wellbeing who by definition are not formally diagnosed but are clearly in need of an appropriate form of help or intervention.

Our community of school leaders identify emotional and mental health issues as a significant barrier to learning. This group also highlight transition points and exam years as periods of heightened risk for their children and young people's emotional and mental wellbeing.

Nationally, young people not in education, employment or training, report particularly low levels of happiness and self-esteem. The Macquarie Youth Index, 2014 reported 40% of jobless young people have faced symptoms of mental illness as a result of being out of work, and a third of long term unemployed have contemplated suicide.

We know that the health and well-being of children in York is generally better than the England average. In 2012/13, children were admitted for mental health conditions at a similar rate to that in England as a whole. However, the rate of inpatient admissions during the same period because of self-harm was higher than the England average.<sup>3</sup>

In York, our looked after population, young carers, children and young people subject to protection plans, care leavers, children and young people with complex needs, children and young people involved with our Youth Offending Service and those from BME backgrounds are all identified as priority groups in planning services to support the emotional and mental health outcomes for children and young people in the City.<sup>4</sup>

A review of those children who have received a Tier 3 local authority social care intervention has highlighted some key areas requiring specialist input. These are:

- a) Responding to emotional/behavioural regulation issues
- b) Dealing with the *impact of domestic abuse*
- c) Addressing parental unmet needs
- d) Responding to attachment issues

<sup>&</sup>lt;sup>3</sup> Child Health Profile - March 2014 [Public Health England]

<sup>&</sup>lt;sup>4</sup> Priority groups for the Local Authority and the Clinical Commissioning Group

#### 3. York's Strategy

Our strategy in York is underpinned by the following principles:

- early identification and support will secure for many children and young people the best future outcomes and reduce the likelihood of future emotional and mental health issues
- where possible support for young people will be provided by known and trusted adults
- where possible services will be delivered as close to the local community as possible exploiting the established school cluster model
- health and social care pathways for children and young people are integrated and take account of each 'child's journey' through services
- a committed and knowledgeable childrens workforce ensures that only those children who are in need of Tier 3 CAMHS progress to the specialist providers
- our specialist providers will work to support the whole childrens workforce to equip them with the necessary advice and information to help them support children at Tiers 1 and 2
- Joint planning and commissioning underpinned by a vigorous need assessment ensures the outcomes for children and young peoples' emotional wellbeing and mental health are improved across the City.

#### 4. Strategy Bookcase<sup>5</sup>

Childrens and Young Peoples Mental Health

- Improving Health and Well-being in York 2013 -2016
- Childrens and Young People's Plan 2013 2016
- Children and Young People's Mental Health Strategy 2011 2014
- Children and Young People's Mental Health Strategy Part 2 [Action Plan 2013 -2016]

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<sup>&</sup>lt;sup>5</sup> A summary of key national strategies and guidance is available at appendix 1

#### Related Local Strategy and Planning Documents

- Joint Strategic Needs Assessment 2014
- Looked After Childrens Strategy 2012-2015
- Vision for York Children's Social Care 2013 2016
- Poverty Strategy 2011-2020
- Narrowing the Gap: Breaking down Barriers
- Early Help (including Risk and Resilience) Strategy 2014/16

#### 5. The Vision

We will secure good mental and emotional well-being for all children and young people in the city of York to ensure they achieve their optimal potential.

To achieve this Vision

#### We Will:

- Ensure that strategic planning and commissioning bodies work together (in *partnership with families*) to effectively support/promote good child and adolescent emotional and mental health and well-being.
- 2. Develop a supported, qualified, **experienced and confident workforce** that work across agency boundaries.
- Ensure that children, young people and their families are treated with *respect and dignity* and those services reflect the choices and preferences of children and YP and are provided in a way to minimise any perceived stigma.
- 4. Ensure **service provision is well-coordinated** and joined-up across professional/organisational boundaries.
- Encourage schools and the universal services to adopt a 'nurture to learn' culture to promote good emotional and mental health of children and young people in their settings.

- 6. Promote and facilitate *early identification and intervention* to support the emotional health and wellbeing of children and young people across all settings.
- 7. Ensure high quality *specialist and targeted services are available in a timely* way to those children and young people most in need or at most risk.

### 6. The Stakeholders

The YorOK Community of Childrens Service Providers [Including CCG] Children, Young People and their Families

### 7. User Voice tells us<sup>6</sup>

- We must tackle the issue of stigma that can be a barrier to accessing services
- Children and Young people want to receive support from known and trusted adults in their lives (including: school based staff)
- We should create a nurture to learn culture across our school community
- Frontline children services professionals should be confident and competent in identifying and responding appropriately to the emotional and mental health needs of children and young people in the City.
- Any CAMHS strategy should maximise the importance of peer support for children and young people.
- Specialist CAMHS services should be delivered whenever appropriate in non-clinical settings.
- Specialist CAMHS services should always work in partnership with other professionals in a child / young person's life.
- Early identification of emotional and mental health issues is welcomed and effective

<sup>&</sup>lt;sup>6</sup> Captured through children and young people's voice at Childrens Mental Health Matters Conference / feedback from York Youth Council / Young People's involvement in Learning and Culture Overview and Scrutiny Review

Monitor and tackle the issue of bullying

### 8. Financial cost of child and adolescent mental health problems<sup>7</sup>

The costs incurred to the public purse of not treating children and young people early in their lives are considerable, for example:

- Nationally mental health problems in children and young people are associated with excess costs estimated between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and youth justice) and also include the direct costs to the family of the child's illness.
- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems
- The costs of providing safe and effective interventions associated with supporting Children / young people and young people in the community with crisis support or outreach can be considerably less than inpatient care

### 9. Delivering the Strategy

YorOK
Childrens Trust Board

CAMHS Executive Group

Task and Finish
Groups

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<sup>&</sup>lt;sup>7</sup> Taken from: Yorkshire and the Humber Strategic Clinical Networks – Draft Specification

### 10. The CAMHS Executive Group

This Executive group and the agencies, organisations and constituencies that are represented within the Executive, have as their shared aim the implementation of the CAMHS Strategy.<sup>8</sup>

### 11. Key Developments, Investment and Work Streams

Initiatives that have Improved Outcomes for Children and Young People in York:

- F.I.R.S.T. Initiative Support children and young people with complex needs in York
- Annual Anti-Bullying Survey and Action Plan
- Training and deployment of Emotional Literacy Support Assistants [ELSA] across York Schools
- York's Autism Strategy
- Specialist Teaching Service
- CAMHS Looked After Childrens Service
- Nurture Groups x 2 [Carr Infants & Clifton Green]
- Mental Health Tool Kit for Year 10 students
- Accredited Attachment Training for Foster Carers
- Multi agency Forensic Panel for Children with Harmful Behaviour
- Healthy Schools Programme
- Healthy Settings Programme
- Healthy Minds Programme
- Healthy Child Programme

<sup>8</sup> Terms of reference included at Appendix 1 - <u>Children and Young People's Mental Health</u> <u>Strategy 2011 – 2014</u>

### 12. The Outcomes we are Achieving<sup>9</sup>

Our CAMHS strategy 11/14 achieved some strong outcomes for Childrens and Young People. A summary of some of the key initiatives and outcomes are set out below. Our 15/17 strategy is shaped and informed by the experience of delivering these successful initiatives. Securing what works and developing new service delivery arrangements with the specialist provider to target the most vulnerable children is at the heart of this refreshed strategy for 15/17

- The City's ELSA programme has contributed to a reduction in the number of children and young people who are referred to a Tier 3 service.
- FIRST initiative achieving a significant reduction in the number of young people with complex needs requiring specialist out of City provision.
- Forensic Panel received national recognition for its work to triage and signpost young people who pose a risk to others to appropriate specialist assessment.
- The Specialist Teaching Service has effectively supported the continued education and achievement of those young people requiring Tire 4 CAMHS
- Online Cognitive Behavioural Therapy project in schools delivered non stigmatising low cost solution for children and young people in schools who may have low mood / anxiety or disorders.
- York's autism strategy delivered clear assessment and support pathways across agencies for children and young people.
- Attachment Training for Foster carers providing accredited training for carers to develop more resilient stable placements for Looked after Children.

<sup>&</sup>lt;sup>9</sup> It is not possible here to set out a full account of the impact of those services developed through the CAMHS partnership. Each of those services named has been separately evaluated and the findings available.

Annex A

 Nurture Groups – providing early support and integration for vulnerable children in primary settings and preventing future learning and transition difficulties.

### 13. The Next 24 Months – Outcomes and Priority Actions Overview

### **Outcome 1**

Children and young people with emerging emotional and/or mental health issues are quickly identified and provided with timely information, advice or support where possible within a universal setting and by familiar well supported professionals.

### **Priority Actions**

Harness and co-ordinate the commitment from the early years, school<sup>10</sup>, FE and higher education communities<sup>11</sup> to further invest in and develop 'in setting' arrangements to support the emotional and mental health needs of children and young people in the city.

### This process will seek to;

- Achieve an extension of the ELSA Programme / Principles to every school, college and university setting in the City
- Seek to build on a cluster approach to providing direct support to children and young people<sup>12</sup>
- Review the role of School Nurses in relation to the emotional and mental health of children and young people
- Review the Primary Mental Health Worker role/approach to better support front line staff who are working with children and young people with emotional and mental health issues.

<sup>&</sup>lt;sup>10</sup> A key undertaking from the head teacher community of York given at the March 2014 Annual Conference

<sup>&</sup>lt;sup>11</sup> Commitment from Higher York on behalf of the University and FE providers 5<sup>th</sup> December 2014

<sup>&</sup>lt;sup>12</sup> Exploring the benefits of the Leeds cluster model to delivering emotional and mental health support

- Develop in partnership with York College<sup>13</sup> a tiered model of need / intervention for use within the FE and Higher education settings.
- Promote the participation of every school in the Youth Council's Charter Mark for emotionally healthy schools

Specialist CAMHS are accessible, well targeted and aligned with the City's overall emotional and mental health promotion strategy.

### **Priority Actions**

Through the Tier 3 re-tendering<sup>14</sup> process work with the CCG, Providers and the Local Authority to negotiate better integrated pathways for children and young people. As part of this process we will review the use of the local authority's commissioning budget<sup>15</sup> to strengthen the early help offer to children and young people with emerging emotional and mental health issues.

### This process will seek to:

- Maximise the appropriate use of shared resources across the Childrens Trust / Specialist CAMHS provider to deliver services to children and young people in the context of the 'Child's Journey'.
- Skill up the wider children's workforce to better respond to and support children and young people's emotional and mental health needs closer to the front line.
- Ensure timely access to specialist services for those children and young people who cannot be supported at Tiers 1 & 2.
- Help to inform a clearer shared understanding of need and threshold across the whole childrens workforce.

<sup>&</sup>lt;sup>13</sup> Project led by Graeme Murdoch – Deputy Principal, QA and Support – York College

<sup>&</sup>lt;sup>14</sup> See appendix 1

<sup>&</sup>lt;sup>15</sup> This will include a review of the shared social work role currently located in Limetrees

More young people who are looked after, with mental health problems will recover. More children and young people who have mental health problems will have a positive experience of care and support offered to them.

### **Priority Action**

Review the contribution of the CAMHS LAC service in conjunction with the LA's New Deal for Foster Carers initiative and including the recently developed innovation programme plan.

### This process will seek to:

- Help to strengthen and build the capacity and resilience of the local fostering offer to improve the placement stability and overall outcomes of the City's looked after children.
- Help to achieve an increase in the stability of foster placements and an associated reduction in the number of placement moves
- Re-focus the CAMHS LAC resource to strengthen our response to children and young people on the 'edge of care'.
- Clarify the CAMHS offer to children who are temporarily placed out of the City
- Develop arrangements across Childrens Social Care and specialist CAMHS for effective shared identification, assessment and management of young people with high risk taking behaviours in order to provide a joint package of care to maintain the young person in a community setting.

To improve the emotional and mental health needs of young people within the youth justice system.

### **Priority Action**

Review the emotional and mental health support arrangements for children and young people who may offend.

### This process will seek to:

- Clarify, in the context of the Youth Justice plan, the health offer to children and young people and in the context of the preventative and Restorative Justice aspirations of the services.
- Provide consultation and clinical advice to the Youth Offending (YOT), supporting staff to identify and meet children's emotional &mental health need
- Achieve a reduction in offending that is linked to emotional and mental health
- Clarify the contribution of this resource / service to the refreshed 'responding to children who sexually harm' work.
- Develop arrangements across YOT, Childrens Social Care and specialist CAMHS for effective shared identification, assessment and management of young people with high risk taking behaviours in order to provide a joint package of care to maintain the young person in a community setting.
- Confirm the overall health contribution to the YOT partnership as part of the CAMHS retender.

Children and Young People across the NYCC and CoY and particularly those in need of low demand 'high cost' services have timely access to specialist services in relation to sexually harmful behaviours, children and young people who may be hard to place and those with complex learning needs

### **Priority Action**

Explore the opportunity for greater collaborative working across York and North Yorkshire including:

- New placement arrangements developed as part of the DfE Innovation Programme<sup>16</sup>
- Children and Young People who sexually harm
- Children on the edge of care

### This process will seek to:

- Clarify the role of Joint Agency Panel as commissioner / gatekeeper for cross border allocation of high cost low demand specialist services
- Create opportunities for shared learning and support
- Build resilience across some key service areas

 $^{\rm 16}$  CoY is identified as a scaling partner for NYCCs innovation programme

There is a good understanding of the various underlying causes, nature and extent of self harm across the children and young people population of the City. Children who self harm are quickly identified, assessed and supported at an appropriate level of intervention.

### **Priority Actions**

Investigate the issue of children who self harm as part of a wider exercise to understand the emotional wellbeing of York's children and young people in relation to the national picture.

### This process will seek to:

• inform the strategy to reduce the incidence of self harm in children and young people

Young people who need continued emotional and /or mental health support into adulthood are supported to make a smooth transition into adult services through clear integrated pathways

### **Priority Actions**

With colleagues from adult services, PCU/CCG and service users, the CAMHS executive will commission a review of the pathways into adult services for young people who need continued mental health support / interventions.

### This process will seek to:

- Clarify pathways, thresholds and eligibility for continued support for young people 18 – 25
- Identify opportunities and approaches across the 0 18 arrangements to reduce the number of young people who may need an ongoing service.

### 14. The Gaps, Barriers and Risks

The CAMHS executive has identified some areas of risk that may prevent the effective delivery of our local strategy. These include:

- Accessibility of specialist services for the most vulnerable and disengaged children, young people and families
- *Misalignment* between the specialist CAMHS offer and local preventative strategies
- Services for children and young people with attachment and bereavement issues
- Addressing parental mental health issues and the impact on children
- Evaluation of impact of services using evidence based approaches (including distance travelled measures)

### 15. How will we know if we are succeeding?

- An emotional health survey of children in the City will demonstrate that childrens and young people's view of their overall emotional and mental health is good or improving.<sup>17</sup>
- 2. There will be a reduction in the number of children and young people who are referred to specialist CAMHS.
- The outcomes measures from specialist CAMHS, for example, the childrens health of the nation outcomes scores will be used as a quality measure.
- 4. Timeliness of pathways for those children who require a Tier 3 service (including a specific take up and engagement measure)
- 5. Contract meetings with Providers' of services (i.e., School Nurses) will highlight the number of referrals to specialist CAMHS services, but also the number of children and young people they are seeing with emotional health problems.
- 6. Our Local and National annual child health profile will demonstrate a reduction in the number of children who are referred for concerns of self harming behaviour.
- 7. The stability of the number of children who have Social Emotional Mental Health [SEMH] as their primary need on Education Health and Care Plans (currently about 12-13% of CYPs have 'BESD' as their primary area of need)
- 8. You're Welcome Quality mark will assess the quality of services from a young person's perspective

### **ER/AD/CSS**

<sup>17</sup> Conducted in partnership with Leeds University

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### Health and Wellbeing Board

15 July 2015

Report of the Acting Director Of Public Health and Director of Children's Services, Education and Skills

### **Update on the Healthy Child Programme 0-19 years**

### **Summary**

 The purpose of this report is to provide the Health and Wellbeing Board with an update on the transfer of the Healthy Child Programme 0-5 years from NHS England to City of York Council on 1 October 2015 and the proposal to establish an integrated 0-19 Healthy Child Service for York.

### **Background**

2. The Healthy Child Programme <sup>1</sup>(HCP) was published in 2009 and sets out the recommended framework of services for children and young people aged 0-19 years to promote optimal health and well-being, prevent ill-health and provide early intervention when required.

- 3. The HCP delivers universal services to all children and families, including routine screening and developmental checks. Through the programme, families in need of additional support and children who are at risk of poor outcomes can be identified and the appropriate support provided; a key aim of the HCP is to reduce health inequalities.
- 4. Effective implementation of the HCP 0-5 years contributes to a range of health and well-being outcomes such as:
  - Strong parent-child attachment and positive parenting;
     resulting in better social and emotional wellbeing and improved

<sup>&</sup>lt;sup>1</sup> The HCP comprises three guidance documents: HCP – pregnancy and the first 5 years of life; HCP – the 2 year review: HCP – from 5 to 19 years. The documents include a programme schedule of age appropriate health and development reviews.

### resilience

- Care that helps to keep children healthy and safe
- Healthy eating and increased physical activity contributing to a reduction in childhood obesity
- Prevention of some serious and communicable diseases through promoting uptake of immunisation programmes
- Increased rates of breastfeeding
- Improved readiness for school and improved learning
- 5. The HCP 5-19 years aims to improve a range of public health outcomes including:
  - Improved sexual health and a reduction in rates of sexually transmitted infections in young people
  - Reduced numbers of teenage pregnancies
  - Healthy diet and exercise contributing to a reduction in obesity
  - Improved learning and educational outcomes
  - Smoking prevention and cessation
  - Alcohol and substance use prevention and awareness
  - Improved emotional health and well-being and improved resilience
  - The programme also incorporates the mandatory function of the National Child Measurement Programme (NCMP).

### Main / Key Issues

- 6. On 28 January 2014 the Department of Health confirmed the transfer of 0-5 child public health services commissioning. The transfer on 1 October 2015 completes the transfer of public health responsibilities to local authorities.
- 7. The scope of the transfer includes the 0-5 Healthy Child Programme specifically:
  - Health visiting services (universal and targeted)
  - Family Nurse Partnership services (targeted services for teenage mothers)
- 8. The following commissioning responsibilities will remain with NHS England (NHSE):

- Child Health Information System (CHIS)
- The 6-8 week GP check (Child Health Surveillance)
- NHSE are also responsible for the antenatal and newborn screening and childhood immunisation programmes.
- 9. The Government has announced that certain universal elements of the HCP will be mandated in regulations in the same way it has for sexual health and some other public health services. The universal elements that are mandated are:
  - Antenatal health promotion review
  - New baby review by a health visitor usually around 10-14 days after birth
  - 6-6 week assessment
  - 1 year assessment
  - 2 to 2.5 year review (this is to be a joint review carried out by the health visiting service and the early years provider where a child is accessing early years provision).
- 10. NHSE issued guidance in October 2014 to support local areas with contract transition for health visiting and Family Nurse Partnership (FNP). York does not have a FNP service; for health visiting, in order to ensure a smooth transition of responsibilities and sustainability of services, CYC has approved a Deed of Novation to confirm the contract with York Hospital Teaching NHS Foundation Trust will transfer to the Council on 1 October 2015.

### Consultation

- 11. The transfer of responsibility for the HCP 0-5 to the local authority provides a unique opportunity for CYC, together with our partners, to think about how we want to transform and integrate health, education and children's social care services and improve quality health and wellbeing outcomes for our children and young people.
- 12. Some of the opportunities already identified include:
  - Joining up commissioning for children's public health services, early help and wider family services

- Streamlining universal access to the HCP with early intervention and targeted programmes for families needing more help
- Better integration of services at the point of delivery with improved access and improved service user experience helping to lead to improved outcomes for children, young people and families and reduced health inequalities
- 13. CYC is intending to take advantage of the opportunity by developing a new Healthy Child Service that will offer an integrated child and family centred approach and deliver the HCP 0-19 years.
- 14. A public consultation was recently undertaken, targeted at a wide of stakeholders through the YorOK network and using different approaches including local media, web-based survey using Survey Monkey, newsletters, presentations to different groups and discussions at a range of professional meetings. The views of young people were sought via the Youth Council.
- 15. There were 178 responses to the online survey, with 90 of these from parents. 92% of respondents agreed with the proposed vision and strategic framework for the new 0-19 Healthy Child Service set out as annexes 1 and 2 to this report. Some of the gaps in provision and priorities emerging from the consultation include:
  - The importance and increasing demand for help with issues related to emotional wellbeing and mental health
  - Lack of advice and practical help after children have been weighed and measured as part of the National Child Measurement Programme
  - Lack of provision for young people aged 16 and over
  - Insufficient focus on the needs of children and young people who are at higher risk of poor health outcomes
  - Lack of clarity and publicity about what the services provide
  - Inconsistency of services being offered in different settings, particularly education settings

- The importance of having effective screening and health checks to identify problems that may be impacting on the child's development and identifying these problems early
- Better integration of services universal, targeted and specialist

### Recommended Model for a New 0-19 Healthy Child Service

- 16. The new service is intended to give every child in York the best start in life and enable young people to achieve their full potential through supporting them to make healthier life choices.
- 17. Some of the challenges that the new delivery model will need to address include:
  - Ensuring the accessibility and visibility of the service and better communication about the role
  - Ensuring that there is a standard operating framework in place to ensure consistency of quality of care across all settings where the service is offered and measurement of outcomes
  - Establishing a seamless HCP 0-19 including having due regard to key transition points such as on entering school, leaving care and transition to adult provision
  - Effective partnership working with NHSE and CCG commissioned services including screening, childhood immunisation, maternity, primary care and paediatric services for children and young people with long term health conditions and complex health care needs
  - Meeting unmet need including outreach work with children and young people not in mainstream school including those being educated at home, those in Pupil Referral Unit and alternative education as well as 16-19 years old who may be in need or at risk of unhealthy behaviours
  - Prioritising important public health action such as breastfeeding, emotional health and wellbeing, smoking prevention, alcohol and substance misuse, healthy weight and improved sexual health and reduction in teenage pregnancies and stopping work that is not included in the service specification.

 Ensuring appropriate data collection and reporting systems are in place across the service, to collect evidence of activity and impact as well as routine feedback from service users, partners and stakeholders.

### **Options**

18. There are no specific options for the Board to consider other than to note the preparations for the transfer of 0-5 services from NHS England to City of York Council and the strategic intentions to develop an integrated 0-19 Healthy Child Service.

### **Analysis**

19. There are no specific options for the Board and therefore no analysis is required.

### **Associated Implications**

- 20. In order to ensure seamless delivery of the 0-19 Healthy Child Programme to children, young people and families in York it will be imperative that commissioners of children's services work together to shape integrated models of service provision, agree shared priorities and outcomes and make decisions on the most effective allocation of resources.
- 21. The YorOK Board will provide the vehicle for this to happen.

### Recommendations

22. The Health and Wellbeing Board are asked to note the contents of the report.

Reason: To keep the Health and Wellbeing Board appraised of the progress being made to prepare for the transfer of the Healthy Child Programme 0-5 to City of York Council on 1 October 2015 and plans for the establishment of an integrated 0-19 Healthy Child Service.

Contact Details
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Author: Chief Officers Responsible for the report:

**Sharon Stoltz** 

Jon Stonehouse

Interim Consultant in Public Health

Director of Children's Services, Education

and Skills

Tel No. 01904 553224

**Julie Hotchkiss** 

Acting Director of Public Health

Report Approved



**Date** 01.07.2015

Specialist Implications Officers: None

All

X

Wards Affected: List wards or tick box to indicate all

For further information please contact the author of the report

### **Background Papers:**

https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

https://www.gov.uk/government/publications/healthy-child-programme-review-of-children-aged-2

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\_107566

### **Annexes**

**Annex 1** - Vision and Strategy: an approach for health visiting and school nursing

Annex 2 - Life Course Healthy Child Programme 0-19



Improving the health and wellbeing of children and young people 0-19. The Health Visiting and School Nursing contribution to improving health outcomes for children, young people and families, below outlines the health visitor and school nurse contribution to leading and delivering the Healthy Child Programme 0-19 years (October 2009). The Vision and Service Models for Health Visiting and School Nursing have been set in the context of the broader national nursing strategy - Developing a Culture of Compassionate Care (December 2012), which includes the six Cs – values and behaviours together with the six priority actions for maintaining health and wellbeing outcomes.



### Care

- Care about the health and wellbeing of children, young people, families and communities.
- Deliver high quality, personalised care, spend time providing children, young people and families with current evidence based resources enabling them to support their child's health and wellbeing.
- Deliver high quality, personalised care.
- Support children and young people with additional or complex health needs.
- Provide tailored support.

### Compassion

- Compassion for children, young people and families in distress or those experiencing difficulty.
- Listen and act on what parents, children and young people say are important to them.
- Recognise the uniqueness of the family context and supporting positive relationships.

### Competence

- Ensure teams are led by a SCPHN qualified nurse.
- Ensure training and development infrastructure delivers competency, including through Healthy Child Programme learning materials, adolescent health e-learning and the Building Community Capacity programme, alongside others.
- Ensure the skill mix within the team reflects local population needs.
- Provide support and supervision to develop staff.

### Communication

- Communicate with children, young people and families to promote health and wellbeing, prevent ill health and empower communities.
- Ensure a comprehensive needs assessment is undertaken and is supported by early offer of help.
- Act as a conduit for information – supporting children, young people and families.
- Communicate with partner organisations to ensure seamless links and interfaces.

### Courage

- Have courage to make difficult decisions and to stand by their beliefs and values.
- Advocate for the needs of children, young people and families to ensure their best interests are met.
- Provide challenge.

### Commitment

- Commit to public health agenda and to the communities in which they work, improving public health outcomes.
- Find solutions through effective partnerships, negotiation and influencing.
- Empower parents and young people to make changes for themselves and to be the best they can be.

### **Leading and delivering the Healthy Child programme 0-19**

### 'The Health Visitor and School Nurse Service Offer'

**Your Community** has a range of health services (including GP and community services) for children, young people and their families. Health visitors and school nurses develop and provide these and make sure you know about them.

**Universal Services** from your health visitor and school nursing teams provide the Healthy Child Programme to ensure a healthy start for every child (e.g. Public Health, parenting advice, including immunisations and health checks). They support children and parents to ensure access to a range of community services.

**Universal Plus** delivers a swift response from your health visitor/school nurse service when you need specific expert help e.g. with post natal depression, sleepless baby and weaning, sexual health, mental health concerns, long-term health issues and additional health needs.

**Universal Partnership Plus** delivers ongoing support from your health visiting and school nurse team from a range of local services working together with you to deal with more complex issues over a period of time (e.g. with voluntary and community organisations and your local authority).

### **Quality Standards**

The school nursing service provided should encapsulate the "You're Welcome" quality criteria\* and therefore address:

- Accessibility:
- Accessibility,Publicity;
- Confidentiality and Consent;
- Environment;
- Staff training, skills, attitudes and values;
- Joined-up working;
- Young people's involvement in monitoring and evaluation of patient experience;
- Health issues for young people;
- Sexual and reproductive health services;
- Specialist and targeted child and adolescent mental health services.

### \* Department of Health 2011, British Youth Council 2011

The health visiting service should be delivered in line with the Healthy Child Programme 0-5 framework, an evidence-based programme of screening, visiting and interventions from pregnancy to age 5, ensuring:

- Working practice that uses the latest evidence from neuroscience;
- Parenting support programmes including Preparing for Pregnancy, Birth and Beyond;
- Evidence based interventions using principles of motivational interviewing/promotional interviewing;
- Early identification of risk and need at an individual, family and community level;
- Early intervention and prevention work that meets the needs and aspirations of the family;
- Appropriate networks of support through close working partnerships with a range of organisations.

### Outcomes: leading & contributing to:

- Improved health and wellbeing and a reduction in health inequalities.
- Promoted healthy lifestyles and social cohesion by reaching and influencing the wider community.
- Improved planning of local services to reduce health inequalities.
- Promote healthy lifestyles and work with communities to build and use the strengths within those communities to improve health and wellbeing and reduce inequalities.
- Achieve population (or 'herd') immunity through the increased uptake of immunisations.
- Increase access to evidence-based interventions through the Healthy Child Programme to children and families tailored to specific need.
- Increased breastfeeding, appropriate infant nutrition and lifestyle changes to tackle rising obesity and related illness in later life.
- Improved maternal mental health and wellbeing enabling strong early attachment and infant emotional wellbeing.
- Improved school readiness.
- Reduced number of children requiring formal safeguarding arrangements – achieved through early identification and intervention.

Making this happen for children and young people - health visitors and school nurses should lead in these six areas and embedded throughout is Leadership, Ownership, Partnerships

### Maximising health and wellbeing. Helping people to stay independent

- Create communities that understand how to support children and young people's health and wellbeing
- Lead, deliver and evaluate public health

### Working with people to provide a positive experience

- Understand the needs and challenges for children and young people
- Recognise the signs and risk factors and respond to the individuals' and families needs to support improved health and wellbeing

### Delivering care and measuring impact

- Ensure care and support is evidence based
- Ensure robust systems to report outcomes and measure effectiveness of interventions including service user feedback

### Building and strengthening leadership

- Act as a professional role model for all, providing leadership and support to the team in improving health outcomes and efficient service delivery
- Lead the HCP and influence wider public health agenda

### Ensuring we have the right staff, with the right skills and attributes in the right place

- Ensure the team is led by a SCPHN, supported by a team who understand public health nursing and develop expertise through competencies
- Expand knowledge of neuroscience

### Supporting positive staff experience

- Enable time to listen, reflect and support staff to provide a family-centred service within a variety of settings
- Develop future nurse leaders by providing excellent practice placements



# Life Course Healthy Child Programme 0-19

### Universal

Health and development reviews Screening and physical examinations

Immunisations

Promotion of health and wellbeing, e.g.

- smoking
- diet and physical activity
- breastfeeding and healthy weaning
  - keeping safe
- prevention of sudden infant death
  - maintaining infant health
- dental health

Promotion of sentsitive parenting and child development

**Involvement of fathers** 

Mental health needs assessed

Preparation and support with transition to parenthood and family relationships Signposting to information and

## Universal plus

Emotional and psychological problems

essed

Promotion and extra support with

breastfeeding

Support with behaviour change (smoking, diet, keeping safe, SIDS, dental health) Parenting support programmes,

including assessment and promotion of parent-baby ineraction Promoting child development,

including language

- additional support and monitoring for infants with health or developmental problems
- common Assesment Framework completed

## Higher risk

High-intensity-based intervention

Intensive structured home visiting programmes by skilled practitioners

Referral for specialist input

Action to Safeguard the child

Contribution to care package led by specialist service.

# The best start for all children

Safeguarding







### **Health and Wellbeing Board**

15th July 2015

### Report of the Independent Chair of The City of York Safeguarding Children Board

### Safeguarding Children- Update June 2015

### **Summary**

- 1. The purpose of this report is to update the Board on key safeguarding activity as agreed in the protocol between the Health and Wellbeing Board (HWBB), its sub group, the Children Trust YorOk Board (YorOK) and The City of York Safeguarding Children Board (CYSCB).
- 2. The report of the Independent Chair of York Safeguarding Children Board to the York Health and Wellbeing Board July 2015 is attached at Appendix 1

### **Background**

- 3. The Health and Wellbeing strategy includes the key objective of Enabling all children and young people to have the best start in life. Delivery of this will significantly strengthen safeguarding arrangements for the children of York. The CYSCB have provided suggestions for inclusion in the refreshed strategy (See Appendix 2).
- 4. The City of York Safeguarding Children Board has the statutory objective set out in Section 14 of the Children Act 2004 to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and to ensure the effectiveness of what is done by each such person or body for those purposes.
- 5. Member organisations of the Health and Wellbeing Board and the YorOk Board are represented on the Safeguarding Board.

6. In order to provide effective scrutiny, the CYSCB should be independent. It should not be subordinate to, nor subsumed within, other local structures.

### Main/Key Issue to be considered

- 7. It is critical that the Boards work closely together to drive forward improvements in prevention, early help and ensuring local safeguarding arrangements are effective.
- 8. To ensure arrangements for safeguarding children are effective, local leaders and strategic priorities must be agreed and shared, governance and leadership clear and a culture of continuous improvement in place.

### Strategic/Operational Plans

- 9. The Independent Chair of CYSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report will be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board in September 2015.
- 10. The Health and Wellbeing strategy and The YorOk Board plan "Dream Again" 2013-16 include the key objective of "Ensuring children and young people always feel safe" and states that Safeguarding lies at the heart of all our work, as does ensuring that there are "arenas of safety" at home, at school and in the community.
- 11. This Children's Plan is being revised and the CYSCB will make recommendations in its statutory annual report for inclusion in the refreshed Children's Plan from 2016 onwards.
- 12. Joint Strategic Needs Assessment Working Together 2015 states; The Director of Public Health should ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the health and well-being board. The LSCB should use this assessment to help them understand the prevalence of abuse and neglect in their area, which in turn will help shape services."

### **Options**

13. This report is for consideration and noting; there are no specific options for the Board to consider.

### **Implications**

### **Financial**

14. In previous years the cost of the infrastructure to support the CYSCB has fallen disproportionately on the local authority. After negotiations during the year a three year strategy to rebalance the contribution was agreed by the key funding agencies. The CYSCB budget has been agreed for 2015/16.

Statutory Guidance; Working Together 2015 states, " All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

### Other

15. There are no HR, Equalities, Legal, Crime & Disorder, IT or Property implications arising from this report.

### **Risk Management**

16. The safeguarding arrangements for the City of York are subject to external inspection by Ofsted. Evidence from those areas judged to be good included effective working with the Health and Wellbeing Board and evidence of reciprocal influence and joint priorities.

### Recommendations

- 17. The Health and Wellbeing Board are asked to:
  - Consider the update report of the Independent Chair of the CYSCB and make suggestions for further detailed scrutiny
  - Provide their views on how the HWBB will contribute to the safeguarding priorities for 2015/16 and beyond

- Ensure, through the YorOK Board, that information sharing arrangements for early help services are clear and understood by partners
- Support the CYSCB by including ongoing therapeutic support services for victims of child abuse as a priority in the Health and Wellbeing Strategy refresh and in future commissioning plans for Child and Adolescent Mental Health Services
- Note that the Early Intervention pilot in relation to domestic abuse funded through Safer York ends in November 2015 and consider whether this will impact on early help services for children.

Reason: This will ensure that strategic leadership for safeguarding children is strengthened and key priorities shared and understood

### **Contact Details**

Author:

Chief Officer Responsible for the report:

Simon Westwood
Independent Chair
City of York Safeguarding
Children Board

Chief Officer Responsible for the report:

Jon Stonehouse
Director of Children's Services,
Education and Skills
City of York Council

Report Date 30 June 2015

**Wards Affected:** 

All ✓

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

### **Background Papers**

- More detailed information can be found on the Safer York Website http://www.saferchildrenyork.org.uk
- Working Together 2015
- "Dream Again" York Children's Plan
- York Health and Wellbeing Strategy
- Protocol between the City of York Health & Wellbeing Board, YorOK Board and City of York Safeguarding Children Board.

### **Annexes**

**Appendix 1** - Report of the Independent Chair of York Safeguarding Children Board to the York Health and Wellbeing Board – July 2015

**Appendix 2** - Comments and suggested additions for the HWBB Strategy Refresh

### Glossary



### Appendix 1



Working with children, parents and professionals to make our childrens' lives safer.

### Report of the Independent Chair of York Safeguarding Children Board to the York Health and Wellbeing Board – July 2015

### **Report Details**

### 1. Safeguarding – Progress on 2014/16 priorities and review of Priorities for 2015/16

The priorities for 2014/15 - neglect, domestic abuse, child sexual abuse, children who go missing and early help will continue to be addressed until they are refreshed for 2015 onward in the annual report due for publication in September 2015.

### 2. Summary progress on priorities 1<sup>st</sup> quarter of 2015/16

### The CYSCB Key priorities in 2014/15 were:

### 2.1 Neglect:

CYSCB is currently in the process of applying for a pilot in relation to training for all practitioners in the Graded Care Profile. Rolling out training in this method of assessment for neglect may have an impact on the volume, nature and quality of enquiries to Children's Social Care. The CYSCB Neglect Sub-group will monitor this.

On the Board's recommendation Health Visitors and School Nurses have agreed to continue using dental audit forms for children newly subject to a child protection plan. The data in regard to the dental health of children who become subject to a child protection plan is a good indicator of neglect but the process also ensures that these children receive dental treatment if they need it.

Paediatric Dentistry are also looking at possible solutions with health colleagues which will make it possible to record and address the dental health of these children.

### 2.2 Domestic abuse:

The CYSCB Domestic Abuse Group has a specific focus on children affected by domestic abuse affecting children. The percentage of children present at incidents of domestic abuse has remained roughly the same over the year but the numbers for 2014/15 are now greater than those in 2013/14. (This is in the context of the total number of reported incidents) The figures merit further investigation as no positive or negative conclusions can be drawn from them as they stand.

Quarter 4 shows an increase in the percentage of Domestic Abuse prosecutions which result in convictions at 80.9% this brings the rate to the highest for the year and puts the year's total average at similar to last year.

In Quarter 4 83 children received one-to-one support from IDAS (a charity that provides support services to those experiencing or affected by domestic abuse and sexual violence. The services include refuge accommodation, outreach support and access to a free, confidential helpline)

11 of these children were living at a refuge at the time. The others were supported through outreach contact. At the Board meeting in April, a brief report was given on the positive outcomes of the Early Intervention Pilot funded through Safer York. This pilot ends in November 2015 and funding has not been secured to continue this. The CYSCB are concerned that this may lead to a reduction of overall capacity to support children affected by domestic abuse.

### 2.3 Child sexual abuse:

www.ltsnotokay-York.org.uk is a multiagency campaign, jointly funded by the NSPCC and CYSCB, was launched on 11 May 2015 and received local press coverage. The Trust Board are asked to promote the key messages through their organisations and to use the signature link to the campaign web pages.

Lampard Review - At the June Board meeting the CYSCB received an update report on monitoring the implementation of recommendations from this review in local health services.

Following publication of the Lampard reports, the York Designated Health Professionals sought additional assurance from local NHS provider organisations that the Lampard recommendations were being addressed. Monitor, the national health watchdog also required all NHS Trusts to submit evidence around their response to the report as part of national assurance processes. Responses received by the Designated Professionals indicate that NHS Trusts have responded positively to the recommendations and are either fully or partially compliant. Where compliance is partial, relevant action plans are in place. The CYSCB will receive a further update report later in the year on those action pans.

As I have previously, reported a range of national reports have all highlighted the bleak prognosis for victims. It is essential that all partners work together ensure services are put in place to support children into adulthood.

This remains an area of concern for the Board. As Chair I have written to the Police and Crime Commissioner asking for information about future commissioning plans in relation to this area. This is an area I would recommend for further consideration in the development of the next Children's Plan, Health and Wellbeing Strategy refresh and also in future commissioning plans for Child and Adolescent Mental Health Services. There are positive services provided in York in partnership with the NSPCC but the HWBB, CYSCB and YorOK need to be assured of the sufficiency and timely access to services.

To strengthen accountability the Government have introduced an expectation that all Local Safeguarding Children Boards will conduct regular local assessments on the effectiveness of local responses to child sexual exploitation and publish the outcome of those assessments through their annual reports. They should set out in this analysis how the local partners have used their data to drive their response to vulnerable children and families. The Independent Chair of CYSCB intends to include this in the Chair's Annual report for 2014/15 to be published in the autumn.

### 2.4 Children who go missing:

The CYSCB sub group work supports the operational work between Children Social Care and North Yorkshire Police to enable data matching missing children with those flagged as at risk of CSE. The Government issued updated Safeguarding in Education guidance for schools and colleges in March 2015.

This guidance recognises the inter-relationship between children missing and the risk of exploitation. "A child going missing from education is a potential indicator of abuse or neglect. School and college staff members should follow the school's or college's procedures for dealing with children who go missing from education, particularly on repeat occasions, to help identify the risk of abuse and neglect including sexual abuse or exploitation and to help prevent the risks of their going missing in future. "

In the summer term the Itsnotokay-York campaign is sending out letters to parents in year 6 book bags to raise awareness about how they can help protect their child, signs to look out for and where to go for help.

### 2.5 Early help:

As requested in a previous report, The YorOk Board presented an assurance report to the CYSCB on the effectiveness of early help and revised threshold arrangements The Integrated Working Implementation Group have been refocused as the Early Help sub group support the CYSCB and YorOk. Following their recommendation the Safeguarding Board will nominate a Board representative/s to join the group. The report produced by the Children's Trust Unit of the Council gave a picture of Early Help from agencies across the Board partnership. The Performance scorecard captured some multi-agency data on Early Help but stronger links are needed.

### 3. Other Key Activity

### 3.1 Multi-agency contributions to Single Assessments (WT15)

The national requirement to implement a single assessment process is in place. Working with key agencies, a template has been produced to help improve the quality of partner contributions to Single Assessments. The analysis within the Single Assessment will be the responsibility of the social worker. The Board endorsed the template launched 1 June 2015 for use by Health Visitors, School nurses and midwives and is planned to be extended for use with other partner agencies by 1 October 2015.

### 3.2. Safeguarding Board Membership, Compacts and Budget

A review of the structure, membership and governance of the Safeguarding Board has been undertaken and formal consultation on future working arrangement completed. Final proposals were agreed and are now being implemented. The budget for 2015/16 has now been agreed and proposal for a three year budget plan are agreed in principle and will inform agencies budget planning in the autumn. Individual compacts have been developed that formally confirm expectations and commitments required of Board members. The compact between the HWBB, YorOK and the CYSCB is due for review. The CYSCB suggests that the review should consider including the Adult Safeguarding Board and the Safer York Partnership within the compact agreement. Quarterly meeting have now been established between the Independent Chairs of the Children and Adult Safeguarding Boards.

### 3.3 Child Death Overview Panel (CDOP)

This is a statutory sub group of the CYSCB run jointly with North Yorkshire Safeguarding Children Board. The annual report for 2014/15 was received by the Board in June. Positively this reports that there has been a year on year decline in child death between the end of 2011 and 2015 which is consistent with the national picture.

Within that period the number of unexpected death has also fallen. The riskiest age group for child death are under 1 and between 15 and 17. A key area of learning was a review of child suicides which identified that although small in number the high risk group were males aged between 15 and 17.

The report from this work has been passed to the Suicide Prevention Task group and also through the Independent Chair of CYSCB links have been made with similar work done in Greater Manchester. There is a national Child Suicide Research being carried out by Manchester University which the CDOP will monitor.

### 3.4. City of York and North Yorkshire Safeguarding Children Board Awards

The joint safeguarding boards are holding an awards evening to recognise the contribution to safeguarding of individuals and teams nominated by Board partners. Each nominee will receive a Certificate of Appreciation for contribution, dedication, professionalism and partnership work relating to the safeguarding of children across North Yorkshire and the City of York. The Board wishes to thank North Yorkshire Police who have resourced this and are hosting the Ceremony which will be held on Thursday 2 July 2015 at North Yorkshire Police Headquarters, Newby Wiske, Northallerton.

### 3.5. National Updates

### Child Protection Taskforce

On 24 June 2015 Prime Minister David Cameron announced a new Child Protection Taskforce to drive forward fundamental reforms to protect the most vulnerable children in our society and give them the opportunity to succeed.

Chaired by Education Secretary Nicky Morgan, the taskforce will be responsible for leading improvements across police, social services and other agencies – focusing on transforming social work and children's services and improving inspection. The Prime Minister said "Through this work we will accelerate our current reforms to children's social work, and will overhaul the way that police, social services and other agencies work together locally."

### **Information Sharing**

The importance of ensuring Information Sharing guidance and arrangement were in place was set out in a joint ministerial letter on the 3 March 2015 sent to the Chief Executives of local authorities, Directors of Children's Services, Police and Crime Commissioners, Local Safeguarding Children's Boards, Health and Wellbeing Boards and GPs. This emphasised that "The golden thread throughout all of this is that the duty to safeguard children must be paramount."

This is an area that the CYSCB will seek renewed assurance on from all partners.

It is recommended that the HWBB support this, in particular, in assisting in ensuring arrangements are in place for sharing information and intelligence at an early stage as part of early help services

## Multi-inspectorate Inspections

Multi- inspectorate inspections of child protection services were due to begin in April 2015. However following pilot inspections it has been concluded that the integrated methodology did not add enough inspection value to enable a proper multi-agency evaluation of services for vulnerable families, children and young people living in that local authority area.

There remains a commitment to find ways of the inspectorates working together and they intend to complete six targeted inspections in a locality area before March 2016. These targeted inspections will evaluate how local agencies work together to protect children, focused on specific areas of concern such as the sexual exploitation of children and young people.



## Simon Westwood – Independent Chair - York Safeguarding Children Board

# Comments and suggested additions for the HWBB Strategy Refresh

- 1. Foreword needs updating to make specific reference to safeguarding as a key element of health and wellbeing and to reflect and acknowledge Early Help (this is mentioned as a bullet on p 5 but should be in foreword as well) and new statutory guidance Working Together 2013.
- 2. Diagram on p5 should include a circle to represent national safeguarding guidance
- JSNA needs updating to include statistical estimates of prevalence of neglect and those at risk of sexual exploitation (that could also include vulnerable adults)
- 4. The body of the report should reference the priorities of the safeguarding board as set out in the annual report. Below are suggestions for this

Neglect could be added to reducing health inequalities section – e.g. Identify a range of indicators to identify the prevalence of neglect in York and to measure progress in tackling this.

# Domestic Abuse could be added as a cross cutting theme for action: e.g.

To further develop services within the city to effect cultural change in relation to domestic abuse and create a centre of excellence. Develop an implementation plan to deliver the strategic aims and objectives contained within the York and North Yorkshire Domestic Abuse Strategy. Develop a commissioning process underpinned by a strategic needs assessment for the commissioning of domestic abuse services in the city. There should also be reference to working with the Police and Crime commissioner (PCC) in commissioning for victim support services.

**Section 4** should make specific reference to the CYSCB e.g. "Annually consider and update plans to respond to challenges set out in the Annual report of the Safeguarding Children Board"

Early Help wording could be amended to reflect annual report e.g. "making sure problems are identified early and that families are provided with the right help at the right time"

Missing Children could be added to section 4 e.g. "Children who go missing are vulnerable to abuse and being exploited. Continue to educate children about the dangers of going missing. Develop across all sectors a coordinated, interagency approach and strategy to tackle this.

Child Sexual Abuse this could be added to section 4 – e.g. HWBB will contribute to work to establish a better understanding of the known prevalence and nature of child sexual abuse and exploitation and support effective interventions to tackle this

- 5. P6 finance needs to give an updated position on the CCG and council financial position and forecast for future
- 6. P 7 Should explicitly reference engagement with children and young people as part of long term citizen engagement
- 7. P8 Priority 4 should be amended to end with "and keep them safe"
- 8. In the section "Delivering and Monitoring the Strategy" reference should be made to the CYSCB and it role in seeking assurance from the HWBB via YorOK on progress in Early Help and refer to the joint protocol.
- 9. P9 Principles should also include: "Do all we can to create a safe environment for all the children of York to grow up in safety and to always feel safe"
- Action P 11 should have an action linked to the joint protocol e.g. "the HWBB, Safeguarding Children Board and YorOk Board will promote joint working and co-operation between partners to

improve the wellbeing of children and young people in the City of York"

- 11. P 30 third bullet should make specific reference to reduction of self-harm as a priority
- 12. P 33 Integrated commissioning should also refer to services for children with specific reference to changes in school nursing and health visiting
- 13. Lastly the reference list should include the Annual Report of the Safeguarding Children Board.



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## **Glossary**

CDOP Child Death Overview Panel

CYSCB City of York Safeguarding Children Board

HWBB Health and Wellbeing Board

JSNA Joint Strategic Needs Assessment LSCB Local Safeguarding Children Board

YorOK York Children's Trust





## **Health and Wellbeing Board**

15 July 2015

Report of the Interim Director of Public Health

## **Update made on progress to Health Inequalities**

## **Summary**

1. This report is to provide the Health and Wellbeing Board with an update and information on progress made towards the actions on 'Reducing Health Inequalities' as outlined in the 'Improving Health and Wellbeing in York – Our Strategy 2013-16' The Board should note that this report provides a 'snap shot' of the work around Health Inequalities as each of the action areas could be a report in their own merit.

## **Background**

- 2. At the Health and Wellbeing Board meeting which took place on 21 January 2015. At this meeting a public speaker made a request for an update as he felt that the issues and solutions for health inequalities were both complex. He asked if the Board had any responsibility for the implementation of the health inequalities agenda and what arrangements it had in place to report on its progress'. This paper is in response to that request.
- 3. In the Joint Health and Wellbeing Strategy (JHWBS) 2013-16, reduction of health inequalities was identified as an area which required targeted work. It had initially been suggested that a Health Inequalities sub-group was formed to ensure that the actions identified were delivered. However this sub- group was not formed but despite this work on Health Inequalities is clearly embedded within the work of the City of York Council, the NHS Vale of York Clinical Commissioning Group (VoYCCG) and other partnership organisations.

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As an example, this is reflected in the work of the Fairness and Equalities Board, the continued focus of key themes highlighted in the Joint Strategic Needs Assessment (JSNA) and the NHS Vale of York Clinical Commissioning Group's Operational Plan.

- 4. The Health Profile for York 2015<sup>2</sup> concludes that: 'The health of people in York is varied compared with the England average. Deprivation is lower than average, however about 11.7% (3,600) children live in poverty. Life expectancy is 7.4 years lower for men and 5.8 years lower for women in the most deprived areas of York than the least deprived.
- 5. The placing of projects under each of the actions below has been the decision of the author and Chief Officer responsible for the report and any inconsistencies are theirs. It is acknowledged that many of these reports could have been placed under a number of actions.

## Updates on the actions identified in the current HWB strategy.

6. The Joint Health and Wellbeing Strategy sets out a number of actions to work towards, these are identified below with updates

# Action 1: Steer investment in health improvement programmes that offer bespoke interventions that demonstrate an improved health outcomes.

## **Progress**

- 7. VoY CCG together with the City of York Council's Public Health team are coordinating the delivery of challenging public health and prevention improvements which address some key health inequalities in the local population.
- 8. A number of individuals experience mental distress in the context of a range of other disadvantaging factors, including substance misuse, trauma, abuse, learning difficulties or homelessness (sometimes referred to as 'complex distress'). Crises and reappearance within services tends to be blamed on individuals experiencing complex distress rather than the systems that surround them. Therefore, traditional services and commissioning structures fail individuals with complex and multiple needs who present on a practical and psychological level.

<sup>&</sup>lt;sup>2</sup> http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=Y

- 9. In 2014, North Yorkshire Police (NYP) and the national charity Together: for Mental Wellbeing examined potential solutions. As a consequence, City of York Council, VoY CCG, NYP, Leeds and York Partnership NHS Foundation Trust, North Yorkshire Fire and Rescue, ArcLight and Together constructed a project to address these issues.
- 10. Investment from VoY CCG, NHS England, and CYC together with additional funding from a national charitable foundation enabled the partnership to deliver this truly innovative project, which commenced on 1<sup>st</sup> April 2015.
- 11. The Sport and Active Leisure (SAL) team within Public Health has continued to develop the *Inclusive York Programme* in 2 distinctly strong brands: Health, Exercise, Activity and Lifestyle (HEAL) and Disability Sport and Physical Activity. The HEAL Programme has focussed this last year on developing the programme on offer for individuals with a long term limiting medical conditions through an Exercise Referral programme. While the Disability Sport and Physical Activity Team have extended their remit into working with individuals with a Physical (profound disability), Sensory (Deaf and hearing impaired) and those with a learning disability (particularly Autism Spectrum Condition ASC) to get them to become more physically active.
- 12. The *Moving More Often* programme based in City of York sheltered housing schemes has brought physical activity to sheltered housing residents and members of the local community by introducing them to new physical activity opportunities. Such activities enable older people to engage and to socialise with fellow scheme residents, to build lasting friendships and to lower socialise isolation, through bringing the community closer together.
- 13. The Moving More Often programme is a bespoke intervention that promotes healthy lifestyles, through incorporating the foundations of community development practice to build stronger communities. The programme aids to improve access to health and wellbeing opportunities by 'taking the service' to the residents. The programme is targeted towards older people, but also positively engages older people with specific medical conditions such as Dementia, Depression, learning disabilities, physical disabilities and Parkinson's Disease.

- (It should be noted that the SAL team also make a universal offer for residents of the city but this report focuses on the targeted activities).
- 14. In 2013 a Health Needs Assessment of the Gypsy, Roma and traveller community was completed. This identified the need for the community to have a dedicated Health Visitor which the community had previously been commissioned as part of a Primary Medical Services project. This post had not been replaced following the retirement of the incumbent. As part of the stakeholder engagement for the provision of the 0-19 service this gap has been addressed by ensuring that the new service has a dedicated Health Visitor for the community. The post will not only champion child health but also encourage the community to make use of universal services, including registration with GP practices, dentists, education etc.
- 15. The Mental Health Crisis Care Concordat\_is a national cross-governmental and multi-agency agreement. It describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs. Agencies in the City of York signed a declaration of support to the Concordat and since then work has been undertaken to develop a supporting action plan to set out how they will collectively deliver the aims of the Concordat, focusing particularly on: Early intervention and responsive crisis services, access to support, urgent and emergency access to crisis care, quality of treatment and care when in crisis and recovering and staying well.
- 16. The action plan was formally endorsed by the Police, Health and Social Care Strategic Board (Gold) Group on 16th March 2015. Work is continuing to deliver the programme over the next year. Although completion of the action plan was a crucial landmark, the delivery of the plan will be the most demanding element.

Action 2: Champion a joint approach to addressing complex, interlinked issues that a number of families experience in the city, through our work with troubled families.

## **Progress**

17. The Family Focus Programme aims to support families in York. From January 2015 the programme is expanding to support families with a wider range of needs these include: those involved in anti social behaviour, schools attendance, those at risk of financial

- exclusion, those affected by domestic violence and families who are experiencing health problems. Health problems can include both mental and physical health, substance misuse, poor parenting and unhealthy behaviours resulting in malnutrition or diabetes.
- 18. Families eligible for the programme are identified through the merging of data from partners across the city and it is then the role of Family Focus to ensure that each family identified has a practitioner from a relevant service working with them who can; undertake a whole family assessment and develop an action plan and have regular review meetings. Coordination of services and interventions together with provision of information ensures the families are not overwhelmed and supporting the family to sustain progress going forward is important to the sustainability of the programme.

Action 3: Adopt a joint approach to community development in deprived areas of York, where communities define their own issues and how to address them.

## **Progress**

- 19. A joint project to understand what communities thought about poverty took place between October 2014 and January 2015 led by the Joseph Rowntree Foundation. This research focused on the personal experiences of those in financial hardship in York. It provided direct discussion with residents on issues that concern them every day.
- 20. Some of the key challenges highlighted included the general cost of living, especially food, fuel, debt, high rents and lack of affordable housing. Areas of support which would help included: being better able to budget, better pay when in work and more awareness of benefits and financial advice.
- 21. The research provided a unique and invaluable insight into residents' lives and concerns. Some residents presented the results of the research to CMT in April 2015.
- 22. The Loneliness and Social Isolation Working Group brings together representatives from organisations across the City of York who are prepared to deliver activity to reduce loneliness in the City, as part of the activity of the Fairness and Equalities Board, a subboard of the local strategic partnership, the Without Walls Board.

The Loneliness Working Group will provide the leadership in the coordination and delivery of work programmes intended to reduce loneliness, as recommended in the Healthwatch report 2014.

The group is currently collecting together detail of existing work in the city intended to tackle social isolation, as well as asking about barriers to accessing activities that prevent loneliness. The materials developed by the Campaign to End Loneliness are being used as a basis to formulate proposals for future activity.

Action 4: All organisations on the Health and Wellbeing Board will commit to exploring the implementation of the Living Wage, and encourage others in the city to do so.

## **Progress**

- 23. The creation of a city-wide Living Wage Coalition consisting of Aviva, Joseph Rowntree Foundation and Housing Trust, City of York Council, York CVS and York CAB has been instrumental in moving this forward. Living Wage events have also been held with local businesses to they can find out more about the Living Wage, this partnership included local businesses, e.g. Nestle.
- 24. Research is being conducted in partnership between City of York Council, York St John University and the Joseph Rowntree Foundation. This research aims to provide an insight into the challenges faced by low-paid staff, outline what employers can do to help them as well as to identify what the consequences of implementing the Living Wage have been.
- 25. The VoY CCG governing body approved a recommendation to adopt the living wage for its directly employed staff and consider how to incorporate this into commissioning at its June meeting.

Action 5: All organisations on the Health and Wellbeing Board commit to running supported employment programmes within their organisations and if successful, encourage other organisations or business to follow.

## **Progress**

26. City of York Council offer a range of courses to meet the needs of those recovering from Mental illness (Learning to Recovery Programme) and for those with a leaning disability or On the Autistic

Spectrum alongside the Blueberry Academy. These include employability, Customer Service, Confidence Building, Assertiveness etc. A number of CYC departments involve volunteers to assist/enhance the service delivery e.g. mentors for young people in care, adult learning assistants, or gardeners. Some services are provided solely by volunteers - parent mentoring, or neighbour mediation.

Action 6: Encourage investment in Community based programmes which increase residents' income and/or reduce their expenditure, such as debt, benefits or employment advice. We support the recommendations in the Financial Inclusion Strategy and acknowledge that this work is continuing.

## **Progress**

- 27. CYC has been working with partners and has supported the opening of a South Yorkshire Credit Union (SYCU) branch in Acomb to provide affordable credit to York's residents, as well as providing the SYCU with space in West Offices customer centre.
- 28. Delivery of Loan shark training for 100 staff/partners has taken place and York residents are being encouraged to fight back against loan sharks by signing up to an *Anti-Loan Shark Charter* and joining a credit union. The England illegal money lending team went door knocking at 200 homes in Bell Farm to raise awareness of the dangers of using illegal loan sharks.
- 29. A *Rental Exchange Scheme* has been developed by the Big Issue and Experian to help build up credit scores of Social Housing tenants using their rent payment histories. This will be implemented during 2015.
- 30. CYC has employed two *Money and Employment Advisers* in the housing team to help residents manage changes to benefits and maximise their incomes.
- 31. CYC secured one off funding from central government of £35,000 for 2013-14 for a Welfare Reform targeted support scheme which was delivered by Housing services. This awarded 100 grants to those in significant need. The grants were integrated with wider support which helped 40% of recipients to 'completely solve' their problems.

- 32. The *Financial Inclusion Steering Group (FISG)* has allocated grants to the value of £300k to a number of projects in the city including:
- The creation of Advice York (11 members are currently signed up to it) through £80,000 of FISG funding levered £248k lottery funding to deliver a 2 year project to transform advice provision in York. This has included: offering free, independent, impartial, confidential legal advice in areas of social welfare law, an Advice Strategy for the city will be launched in early July, a website has been launched, advice training has been delivered jointly with Citizens Advice Bureau (CAB) in North Yorkshire, a Benefits Advice and Tribunal Support worker provided 338 instances of support and helped 139 residents with appeals and specialist benefits support was provided to 322 residents which helped gain £570k in unclaimed benefit income.
- Big Community Switch events have so far resulted in 720 residents switching energy suppliers, saving an average of £206 per year, resulting in a cumulative saving of over £149,000. This was partially funded through £28k Financial Inclusion Steering Group grant funding over 18 months.
- The My Money My Life project run by Peasholme Charity and funded by FISG (£27k) aims to provide financial capability support and education for vulnerable and excluded people through a combination of one-to-one supported learning offering 20 hours of intensive financial capability support, small group training offering 12 hours of supported learning delivered over 4-6 weeks and open events/drop ins providing one off themed sessions. 50 residents have so far engaged with this and most have achieved positive outcomes (for example, 88% reported feeling confident dealing with official letters or financial statements).
- Digital Inclusion Project (York Housing Association, funded through FISG - £37k) aimed to provide hands on training to tenants (YHA & CYC) with internet usage. The project began in October 2014 and by the end of March 2015 had provided tailored support to 136 people. Residents affected by claiming Universal Credit are given priority. In addition to providing training to meet individual needs clients are shown how to save money on line.

 York CAB - GP Surgeries Outreach Advice Service began in January 2015 working closely with Priory Medical Group providing a generalist advice service focusing on welfare benefits and debt in GP surgeries in Rawcliffe and Cornlands Road. This two year project was funded by a grant from FISG.

Action 7: Explore and identify opportunities where we can take a range of services to residents who would benefit most from this. This includes: Community Stadium, range of support available from GP and Pharmacies.

## **Progress**

- 33. The community stadium project is due for completion in 2017 and will integrate sport and leisure opportunities with Hospital services and outreach services, as well as advice and support 3<sup>rd</sup> sector organisations. Burnholme community hub is also in planning stages which will integrate community sport, physical activity and leisure services with a GP's practice and an adult social care facility.
- 34. Co-location of services for residents' convenience has included presence of the Citizens' Advice Bureau and the Credit Union in West Offices. The Credit Union plan to work with other community based assets to extend the reach of the services they offer.
- 35. A trial of placing a CAB adviser in 2 GP surgeries in wards with high deprivation (Rawcliffe Surgery and Cornlands Road) has 14 clients so far gained annualised income equivalent through benefit take up of just under £41k by the end of April (funded by FISG see above).
- 36. The CCG is also embracing the opportunities for 'place-based commissioning' through the delegation and co-commissioning of primary care and specialised services with NHS England. This will enable the CCG to align investment, whole system strategies and the needs of local populations so it can further target local health inequalities.

Action 8: Recruit, train and support health and wellbeing champions from within those communities experiencing poorer health outcomes. They will signpost and provide health and wellbeing information and peer-led support. We will learn from recent research on this subject area in York and put these findings into practice. We acknowledge the role of 'Healthwatchers' who are already working in some areas of the city.

## **Progress**

- 37. Healthwatch York now has Community Champions (rather than Healthwatchers) attending regular monthly drop ins at Lidgett Grove, Spurriergate Centre, St Sampson's, NELLI Café (New Earswick), and Sainsbury's. Healthwatch also attend a regular lunch meeting at Clements Hall.
- 38. The VoY CCG has been identified as one of the six pilot sites for the New Models of Care for integrated working. The key components of this include prevention of ill health, self care, wellbeing and reducing inequalities.

Action 9: Undertake targeted work to investigate and address health behaviours and lifestyles in York, focused on smoking, alcohol use and obesity.

## <u>Progress</u>

- 39. The development of an alcohol needs assessment and strategies are in progress and one area identified was the need to focus on prevention and early intervention. Public Health has committed to develop IBA (Identification and brief advice) training which targets interventions early in people's overuse of alcohol.
- 40. Whilst every person who smokes is harming their health, there are specific groups of smokers identified as being more at risk. Prioritising these groups will result in the greatest reduction in tobacco related harm. Although smoking cessation support will be available to everyone who wants it through a variety of sources, the focus the specialist stop smoking service will be those who need it most, those who find it harder to stop smoking or are at a higher risk of developing smoking related diseases or harming others through their nicotine addiction.

- 41. A full needs assessment has been produced and will be published shortly; these groups have been identified as: routine and manual workers; pregnant women; those with long term conditions and young people in terms of prevention and support to stop smoking.
- 42. In York there are some groups that have been difficult to engage or those we have no data for. These include BME communities, those with mental health disorders and LGBT and disabled residents. A Community Impact Assessment Has been taken to the Equalities Advisory Group to better understand the communities they represent with regard to the re-procurement and redesign of the specialist stop smoking service provision to ensure we make the services accessible to those who need them.
- 43. Self-harm is a largely-unseen and significantly misunderstood issue. However, there are clear indications that its prevalence is increasing, particularly amongst younger females. There are a number of potential sources of information and intelligence to quantify the scale of self-harm, but these are fragmented across agencies and situational awareness may not be effectively shared to promote more intelligent responses.
- 44. To assist in developing a greater understanding of the issue, City of York Council is working with partners to develop a "Deep Dive", part of the Joint Strategic Needs Assessment (JSNA) to draw together the various sources of data and information.
- 45. Mental Health "Street" Triage CYC, VoY CCG entered into collaboration with NYP and Leeds and York Partnerships NHS Foundation Trust to introduce Mental Health Triage. This partnership scheme, which is initially funded for 2 years, commenced in October 2014. If police encounter a person (whether victim, witness, offender or other contact) and suspect that mental illness, alcohol dependence or substance misuse might be a contributing factor, they can seek advice and assistance from the Mental Health Triage Team. It creates a direct link between the police and trained mental health professionals with access clinical notes, enabling informed decision-making about how best to address that person's issues, minimise risk and reduce the chance of further escalation into crisis. This has a direct benefit to the patient by allowing the earliest possible intervention at the lowest appropriate level.

#### Action 10: Establish an effective York model for tobacco control

## <u>Progress</u>

- 46. A full needs assessment has been completed which highlights the specific needs for City of York. This showed a need to focus on smoking cessation for young people and pregnant smokers as well as under represented BME groups. The majority of smokers accessing services are white British and a higher proportion of females with an under representation of people from vulnerable or less affluent groups.
- 47. A specification for the stop smoking service is currently being developed looking a wider health behaviour model. A high-level strategic Tobacco Alliance is being planned and will launch in the autumn.

Action 11: Undertake joint campaigns across all partners and use our understanding of communities and individuals to target communication. We will adopt innovative approaches which actively engage more people in health and wellbeing issues.

## **Progress**

- 48. The communications team in CYC have:
- Developed joint campaigns and messages with the CCG, York
  Hospital NHS Foundation Trust and other health partners in the city
  to add strength to key message including sexual health, winter health
  and the children and young people agenda.
- Worked in partnership with community pharmacies to roll out a fully integrated campaign to encourage more people to use their pharmacies over the winter/Christmas period.
- Current work included the development of a communications plan which will look at 'universal' messages around prevention and identify targeted messages at identified groups within the city.
- The CCG have developed Stop before your op scheme and provision of smoking cessation advice, and have a
- Planned approach to raising awareness of health and wellbeing campaigns via twitter, web information and media releases.

#### Consultation

49. A number of partners have provided information for this paper, including various departments within CYC, HealthWatch, Vale of York CCG and North Yorkshire Police.

## **Options**

50. This report is for information only and contains no options.

## **Analysis**

- 51. It is recognised that the content of this paper is limited to only a few of the partners represented on the Health and Wellbeing Board and it is recommended that the next update should include information of the work of all partners.
- 52. There appears to be significant investment in health improvement programmes that offer bespoke interventions and work in collaboration to demonstrate improved health outcomes. In the future it will be interesting to examine the evaluation and outcomes of some of the innovative projects mentioned in this report including the *Together: for Mental Wellbeing*, the Family Focus programme, the research around financial hardship in York and the Living Wage Coalition.
- 53. The trial of CAB officers in two GP practices via funding from the Financial Inclusion Group is an excellent example of collaborative working to address the wider determinants of health. Lack of income, inappropriate housing and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education and support for healthy living can all contribute to healthier communities. This example and the work of the FISG outlined in this paper are excellent examples of working to address these wider determinants.
- 54. The paper demonstrates the breadth of work which has taken place around Health Inequalities and clearly indicates that partners have this subject at the very centre of the work they are doing. However it would be fair to say that this work is happening within individual organisations and is not necessarily being monitored and led in a holistic way. It is important that organisations work together to tackle Health Inequalities which are exacerbated by the wider determinants of health.

## **Strategic/Operational Plans**

- 55. This report is directly linked to the Joint Health and Wellbeing Strategy *Improving Health and Wellbeing in York 2013-16.*
- 56. Health Inequalities is a cross cutting theme which places it in most strategic and operational plans developed by members of the Health and Wellbeing Board, which includes, but is not limited to:
  - Fairness and Equalities Board
  - Joint Strategic Needs Assessment
  - NHS Vale of York CCG Operational Plan.
  - CYC Council Plan

## **Implications**

57. As this report is for information only it contains no implications. Each project identified within the paper will have identified its own implications. However the HWB Board should acknowledge the implications of not working towards reducing Health Inequalities and seek to continue to address this as the next strategy is written.

## **Risk Management**

58. Our health is influenced by a wide range of social, economic and environmental factors. These factors influence the health of individuals and populations, they determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. There is a clear link between the wider determinants of health and health inequalities, defined by the World Health Organisation as "the unfair and avoidable differences in health status seen within and between countries".

The partners of the Health and Wellbeing Board together have a vital role to reduce the wider determinates of health of the residents of York, together with the capacity and capability to make a difference. It is essential that partners continue to work together and the Board continues to have Health Inequalities as one of its core areas.

#### Recommendations

59. The Health and Wellbeing Board are asked to accept this report and provide advice and direction on the next steps.

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

#### **Contact Details**

Author:	Chief Office	cer	Responsible	for	the
	report:				

Philippa Press Julie Hotchkiss

Health Improvement Manager Acting Director of Public Health

Public Health City of York Council
City of York Council Tel No: 01904 55

Tel No: 01904 555756

Report	/	Date	30.06.2015
Approved	<b>V</b>		

Wards Affected: All  $\sqrt{\phantom{a}}$ 

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

## **Background Papers:**

Improving Health and Wellbeing in York – Our Strategy 2013-16.3

#### **Annexes**

None

3

https://www.york.gov.uk/info/20139/health\_and\_wellbeing\_partnerships/973/health\_and\_wellbeing\_board



## Page 91

## Glossary

ASC Autistic Spectrum Condition

BME Black and Minority Ethnic (groups).

CAB Citizens Advice Bureau

CCG Clinical Commissioning Group
CMT Council Management Team
CVS Centre for Voluntary Services

CYC City of York Council

FISG Financial Inclusion Steering Group

GP General Practitioner

HEAL Health, Exercise, Activity and Lifestyle

HWBB Health and Wellbeing Board
HWBS Health and Wellbeing Strategy
IBA Identification and brief advice

JSNA Joint Strategic Needs Assessment LGBT Lesbian, Gay, Bisexual, Transgender

NHS National Health Service

SYCU South Yorkshire Credit Union

VoY CCG Vale of York Clinical Commissioning Group

YHA York Housing Association







## **Health and Wellbeing Board**

15 July 2015

Report of the Chief Operating Officer – NHS Vale of York Clinical Commissioning Group

## **Update on the Better Care Fund**

## **Summary**

1. This report asks the Health and Wellbeing Board to note progress made and to continue their support of the implementation and delivery of the Better Care Fund plan.

## **Background**

2. The Better Care Fund (BCF) is a nationally agreed process to 'pool' elements of Health and Social Care Budgets to help Health and Wellbeing Board (HWB) areas integrate and improve services which support local wellbeing priorities. A comprehensive update around progress is at Appendix A to this report. A copy of the BCF submission is at Annex A and is available to view online.

## Main/Key Issues to be Considered

3. These are detailed in the Appendix A.

#### Consultation

4. We have continued to consult with partners in the development of our BCF plan and as we move deeper into the implementation phase throughout 2015, we will update and improve our consultation sessions with wider stakeholders and interested parties.

## **Options**

5. This report is for information only and there are no specific options for the Board to consider.

## **Analysis**

6. Not applicable

## Strategic/Operational Plans

The BCF plan is aligned with, and complements the NHS Vale of York Clinical Commissioning Group's Strategic Plan 2014-19 and its Operational Plan 2014-16 and the Joint Strategic Needs Assessment.

## **Implications**

8. Not applicable

## Risk Management

9. Not applicable

#### Recommendations

10. The Health and Wellbeing Board are asked to note the content of this report and continue to support the strategic direction of travel for BCF and wider system integration.

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

#### Contact Details

**Author:** 

Chief Officer Responsible for the report: John Ryan Dr Mark Hayes Service Development Lead Chief Clinical Officer NHS Vale of York CCG NHS Vale of York CCG Guy Van Dichele **Director Adult Social Care** City of York Council

> Report **Date** 30.06.2015 **Approved**

**Specialist Implications Officer(s)** None

**Wards Affected:** For further information please contact the author of the report

**Background Papers:** 

None

Annexes

**Appendix A** – Update Report

**Annex A** - BCF Submission (Online Only)

## **BETTER CARE FUND**

## **UPDATE REPORT FOR HEALTH AND WELLBEING BOARD**

## 1. Background

- 1.1 The Better Care Fund (BCF) is a nationally agreed process to 'pool' elements of Health and Social Care Budgets to help Health and Wellbeing Board (HWB) areas integrate and improve services which support local wellbeing priorities. The mechanics of how the fund works and how budget allocations are made have been devised on a national scale using standard formulas. The performance of the fund is also measured through some nationally agreed performance metrics namely:
  - To reduce Non Elective admissions to hospital by a locally agreed amount
  - To reduce the permanent number of admissions to residential and nursing care homes for residents aged 65 and over, by a locally agreed amount
  - To increase the number of residents (aged 65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/reablement services by a locally agreed amount
  - To reduce the numbers of delayed transfers of care from hospital, by a locally agreed amount
- 1.2 In order to fund the initiatives which will help deliver the ambitions of the BCF, a pooled budget, formalised under a Section 75 agreement has been established between NHS Vale of York Clinical Commissioning Group (CCG) and City of York Council (CYC). For Financial Year 15/16 this pooled budget amounts to £12.127M, with the majority of the fund (£11.176M) coming from the CCG.
- 1.3 It is important to note that the funding for the BCF has had to come out of existing allocations, either as a pass through of statutory funding (eg Disability Facilities Grant) or as a direct transfer from the CCG. It is recognised across organisations that this is causing additional pressures across the system and has the potential to impact on financial performance throughout the year.

1.4 A summary of the most significant key new schemes which will support delivery of the nationally agreed performance metrics are as detailed below. These initial schemes are designed to reduce high cost activity in hospital in order to support the sustainable pooling of current health and social care funds under the existing Section 75 agreement.

Scheme Name	Investment 15/16 (£K)	NEL Reduction Target	DTOC Days Reduction Target	Permanent Residential Admissions Reduction	A&E Attendance Reduction	Savings Target (Based on 30% tariff) (£K)
York Integrated Care Hub	500	312	709	40	1578	676
Urgent care Practitioners	564	1183			2089	674
Hospice at Home	170	361			361	240
Street Triage and Pathways	125				2657	288
Sitting and Crisis Service	164	350			500	211
Whole System Review	4313		3232		2600	593

## 2. System Approach

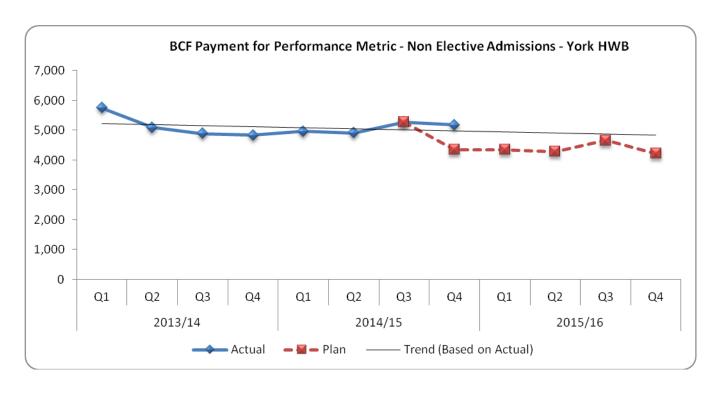
- 2.1 Since the submission of our most recent BCF plan in December 2014 (copy attached at Annex A), we have taken a whole system approach to ensuring our proposals are able to deliver the planned impact. We recognise that many of the interventions planned require close cooperation across systems and indeed this close cooperation is identifying efficiencies and opportunities to remove duplication across numerous existing services. This work is being jointly led by the CCG and CYC, under the direction of the Joint Delivery Group (JDG).
- 2.2 The JDG is a multi-agency commissioner and provider forum which meets monthly to monitor the delivery and effectiveness of BCF performance.

It has been running for approximately 18 months and has recently undergone a refresh to ensure it also addresses the wider strategic issues facing the wider integration agenda. Further work is required to formalise where the JDG sits in the whole system governance structure and what its relationship with Collaborative Transformation Board (CTB) and HWB needs to be.

2.3 In order to provide senior system leadership to the wider integration agenda, of which BCF forms a small but significant part, we have also established a Joint Commissioning Executive (JCE), co-chaired by the Chief Clinical Officer of the CCG and the Chief Executive of CYC. This body sets the direction of travel for our integration plan and has been the catalyst for driving forward the key work stream around provider integration in the city, which is a key component of our overall vision. The role and responsibility of the JCE will mature over the coming months and it is hoped that this will pave the way for joint commissioning posts across the CCG and the Council within the next year.

## 3. **Performance**

3.1 A key performance measure for the BCF across the country is the reduction in non-elective (emergency) admissions to hospital. Based on our projected plan and on actual activity data received, we have currently exceeded or projected activity by 825 admissions for Quarter 4 of 20114/15. The result of this is that we have not generated the required shift in activity to make any additional payments into the pooled Payments for Performance (PfP) element of the Section 75 fund. Whilst this is disappointing, it is a measure of the time it has taken to get our new schemes fully up and running and the traditional pressures that winter places on the health and social care system. We would expect to see a more positive impact of our schemes when Quarter 1 of 2015/16 data is received and analysed.



3.2 Whilst it is still relatively early days to see the tangible impact of the current BCF schemes, JDG is taking an active interest in the current level of performance. Discussions have already started around what additional activities can be put in place manage the potential gap in delivery targets and to mitigate as much as possible the potential impact this shortfall could have on the system. One area which requires early intervention, for which a plan is currently being worked up, is the detail that sits within the 'Whole System Review' element of the BCF submission. System leaders across health and social care recognise more can be done by bringing services together to improve outcomes for residents. The Whole System Review identifies a number of single services or contracts within organisations that can benefit from removing duplication and improve capacity within them. An example of this is the reablement offer across health and social care. Stakeholders are working together to understand better the 'as is' arrangements and to design the 'to be' with a view to having a more therapeutic reablement offer going forward. Future reports will update the Board on proposals

## 4. Next Steps

4.1 Key decisions will be required by the end of Quarter 2 with regard to the longer term funding of the current BCF schemes.

Some early discussions in this area have already taken place at both JDG and at the CCG Governing body private session in June (at which CYC were represented) and it was acknowledged that many of the schemes are still at a very early stage of delivery and statistically relevant impact information is not yet available. Notwithstanding this, we will have to monitor closely the impact the schemes are having against the national defined criteria (as described in paragraph 1.1) in order to make informed decisions regarding funding.

4.2 The Health and Wellbeing Board are asked to note the content of this report and continue to support the strategic direction of travel for BCF and wider system integration.





## Refreshed submission 10 Dec 14

## Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19<sup>th</sup> September 2014. Please send as attachments to <a href="mailto:bettercarefund@dh.gsi.gov.uk">bettercarefund@dh.gsi.gov.uk</a> as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

## 1) PLAN DETAILS

#### a) Summary of Plan

Local Authority	City of York Council
Clinical Commissioning Groups	NHS Vale of York CCG
	The CCG footprint also sits across parts of North Yorkshire County
Boundary Differences	Council and East Riding of Yorkshire County Council.
Date agreed at Health and Well-Being Board:	10/12/2014
Date submitted:	10/12/2014

Minimum required value of BCF pooled budget: 2014/15	£3,354M
pooled budget: 2014/15	23,334141
2015/16	£12,127M
Total agreed value of pooled budget: 2014/15	C2 254M
2014/15	23,334W
2015/16	£12,127M

## b) Authorisation and signoff

Signed on behalf of NHS Vale of York Clinical Commissioning Group	M Llyg
Ву	Dr Mark Hayes
Position	Chief Clinical Officer
Date	10/12/2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the City of York Council	Korsten Englad.
Ву	Kersten England
Position	Chief Executive
Date	10/12/2014

Signed on behalf of the York Health	Constant Contract C
and Wellbeing Board	honsely curring can loss
By Chair of Health and Wellbeing	
Board	Cllr Linsay Cunningham-Cross
Date	10/12/2014

## c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Improving Health and Wellbeing in York. Strategy 2013-16	H&WB Board 3 year plan
My Life. My Health. My Way. NHS Vale of York CCG Integrated Operational Plan 2014-19	CCG 5 year plan and vision
York Health and Wellbeing Joint	Updated 2014

Strategic Needs Assessment 2014	
North Yorkshire County Council Better	32% of Vale of York residents reside in
Care Fund Plan	NYCC
East Riding of York Council Better Care	4% of Vale of York residents reside in
Fund Plan	ERoY
Annual Report of Chief Medical Officer	Public Mental Health Priorities
2013	
Gold Standards Framework – End of Life	Support and best practice for patients on
Care	EOL pathway
York BCF Communications and	
Engagement Plan	
	NHS Wale of Work
	CATS and City
	COS and City

### 2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

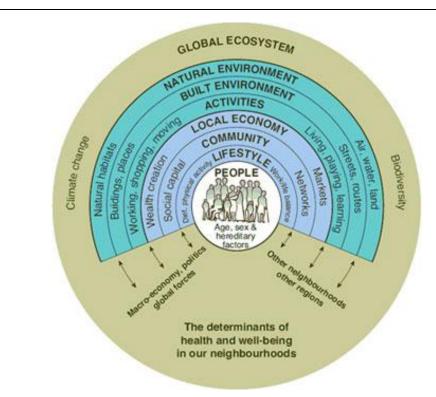
Our joint vision is for a health and social care system that places individuals at the centre with accessible, responsive and effective services built around them:-

"Achieving the best health and wellbeing for everyone in our community" – NHS Vale of York CCG Integrated Operational Plan 2014 – 2019

"York to be a community where all residents enjoy long, healthy and independent lives. We will achieve this by ensuring that everyone is able to make healthy choices and, where they need it, have easy access to responsive health and social care services which they have helped to shape" – York Health and Wellbeing Board Strategy 2013 - 2016

On the whole, people in York have a good standard of life. Most residents can expect to be well educated, have access to good quality employment and, for the most part, live long, healthy and happy lives. However, this is not true for everyone and there are still significant health and wellbeing challenges for the city including the differences in life expectancy between some areas of the city and others, the growing needs of our ageing population and particular challenges around mental health and emotional wellbeing. Based on our understanding of the needs in York (JSNA 2014) our BCF plan sets out our priorities for improving residents' health and wellbeing, and together, as key organisations and as a whole city, what we will do to deliver these priorities. All major providers and commissioners are already signed up to our vision for person centred, integrated health and social care at the highest level via York's Health and Wellbeing Board (H&WB). Our main providers sit on this board. Our integration plan proposed in this submission is absolutely consistent with this vision and the core principles set out in York's Joint Health and Wellbeing Strategy.

Health and wellbeing is about more than illness and treatment. It is about being well physically, mentally and socially, feeling good and being able to live a healthy and fulfilled life. Many factors affect our health and wellbeing, these include: where we live, our housing, the local economy, our income, the environment, our relationship with the local community and the lifestyle choices we make. These determinants of health and wellbeing are shown diagrammatically below:



It is therefore vital that we not only tackle the effects of ill-health but we also address the wider factors and causes. As a Unit of Planning, we will champion good health and wellbeing, identify and harness the determinants that contribute to positive health, building on our strength as a successful and ambitious city.

We recognise that in times of increased demand and additional pressures on budgets and other resources, we need to make sure the health and social care system works as efficiently and effectively as possible. Our joint vision helps us build the necessary programme of work which will take us from our current level of service provision to a new model in 2019 which will ensure:

- Individuals are able to access the right level of care and support in community based settings to help avoid unnecessary admissions to hospital.
- That if individuals do have to go to hospital, we have the right multi-agency teams in place to speed up their journey through the hospital and to make sure they can leave the hospital as soon as it is safe for them to do so.
- Once individuals are discharged from hospital, we have joint teams of health and social care professionals who support them to regain their independence and return to the best level of health possible with a clear focus on effective reablement and enablement.
- That people are able to live in the place of their choice for as long as possible and that when they need to move to a different care setting, this happens quickly and effectively, involving individuals, their cares and families at every step of the way.

The City of York has 3 specific challenges that need to be accounted for in our planning:

Our JSNA highlights the demographic challenges our health economy faces,

in particular the growth in population aged 85 or over (38% locally, compared with 20% regionally or 23% nationally). This growth has been reflected in our calculations as to how, for example, we will maintain current (13/14) levels of social care provision in the areas that prevent hospital admissions and readmissions.

- We are also an outlier in respect of the level of "self-payers" within our system" 68% of people in York currently arrange and pay for their own care. This means that in order to develop prevention and early intervention strategies we need to ensure that these residents can receive excellent information, advice and sign-posting at all points in the journey through our health and social care system. It is often the voluntary sector that has the main contact with this cohort and this places particular emphasis on co-design and co-production of services with the voluntary sector.
- Finally, a particular factor we have to take into account in our planning is the extreme pressure put upon the health and care system in York as a result of the "full employment" status of the city. As a city, York has a very low unemployment rate, with JSA claimants at pre-recession levels of 1.3%, compared to 3.4% regionally and 2.4% nationally. This manifests itself within the employment market as a severe skills shortage. This means that we cannot, even if the budget was available, expand traditional service personal care provision exponentially. We need, perhaps more than in almost any other geographical area, to manage down demand so that we can continue to maintain current levels of front-line service provision. It means we must also pay more than average attention to how we use the provision of equipment and assistive technology instead of "care hours". The need to maintain current levels of equipment and assistive technology budgets is reflected within the "Protecting Social Care" element of our BCF submission.

Our vision therefore draws on the findings of our Joint Strategic Needs Assessment (JSNA) and in particular the 4 key points that emerged from the document of:

- Our population is ageing and will place increased demands on health and social care services
- Health and wellbeing inequalities exist in York and must be tackled
- We need to know more about the mental health needs of our population and design appropriate services to meet these needs
- The importance of intervening early and giving children and young people the best possible start in life

### b) What difference will this make to patient and service user outcomes?

The success of our vision will be measured by the impact it has on individuals, how it contributes to the sustainability of both health and social care provision and what positive outcomes it has had. Specifically, over the next 5 years we expect to:

- Reduce emergency hospital admissions by 14%. Initial plans indicate a reduction in emergency hospital admissions of 11.7% in 15/16. (See Tab 5 of Part 2 of submission)
- Reduce hospital re-admissions by 2.3%

- Reduce the potential years of life lost from causes amenable to healthcare by 15%
- Improve the health-related quality of life for people with long-term conditions by 1.9% per annum
- Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community
- Reduce delayed transfers of care by 6.9% in 15/16. Further modelling required for 16/17 to 19/20 activity based on BCF scheme growth
- Reduce permanent admissions to care homes by 14.8% in 15/16. Further modelling required for 16/17 to 19/20 based on BCF scheme growth

These outcomes will be enabled through the integration of health and social care teams where appropriate and by the implementation of the specific BCF funded schemes outlined in the Annexes. By focusing on the delivery of Care Hubs, supported by additional initiatives such as the roll out of additional Urgent Care Practitioners<sup>1</sup> the expansion of Hospice at Home scheme<sup>2</sup> and the delivery of Mental Health Street Triage<sup>3</sup> we will be best placed to deliver a transformational patient and service user experience as detailed below.

Below is an example of how we see the way in which our residents access and receive care and support change over the next 5 years.

#### **ENID'S STORY**

2014

Enid has standard health care reviews with her GP. Social care provision is reactive. She has problems with slowly deteriorating lung function as a result of COPD and she also has mild dementia.

Enid begins to feel unwell over a weekend and goes to bed. Her daughter finds her and calls NHS111. She is admitted after a long wait in AE. She is given antibiotics for a chest infection. Like many patients she is at risk of further infection and loss of her normal function. She is discharged back home in the evening after a long stay in hospital. Her GP is unaware of her arrival home until her family call stating that she is struggling and confused. Her medications were altered by the hospital team, including an addition of anti-psychotic medication used to

2019

The Care Hub Team identifies Enid as a risk for admission and proactively assesses and manages her health status with her own case manager. Every opportunity is taken to help her to remain independent in her own home.

Enid receives a comprehensive care plan with a named care worker that she and her family can contact for support when necessary. When she contacts the NHS111 and the Out of Hours GP her medical details are available.

Alternatively during the week she is seen by her GP or an Emergency Care Practitioner who steps up her care to the local Community Hospital

When she is admitted the AE Team has her records and then inform the Care Hub Team that she has been admitted.

<sup>&</sup>lt;sup>1</sup> Annex 1B – Urgent Care Practitioners

<sup>&</sup>lt;sup>2</sup> Annex 1 C – Hospice at Home

<sup>&</sup>lt;sup>3</sup> Annex 1D – Street Triage

control her agitation whilst admitted.

She is visited by her GP and a District Nurse who requests Social Care input from the rapid access and reablement teams. She remains at increased risk of admission over the weekend and during the night.

The reablement process falters and Enid is referred for placement in a Care Home. Whilst waiting Enid falls and breaks her hip and is admitted back into hospital.

The system failed Enid through a lack of continuity of care and a lack of joined up services, working together to meet Enid's needs and aspirations.

They begin her discharge planning within 2 hours of her admission. Her discharge process is fully integrated with the Care Hub Team who signal that they are ready to receive her in the community. She is discharged with a clear emergency care plan and updated Do No Attempt CPR Form.

She has social care provision and additional services such as physiotherapy. Enid is assessed as having a risk of falls and is provided with risk mitigation support. The Care Hub Team adjusts her management plan and involves her family to anticipate risks in her disease trajectory.

Enid has benefitted from joined up services that fit around her; they support her continued independence through an integrated team of health and social care professionals who share information and involve Enid and her family in decision making.

To do this for Enid and other residents of York, we need to change the way individuals' access services, both in and out of hospital, so we can deliver Right Care, Right Place, and Right Time, and "making every contact count". A true measure of our success will be reduced hospital based activity and a much greater use of community and home based support.

# c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

How future services, both health and social care, are configured and delivered is perhaps the greatest challenge facing the local economy and the level of transformation we want to achieve. Our 8 key strategic initiatives, outlined within the CCG's Strategic Plan, are:

- Integration of Care
- Person Centred Care
- Primary Care Reform
- Urgent Care Reform
- Planned Care
- Transforming Mental Health and Learning Disabilities services
- Children and Maternity Services
- Cancer, Palliative Care and End of Life Care

The activities with most relevance to our BCF submission are described below.

The demographic challenges we face place additional strain on our health and social care services. This is recognised as a key driver in establishing our Care Hub models.

The development and implementation of Care Hubs is a major strand of our vision which will bring together a comprehensive range of health and wellbeing services to provide for local people. Our Care Hubs will:

- Be dedicated to the needs and aspirations of the communities they serve
- Deliver coordinated care and support that is co-designed and co-owned by individuals and communities
- Consistently deliver high quality, successful and cost effective outcomes

Our care hubs in turn will operate within a much wider integration of health and social care including critical factors of success such as a shared care record and single point of contact. These key components are described in more detail below:

**Care Hubs** – We will develop Care Hubs, whose key responsibility will be to assess, diagnose and activate solutions to enable individuals to remain at home, or return there at the earliest opportunity, following a period of exacerbation or crisis. These hubs will be developed using national and international evidence, ranging from earlier Polysystem models in Redbridge through to fully integrated community models in Canterbury, New Zealand and 'Extensivists' in the USA.

The hubs will be staffed by a multi-disciplinary, multi-agency team who will act as the enablers to ensure care and support packages are put in place as quickly as possible and in the best interests of the individual and their carers. New funding models to incentivise providers to deliver this approach will ensure they truly deliver transformed models of care as alternatives to admissions to hospital or care homes.

We have already established a hub in York, being delivered by Priory Medical Group<sup>4</sup>. Funding for this hub has been made available through the BCF and projections on the efficacy, cost effectiveness and outcomes of this hub are promising. We are putting in place a formal evaluation process in partnership with the University of York and once this initial evaluation has happened (planned for Autumn 2014) we will confirm the additional BCF funding to grow the hub to deliver at pace and scale.

The diagram below shows how we expect our Care Hub model to work, with individuals at the centre, supported by their own networks and community as appropriate through a single contact point. Individuals will access service delivery providers who in turn will ensure individual or joint interventions fit around the individuals' needs.

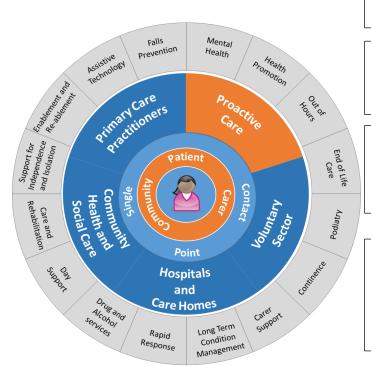
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<sup>&</sup>lt;sup>4</sup> Annex 1A – Care Hub PMG



A range of health and care professionals working together to meet all of the health and care needs of their residents.

Actively liaising with professionals where onward referral for specialist support is needed



### HOW

Doctors, Nurses, Social Care, AHPs and Pharmacists

Working from health and care facilities integral to the Hub

Accountable for outcomes and funding across all settings inside and outside the Hub

**Shared Care Records** – People tell us they "only want to tell their story once". We fully support this and see this not only as one of the greatest impacts the new services can provide it is also one of the greatest challenges we face. We need to join up our different information systems so we can work with partners and the wider business community to look at how we can do this. It will mean new ways of managing data and working across organisations, to share relevant information and we will use the NHS number across both health and social care.

**Single Contact Point** – we will have one care record, and move to a single contact point for residents to contact us. This could be a GP, a care manager, a district nurse, a community matron, an OT or specialist MH worker or any other health and social care practitioner with whom the person has regular contact. This person will retain accountability for their client and will act as the facilitator to all other services and interventions. Clearly when an individual is admitted to a hospital setting, clinical responsibility will transfer to the relevant hospital clinician but the single contact point will still have an accountable role for in-reach and discharge planning.

The pace and scale of what we are trying to achieve is significant and we have used the principles behind the Better Care Fund to mobilise our local economy into action.

Subject to the Ministerial announcement, we fully expect to be part of the national NHS Accelerate programme. At a recent assessment panel (made up of senior members of the NHS, LGA and Monitor) all commented on the depth and range of the initiatives we are proposing; initiatives and conversations that would have been impossible even 18 months ago, without the catalyst of BCF. By participating in Accelerate we will have access to a range of senior support to help drive our joint initiatives forward at pace.

### <u>Implications of Care Act</u>

At present, prior to the implementation of the Care Act, people with the highest levels of need and especially those who are likely to receive public funding, are the most likely recipients of Statutory Social Care Assessment. The implementation the requirements of the Care Act in 2014/15 and 2015/16 will mean that people will be able to access a full social care assessment at a much earlier stage and the assessment will be the same for people who fund their own care as those whose care is funded by the Council.

In addition, as a result of Care Act implementation, people who will not be entitled to funded care will receive greatly enhanced levels of information and advice services to enable them to access care services that complement their healthcare, as well as having a named individual to coordinate their care across health and social care services. Currently in York over 60% of people organise and pay for their own care. The implementation of the Care Act and the move to Community Hubs will provide a coordinated approach for these residents for the first time.

### Dementia care

A further challenge for York in respect of its ageing population is the exceptionally high rise in the over 85 population during the plan period and the associated rise in dementia that can be anticipated as a result. York has committed to being a "dementia friendly" city across a whole range of statutory, voluntary and independent sector service provision. The impact is expected to be to help people with dementia to be able to live as long as possible within the community rather than in residential settings. During the BCF plan period we will redesign service provision for this group of residents within the health and social care context. This will include:

- Provision of specialist dementia step-up and step-down beds to avoid unnecessary hospital admission and speed up hospital discharge for this hard-to-place client group.
- The re-provision of residential care homes in the city to provide a dementia friendly model of care. Capital from the BCF will be used to support this reprovision.
- The redesign of extra-care housing provision within the City providing an option to early entry to residential care.
- Increased availability of assistive technology within people's own homes to enable them to retain independent living for longer and to reduce the burden on their carers, thus avoiding carer breakdown.

### Mental Health

Finally, in respect of mental health services, there has been a recent and very extensive engagement with the residents of York and the neighbouring area of North Yorkshire about the outcomes they want to achieve from a redesigned of mental health service. City of York Council and Vale of York CCG are currently collaborating to establish which core services can be part of an integrated approach and can be jointly commissioned. This work is moving at pace and key decisions will be made

within the next 6 weeks. It is intended to take this joint plan to a competitive procurement exercise later this year.

 Mental health and the often associated issue of alcohol misuse are also given a prominent place in our admissions avoidance strategy. Two schemes, both of which will be in receipt of BCF funding will significantly contribute to reductions in acute sector admissions. These are our Mental Health Street Triage scheme and out "Together" scheme which targets hard-to-reach individuals whose needs are not being met by traditional services.

### Intermediate Care

Another major difference in our local system design in over the plan period will be in respect of our intermediate care services, the services available when people go into crisis in the community and need intensive input to avoid admission to hospital or a residential/nursing home and also when they are discharged from hospital to avoid re-admission. In the Oak Group's Medical Care Appropriateness Protocols (MCAP) this is described on 2 levels:

### Intermediate Care (facilities based)

A step-up or step-down unit to initiate or finish a course of treatment where the frequency of complexity cannot be managed at home or where the patient has problems with activities of daily living including transfer, mobility and safety .....interventions can be provided by physiotherapists, occupational therapists or support workers. Medical care is provided by primary care services when required.

### Intermediate care (home based)

A service to initiate, maintain or complete a course of treatment that requires supervision but where patients can be safely supported at home. The patient requires MDT input but is safe in the home environment.

We will use BCF funding to provide intermediate care services that prevent avoidable hospital admission and readmission. However, we recognise that the current provision of intermediate care in the City is fragmented. During the latter part of 2014/15 and mainly in 2015/16 we will jointly review our current intermediate care pathway and our current services. We will engage with patients, service-users and their carers as well as our providers. Then we will use this information to jointly commission the optimum range of step-up and step-down services during 2016/17 within a fully integrated approach

A cross-cutting theme for our integration programme is how our systems redesign, our integration plans and specifically our BCF funded activities support urgent care and the acute sector. In this respect the approach we have taken is to understand how each of our BCF schemes will contribute to the following systems objectives:

- Schemes to prevent unnecessary conveyance to ED
- Schemes to prevent unnecessary admission from ED
- Schemes to support hospital discharge and avoid re-admission

This information is contained in the schedules to our BCF submission.

### Evaluation

The formal evaluation of the impact of our Care Hub model will also help redesign service provision, as will our determination to see a reduction in hospital based activity. All of these initiatives will have an impact, in some shape or form, across our unit of planning and we recognise the absolute need to understand this impact early on in our planning processes. We do not currently have a high degree of confidence that we have either the capacity or capability to accurately model these impacts and this is a specific area where we have identified that the NHS Accelerate programme would be able to support. Without additional support, accurately modelling, describing and delivering reconfigured services in a sustainable way will be a significant risk to all partner organisations.

We have also approached the University of York with a view to developing an approach to the evaluation of our BCF funded schemes that will provide us feedback on what interventions deliver the best outcomes for patients and the best return on investment.

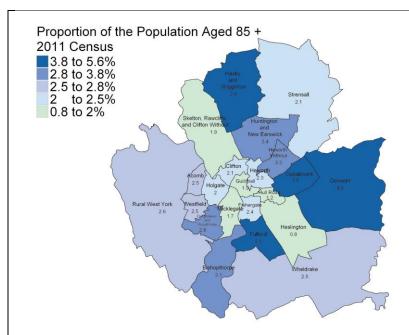
### 3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this

"We aim to help people to remain healthy and independent in their own communities for as long as possible, by working towards delaying the need for care. Driving greater integration between health and social care is a key commitment. We are exploring jointly commissioning health and social care services from 2015 with the Vale of York Clinical Commissioning Group. The Better Care Fund has been set up to support councils and Clinical Commissioning Groups to deliver their local plans for integrating health and social care and is a vehicle to help us deliver this, which is a core purpose of the Health and Wellbeing Board. People should access personalised support which meets outcomes and is better coordinated, making the best use of resources." Extract from CYC Market Position statement 2014

#### **Local Future Demand**

York's population of over 65s is increasing, making up 16.9% of the total population. The most notable growth rate is 38% between 2001 and 2011 for those aged 80 and over, compared to a national rate of 23%. The over 80s are amongst those most likely to be receiving high levels of health and social care services, due to higher prevalence of dementia and likelihood of having more than one health condition or disease. It is predicted that there will be a 44% increase in people in York aged 80 and over between 2012 and 2020. This growth in those aged 80 and over is partly due to increased longevity. There is also evidence that York's higher than average rise may be attributed to the very elderly who often no longer drive, moving out of surrounding rural areas and into York. Cuts in public transport in North Yorkshire and East Yorkshire may have contributed to this, alongside older people wanting to live closer to health facilities. Demand for services and support for older people is expected to rise, with entry in services likely to be later in people's lives.



Mental Health Foundation states that 1 in 4 people in the UK will experience some kind of mental health problem in the course of a year. It is estimated that at any one time there are around 25,000 York residents experiencing mental health problems ranging from anxiety and depression to enduring psychiatric disorders. This figure includes people with dementia. In general we expect demand on services to rise in line with population growth. The Community Mental Health Profile for 2013 records that in York the percentage of adults 18-and-over with depression is 'significantly worse' than the average for England based on 2011/12 data. The percentage of adults 18-and-over with dementia is similarly recorded as 'significantly worse' than the average for England.

The table below highlights the significant challenges facing York in addressing the Mental Health agenda.

Rate per 1,000 population	Period	England Average	Yorkshire and The Humber	York
In-year bed days for mental health	2010/11	193	170	204 (Significantly Higher)
Numbers of people on a Care Programme Approach	2010/11	6.4	6.3	5.6 (Significantly Lower)
Numbers of people using adult & elderly NHS secondary mental health services	2010/11	2.5	2.6	3.1 (Significantly Higher)

Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders	2009/10 to 2011/12	57	54	79 (Significantly Higher)
Directly standardised rate for hospital admissions for Alzheimer's and other related dementia	2009/10 to 2011/12	80	81	119 (Significantly Higher)
Directly standardised rate for hospital admissions for mental health	2009/10 to 2011/12	243	221	268 (Significantly Higher)
Percentage of adults (18+) with depression	2011/12	11.68	11.88	13.71 (Significantly Higher)
Percentage of adults (18+) with dementia	2011/12	0.53	0.58	0.66 (Significantly Higher)

The NHS Information Centre - Mental Health Minimum Dataset - http://www.ic.nhs.uk/pubs/mhbmhmds11

Having a clear understanding of this local data has been the first stage leading to the development for our plans, models and programmes for BCF. This has been the baseline we have used to establish which areas we need to concentrate on first to achieve the objectives of BCF. This data has also been used to support our risk stratification approach described in the following section.

### Our approach to Risk stratification

To prioritise and help us understand the needs within our resident groups and how these are distributed across the York population we have used the Combined Predictive Model (Kings Fund 2006). We will be applying this method to help identify the top 20% users of health and social care services within our care hubs, this will inform future support options and care planning for those residents and each cohort within our BCF plan. These include: Age-related frailty, levels of economic well-being, behaviour, social connectedness, utilisation risk, presence of a carer, and a person's own caring responsibilities. In addition to people's clinical and social care needs, we recognise these may have a significant impact on a person's capacity and willingness to self-manage and the bearing this could have on their dependency on statutory services.

There are three major reasons why we have elected to take this approach:

- 1. Similar risk scores do not automatically mean similar needs two residents may have very high-risk scores, but vastly different needs. For example, someone who is very frail and elderly may have a risk score similar to someone who is middle aged and has diabetes and COPD, but the former may need fall prevention programmes and regular social-care visits, while the latter may need more intensive primary care and regular visits to a specialist for managing their conditions.
- 2. Utilisation risk only measures risk of a non-elective hospital admission while this is a useful indicator for needs, many needs are lost by only focusing on one aspect of care.
- 3. Risk stratification has a low ability to predict non-elective hospital admissions most of the models we have so far interrogated have only very limited ability to positively predict the people who will be admitted to hospital. By understanding the population of York by their characteristics, we will more accurately be able to identify those at risk of unplanned hospital admissions and enable us to improve our preventative approach.

Risk stratification will be used within each group of residents to understand where the level of need is greatest, and therefore where within each group we should begin our initial focus. Using the grouping around condition type and age combined with the risk stratification approach will give us a more detailed and nuanced view of the residents in York. The former tells us where in the local population the types of needs are similar, while the latter tells us where the magnitude of needs is greatest. The CCG is working with its partners, providers and all BCF schemes to share this knowledge, supporting them to deploy their resources effectively and therefore reduce potential avoidable admissions to hospital and costs.

Understanding people with one or more long term conditions and how this information can help us to tailor the intensity of support an individual may need to help prevent avoidable admissions. This will also help us to identify previously possibly neglected individuals and groups and help us to figure out which groups to work with first. It is important we undertake this to help us understand the needs of our residents and in co-designing with them the new models of support through the care hubs.

We will use the best available data to understand the needs of our residents quantitatively as well as qualitatively, making use of risk stratification and segmentation

Developments resulting from our BCF plan are inline and interdependent with CYC and VOYCCG strategic planning and commissioning priorities, and have been aligned to the JSNA. Both organisations have a clear vision for the delivery of integrated care that is integral within the strategy we are developing for co-commissioning and is also at the core of the CCG's Integrated Operational Plan 2014-19.

Modelling for BCF has been based on the agreed activity targets for VOYCCG, the financial impacts for achieving the minimum statistically significant change across all BCF metrics, the value compared to the requirements of the plan and what level of performance against each BCF indicator needs to be to deliver the BCF plan. We have also considered what would be the impact of stretching the BCF metrics to a reasonable level and what the combined value of achieving the BCF targets and QIPP is. The practice level tool enables commissioners and practices to test the activity and financial impact of achieving the minimum level and to compare this to alternative scenarios and target stretches.

Where possible, 2013/14 actual activity has been included and used to apportion targets. We recognise the danger of a potential double count with QIPP initiatives and have therefore factored in separation of activity. To help minimise this, the following rules have been applied:

- Delayed transfers of care. It is assumed in this model that all delayed transfer days incur an excess bed day charge. As there is a currently a transactional QIPP scheme aimed at reducing non-elective excess bed days, 'Improving length of stay', the 2013/14 actuals shown are the number of excess days remaining after the full impact of the 'improving length of stay' QIPP has been realised. Improving length of stay is estimated to remove £136K of excess bed day activity, approximately 1415 days at average price
- Non-elective admissions. Activity as identified by primary diagnoses codes specified in the NHS England guidance 2014/15 BUT NOT non-elective activity with a primary diagnosis code for diabetes (ICD 10 codes E10-E14) or primary diagnoses of epilepsy (ICD 10 codes G40, G41). This is because diabetes and epilepsy admissions are expected to be impacted by the diabetes and neurology pathway QIPP schemes respectively.
- Falls related injuries. Activity coded as "(ICD10 primary diagnosis in the range S00 through T98X) and external cause (ICD10 code W00-W19) and with an emergency admission code in people aged 65 and over" (Admission method 21-28 including new coding 2B etc.).

The diagram below is an example of a CCG wide report which has been produced from a model developed by the CCG to help inform both QIPP and BCF planning. The model allows impacts of interventions to be measured at a pan CCG level, at a federation level (which feeds the Care Hub model) or at an individual practice level. The CCG has been using the model for 3 months and is anticipating investing in a refresh in late 2014 to ensure the outputs remain current and relevant to national metrics and local demand.

All				Current	impact		£	597,521	Stretch	impact	£	597,521			
Better Care fund	Baseline (BCF)	Actual 2013/14	Full year target	Im #	pact 2014   %	1/15 Direction		stimated impact £	Stretch 2014 #			timated mpact £	Stretch % as # #	Bed impact	Workforce impact #
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	377.0		47.4	23.7	6.3%	Decrease	£	188,289			£	188,289			3.4
Older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	439.2		33.1	16.5	3.8%	Increase	£	131,413			£	131,413			2.4
Delayed transfers of care from hospital (EL & NEL excess bed days used as a proxy)	15388.8	19551	553.7	276.9	1.8%	Decrease	£	26,632			£	26,632		0.6	0.2
Avoidable emergency admissions (13/14 actuals less Diabetes and Epllepsy activity)	6864.4	47160	360.9	180.5	2.6%	Decrease	£	100,296			£	100,296		1.8	0.4
Injuries due to falls in people aged 65 and over	1159.6	1607	330.1	165.0	14.2%	Decrease	£	149,977			£	149,977		2.7	0.7
Emergency readmissions within 30 days of discharge from hospital	253.9	213	3.3	1.6	0.6%	Decrease	£	913			£	913		0.0	0.0
													TOTAL	5.1	7.0

### **Avoiding double counting**

A number of the 2014/15 QIPP initiatives focus on reducing non-elective admissions and it is important to ensure the monitoring of performance is not double counting with the BCF metrics and with other QIPP programmes. As a guide, it is often best to consider which schemes are most specific and/or most likely to impact patients first and then to consider that broader schemes e.g. UCP will impact only the residual activity. Table below shows the how 2013/14 activity may be segmented. Excess bed days are not included in the values shown. In addition, it is important to note that the financial values shown have not been adjusted for the 30% Marginal Rate Emergency Threshold (MRET).

### Other important considerations:

### 1. Estimating non-elective savings

In 2014/15, due to the MRET only £42M of the £64M planned non-elective spend (including excess bed days) was paid for at full tariff price: the remaining £22M of activity and non-elective excess bed days was paid for at 30% of tariff.

Based on the average price of a non-elective admission c.£1,800, up to 12,000 non-elective spells of acute activity would need to be removed before the threshold would no longer apply. To put this in context, total annual avoidable admissions at York Hospitals Foundation Trust in 2013/14 were 6,588 and 2014/15, with non-elective QIPP programmes estimated to remove around 2,000 non-elective spells. This means that even if all avoidable admissions activity was removed from the trust and all QIPP non-elective schemes performed as forecast the value of all non-elective activity removed would be 30% of tariff.

### 2. Sharing potential savings from acute activity

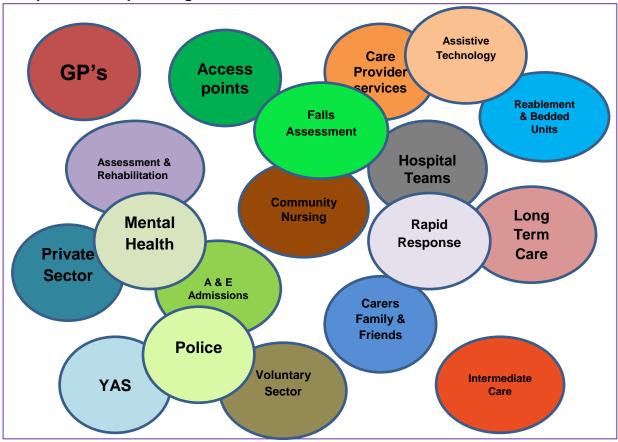
Like all BCF submissions we know there is a dependency related to reducing acute activity that will enable us to transfer funding and deliver our ambition around developing community resources. To support this we will within the next two months develop a section 75 gain share agreement building on the template provided by NHS England.

### 3. Engaging staff and transforming working practices

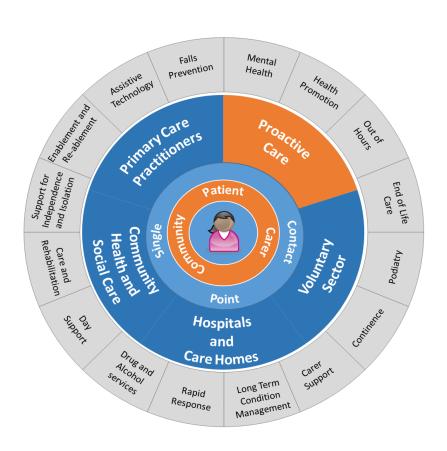
We have begun by creating a powerful narrative which is based on improving care for patients, jointly tackling local population health problems and improving working practices. We are creating a joint approach working collaboratively through JDG because we recognise we cannot do it individually.

We are helping our GP practices to focus on the detail of how it will affect their patient base and in particular 'high demand patients'. We aim to make it easy to engage, designing around practices and moving towards shared MDT meetings to promote consistency and reliability. Making joint working the easy thing to do by removing as much bureaucracy as possible. Using action learning methodology with outside support from University of York. Holding multi-professional design workshops at key stages in the journey and action learning workshops with staff from all professional groups meeting to identify problems and start to problem solve, with JDG acting as a 'high level problem solving group'. We will involve the voluntary sector at every level (including JDG) to embed awareness of local services across all participating groups and organisations

Our plan will help us to go from this...



...to this



# 4) PLAN OF ACTION

# a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

"We have a clear plan of action, agreed across partner organisations, which will help drive our integration plan over the coming months"

Milestones	Responsible/Accountable	Timescales
Milestone 1 : Finance		
Agree pooled budget 15/16	VOYCCG/CYC	Sept -Dec 2014
Develop Section 75 gain share agreement.	VOYCCG/CYC	Oct - Feb 2015
Milestone 2: Organisational and Workforce development		
Carry out a workforce skills and capacity audit.	VOYCCG/CYC	Sept - Dec 2014
Agree and develop new ways of working – joint assessment/joint care planning, trusted assessor.	VOYCCG/CYC	Sept - April 2015
Begin planning processes for integration of staffing/ teams, where applicable.	VOYCCG/CYC	Sept – Dec 2014
Review current provision to ensure sufficient capacity within reablement and intermediate care services including step up/down beds.		Sept – Dec 2014
Milestone 3: Communication and Engagement		
Develop next stage stakeholder plan Communications and engagement strategy.	VOYCCG/CYC comms leads with support of JDG and relevant partners	Oct - Nov 2014
Continue to engage with residents and all stakeholders.	VOYCCG/CYC	Sept – Mar 2015
Develop co-design task and finish groups with residents, partners and stakeholders		ουρι – Iviai 2013
Culture change – ensure arrangements are in place to address emerging issues and staff concerns so individuals and teams know where to go for support and advice.	VOYCCG/CYC	Sept – Mar 2015

	Milestone 4: Delivery of New models including 7 day services and Data Sharing		
	Implement additional care hubs following successful submissions and recruitment	VOYCCG/CYC	Sept 14 – Mar 16
	Schemes in place and fully operational		Sept 14 – Mar 16
	Review clinical standards for 7 day working to ensure these are included in NHS contracts between CCGs and providers for 2015/16 and 2016/17 Review discharge processes and protocols to facilitate 7 day discharge arrangements are in place	VOYCCG/CYC/Trust	Sept 14 - Mar 15
	Milestone 5: Governance and Assurance Ensure IG protocols are in place that will support data sharing between relevant partners including: Consent principles and arrangements	JDG	On – going
	are in place including policy and process that will enable assessments are able to be shared.	All	On – going
	Monitor impacts of BCF developments against agreed performance metrics.	JDG	On- going
	Develop a technical solution that will enable access to both health and social care systems and link data sets where required.	Data sharing task and finish group	July 14 – Apr 16
	Further develop the work stream that will deliver a long-term solution for integrated records.	Data sharing task and finish group	Sept 14 – Sept 15
	TOR for JDG	All	Complete
	Regular dialogue and reports to CTB and HWBB	JDG	On- going

# b) Please articulate the overarching governance arrangements for integrated care locally

The York Collaborative Transformation Board (CTB) has been established to progress and govern our integration plan. CTB reports directly to York's Health and Wellbeing Board, who hold ultimate responsibility and governance for integrating health and social care locally. It also provides assurance to both the CCG and the Council for the delivery of the BCF and the wider integrated health and care agenda. The CTB has been running

since May 2013, chaired by City of York Council (CYC) Deputy Chief Executive and attended by senior representatives from commissioner and provider organisations including NHS Vale of York CCG (VoY), York Teaching Hospitals Foundation Trust (YTHFT), Leeds York Partnership Foundation Trust (LYPFT) and CYC Adult Social Services and representatives from the voluntary sector and health watch. Neighbouring Local Authorities who link with the Vale of York CCG are also represented. YTHFT is fully committed to our plans. As our main provider of acute and community services the Trust has supported our system wide reablement and winter schemes and is playing a strong role in shaping and resourcing our BCF schemes. The Trust is also committed to our vision by running a care hub pilot in Selby and sharing workforce with other 'hub' pilots as well as reshaping its provision to reflect changing demand as our proposed schemes begin to take effect. (See Annex 2 Provider Commentary)

We have also prioritised improvements in mental health services (details of new schemes proposed as part of initial BCF plans are explained later in this submission) as a core part of reforming the care system and Leeds and York Partnership FT (LYPFT) are active partners in helping us re-design and deliver our models of care.

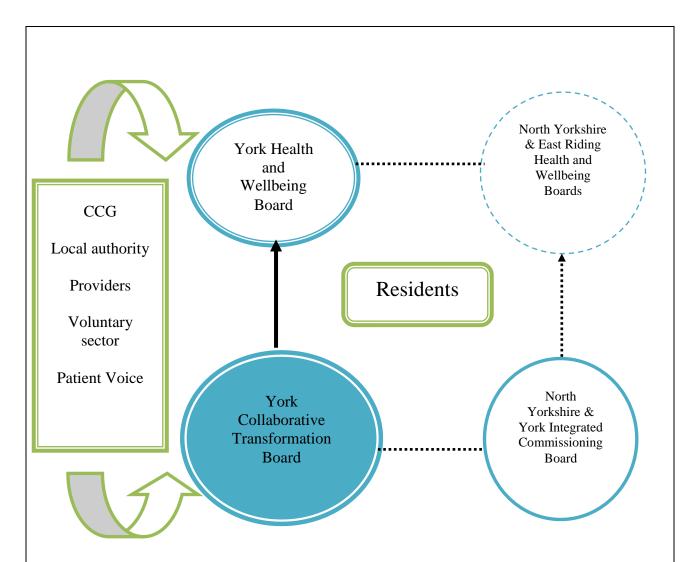
We have established a Joint Delivery Group (a CCG and CYC group which is responsible for driving the delivery of the BCF) which meets monthly and is supported by 2 senior programme leads who work collaboratively across health and social care commissioners and providers; this collaborative approach has allowed significant progress to be made in building sustainable relationships which are translating into joint plans, shared learning and agreed actions.

Joint working groups are being established within our care hub models, consisting of personnel from health, social care teams, providers and the voluntary sector. These have formed into MDT's and the ambition is for these to develop into integrated teams with pooled budgets, consistent processes with the ambition to develop a shared case management record system.

# c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

Because the CCG works alongside 3 Local Authorities, we are actively exploring opportunities to work across geographical boundaries, including working with North Yorkshire and East Riding local authorities, ensuring our plans are aligned across the whole CCG footprint. We have put in place additional service delivery support to help us achieve this.

The diagram below illustrates current governance arrangements for our integration plan.



BCF is a significant component in securing our joint vision for sustainable health and social care, which will be delivered through Care Hubs across the system. We have therefore produced a more detailed delivery framework, driven through a Joint Delivery Group (JDG) which sits below the Collaborative Transformation Board.

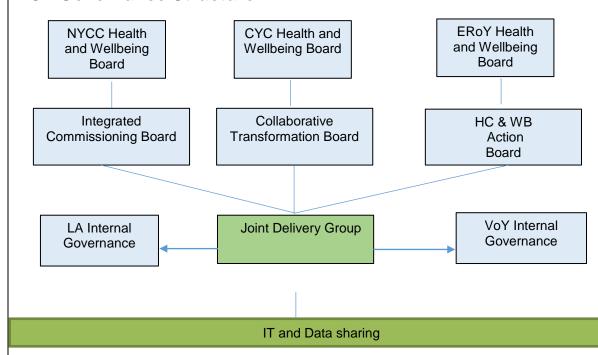
JDG will provide robust and systematic programme management, assurance and scrutiny of proposed plans and all schemes, it will also be the forum for joint learning and problem solving. Project reporting documentation is now in place, each scheme will complete this and report monthly to JDG, through this we are able to measure effectiveness and delivery as well as to chart progress and act quickly should any remedial action be required. An example of this report is included at the end of this section. We are in the process of refreshing both the JDG and the CTB to more accurately reflect the shift in focus from planning to delivery. Part of this refresh will be a change to the current reporting system to focus more clearly on delivery and to help build a more reactive reporting system so that we can see the impact of our schemes and put the necessary actions in place should forecast delivery trajectories not deliver. This will be linked to the HWB Board dashboard and will be the main vehicle for monitoring delivery.

In developing this framework we have taken into account the additional complexities faced by the CCG in having to work with 3 Local Authorities and 3 Health and Wellbeing Boards. We believe our proposed framework represents a pragmatic approach which avoids duplication of effort whilst securing arrangements to deliver the LA accountability

for BCF and providing a realistic level of assurance and challenge to all partner organisations.

We also recognise that there are issues that cut across Local Authority boundaries and we are keen to develop a series of overarching work streams that act as enablers to deliver the overall programme. The diagram below, details these enablers and the new boards and groups now developed.

### **BCF Governance Structure**



Communications, Consultation and Engagement

Organisational Development

### d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
Annex1A	Care Hub - PMG
Annex1B	Urgent Care Practitioners (with North Yorkshire)
Annex1C	Hospice at Home (with North Yorkshire)
Annex1D	Mental Health Street Triage (with North Yorkshire)
Annex1E	Pathways Together
Annex1F	Psychiatric Liaison (with North Yorkshire)
Annex1G	Sitting and Crisis Hours Service
Annex 1H	Whole System Review

### **Example report for Joint Delivery Group**

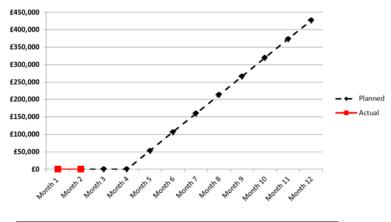
#### G **BCF Fortnightly Progress Report: Priory Medical Group** Overall progress vs. plan w/e 12th September 2014 Clinical Lead: Dr. Lesley Godfrey (PMG; GP and Partner) PM Lead: Martin Eades (PMG Managing Partner) Key Accomplishments Since Last Report **Activities for the Upcoming Month** NHS Accelerate programme visit completed - PMG/MDT observed; Feedback expected 09/14Submit hub expansion business case Business plan for hub development completed (to extend model with additional practices Meeting with YAS re. 111 and integration with hub/use of care plans Unity, Haxby and MyHealth with total hub population of c. 110k); For JDG submission by developed to support admission avoidance Meeting with providers ongoing re. options for development of community Meeting held with YTH Community Services and Rehabon 21/08/14 held and key actions agreed in supporting caseload reviews, involvement of community allied health professionals in IV service to build on paper provided to CCG SMT; Further exploration of cost-effectiveness and cost case required hub/MDTs and utilisation of joint records - YTH teams to support input to SystmOne care plans Community facilitators to hold clinic at PMG on 24/09/14 - renewed marketing with PMG team to increase clinic impact Meeting scheduled for 02/10/14 with local stakeholders re. developing a joint electronic shared Meeting with YTH on 01/10/14 re. community matron/ case manager roles $Hub \ development; New protocols \ developed for potassium, urine \ dip \ testing \ \& \ antibiotics \ to include skin/urine/chest infections.; Syringe \ driver training \ circulated \ to \ care homes.$ and resource use acrosshub and expanded hub geography E-Record meeting on 02/10/14 Progress against deliverables Planned Actual Agreed **Key Deliverables** Completion Completion Status / Comments **Revised Date** Date Date Hub expansion business case submitted for JDG 30/09/14 Draft completed – on track review Paper written and presented to SMT; More detail required and requested from Community IV paper to support hub aims to 19/08/2014 providers in agreeing cost effectiveness case prior to JDG submission (request to complete/gainfurther information prior to JDG presentation) PMG/YTH Meeting re. Case manager/matron 01/10/14 roles and hub interaction Probability Key Issues / Risks Recommended Actions Impact1 Status Issue: Processfor agreeing and realising cost savings Process for agreeing cost savings; Note potential CCG QIPP monitoring and decommissioning/contracting/consultation impact information sent requirements. Hubtracking capacity and activity to Joint approach with support CCG decision-making (monthly report) providers to agreeing impact on whole-system Update 1/8/14: CCG progressing an evaluation of footprint/bed-base "hubs" with Uni. Of York to support tracking benefits contract required,

#### **BCF Fortnightly Progress Report: Priory Medical Group**

w/e 12th September 2014

Metrics (All PMG and all PMG Care Homes against benchmark)	Impact of scheme and supporting evidence
Total acute/social care/ mental health activity and spend (vs. growth)	See Dashboard
Reduction in A&E attendances (vs. GP referred) (BCF)	See Dashboard
Reduction in avoidable emergency admissions (average per month) (BCF)	See Dashboard
IP Admission (Elec/Nonelec)	See Dashboard
OP (FA/FU/PROC)	See Dashboard
Reduction in delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) (BCF)	See Dashboard
Re-admissions 7-day and 28-day (average per month)	See Dashboard
Injuries due to falls in people aged 65 and over per 100,000 population (BCF)	See Dashboard
Activity and case management volume of integration pilot	See Dashboard

(proposal expected in September '14)



Planned Investment YTD (£)	Actual Investment YTD (£)
£65,350 RI1, (To 30 Jun '14)	£22,770 (To 30 Jun '14)
Planned Savings YTD (£)	Actual Savings YTD (£)
£0	-
Planned Net Savings YTD	Actual Net Savings YTD
£0	-

Progress with YTH CS contract meetings

Date: 10/09/14

To adjust values: 1. Double-click on chart 2. Click "convert" 3. Right click on chart area 4. Select "edit data" (an excel chart pops up) 5. Adjust values and click close on excel sheet

# **PMG Overview**

Metric	2013/14 Monthly Average	Pre-Scheme Monthly Average (Preceding 12m)	Post-Scheme Monthly Average – YTD (06/14)
1. Acute spend total	£1,953,522	£1, 930, 876	£1, 906, 148
2. A+E Attendances (GP-ref)*	1322 (56)	1306 (53)	1426 (50)
3. IP Non-Elective Admissions* (Care homes)	434 (35)	432 (36)	405 (24)
4. Total New Outpatient Attendances	1068	1059	903
5. 28-Day care-home Re-admissions	9	9	4
6. Over 65-Falls Related Injuries	17	24	20
7. Avoidable emergency admissions	T.B.C	T.B.C	93
8. DTOCs per 100,000	17.8	17.8	T.B.C
9. Avoided admissions**			T.B.C
10. D/C contacted (within 72 hours)			48
11. Number of patients on case management reg.			843
12. Patient Contacts (face to face: non face to face)			427: 227
13. MDTs held (MDT patient reviews)			17 (104)
14. Number of shared care records			389

<sup>\*</sup>Growth has been subtracted in at (the following rates) 3.0% based on last 12 months and acute uplift for 14/15 at x%

<sup>\*\*</sup>As determined by the use of the hub as opposed to attendance at hospital (audit t.b.c) Note: Metrics 9-14 reported as in-month actuals (scheme started from June 2014)

## 5) RISKS AND CONTINGENCY

### a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely	Potential impact Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)	Overall risk factor (likelihood *potential impact)	Mitigating Actions	Risk Owner
Plans may not deliver financial savings necessary to make them sustainable	4	4 £3.5M benefits 15/16	16	Each element of our planning has an identified exit strategy, should it be necessary to decommission them	HWB,     Managed through monthly reporting to CTB by JDG
Non Elective Admissions do not reduce in line with expectations	4	4 £978K benefits 15/16	16	<ul> <li>Monitoring of activity and metrics to seek early signs of 'failure'</li> <li>Engage staff, GPs, providers and public</li> </ul>	HWB      Managed through monthly reporting to  OTR by JPC
Delayed Transfers do not reduce in line with expectations	3	4 £729K benefits	12	<ul> <li>Communication process to inform of alternatives to admission</li> <li>Develop alternative models of care that provide clear alternatives to admission</li> </ul>	CTB by JDG

## Annex A

		15/16		<ul><li>Clear procedures and training</li><li>Monitoring of process effectiveness</li></ul>	
Admissions to Care Homes do not reduce in line with expectations	3	4 £263K benefits 15/16	12	On-going leadership from the CTB	
Data analysis, segmentation and benchmarking are constrained by perceived and actual restrictions on data and information governance	4	4	16	<ul> <li>Define and engage support / expertise</li> <li>Seek legal clarification of acceptability of proposed approaches</li> </ul>	• CTB
Agreed system changes between partners are not realised	3	5	15	Monitoring and reporting processes in place with reporting to CTB and HWB	HWB     Managed through monthly reporting to CTB  CTB
Commissioners not being able to agree clear common objectives with each other that can translate into workable commercial agreements.	3	5	15	Escalation through CTB and HWB if required.	On-going
There might be double counting in the estimates for scheme achievement	3	3	9	<ul> <li>Scheme planning with clear cohorts identified for each scheme</li> <li>Evaluation of results on a regular basis</li> <li>Adoption of Improved data segmentation and analysis tools</li> </ul>	CTB      Managed through monthly reporting by JDG
Differing Information Governance regimes prevent opportunities for co-location.	3	3	9	<ul> <li>Organisations will achieve separate compliance for local purposes.</li> <li>Local agreements will be needed to achieve cross-organisational</li> </ul>	CTB sponsored     Information     Management and     Technology

# Annex A

				<ul><li>compliance.</li><li>Workaround is to delivery separate systems on separate devices in the same location.</li></ul>	Programme • On-going
Each partner's sovereign transformation programmes / operational plan might pull the organisation in a different direction to that set out in this document or not deliver the required enablers / elements.	3	3	9	<ul> <li>CTB responsible for managing the conflicts of local directional 'pull'</li> <li>CTB will monitor delivery</li> <li>Stakeholder engagement</li> <li>Programme reporting and evaluation of metrics/data</li> </ul>	<ul><li>CTB through monitoring / reporting</li><li>On-going</li></ul>
Financial envelope may not be sufficient to support plans, even with savings identified.	3	3	9	JDG will continue to monitor delivery, as will CTB, and changes can be made as required	• JDG • On-going • CTB
The contractual mechanisms necessary to provide the legal and financial framework to allow new and existing services to be commissioned in partnership may not work effectively enough to enable service change to progress in a timely manner and for providers to be sufficiently confident to properly engage with the process.	3	3	9	A proper contracting function is established, clearly directed by the CTB, and whose responsiveness and performance is monitored by the CTB	• CTB
Public may not welcome all changes to system.	4	2	8	<ul> <li>There has been significant patient and public engagement, and it is intended that this will grow as plans develop further</li> </ul>	<ul><li>All partner organisations</li><li>HWB oversight</li><li>On-going</li></ul>
NHS Number is not used for communication between organisations.	2	3	6	Organisational development plans including staff training will be monitored.	JDG     On-going

The outcome of the National ADASS work on Data Sharing / Matching may recommend a different approach.	2	3	6	The existing DBS tracing service will continue to be used.	CTB     On-going
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### b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

This plan and the supporting financial template sets out a target for avoidance of Non Elective Admissions of 11.7% or 2,284 spells. This equates to six Non Elective Admissions per day. The associated financial return is calculated on the basis of the saving made at the average actual cost of those admissions, substantially lower than national assumptions, which reflects a threshold level set in 2008 over which all admissions are charged at a marginal rate of 30% of the normal tariff. The risk at the 11.7% level therefore equates to £1,020,725, which is 8.4% of the total BCF.

In following the principles of the Payment for Performance (P4P) process described in the guidance, we have not defined specific scheme spend against the performance pool. Should the planned performance be achieved, the "Performance Fund Contingency", £1m, will be released to further invest in any scheme showing superior performance or as otherwise deemed appropriate by the Health and Wellbeing Board.

There is a total of £1.5m being invested in new schemes, with a further £4.3m of spend on existing services being reviewed and redesigned to ensure they are as integrated and cost effective as possible. These two figures fund the schemes that will deliver the planned level of admissions reductions and represent the level of spend for which there will be commissioning flexibility.

Both the CYC HWB and Collaborative Improvement Board (CIB) have BCF as a standing agenda item, with reports and progress evaluation reported at each meeting. CIB meets monthly and receives reports from the BCF Joint Delivery Group which in turn monitors progress and impact on a scheme by scheme basis.

The City of York BCF benefits from the Vale of York CCG supporting two further BCFs (North Yorkshire County Council and East Riding County Council) which will enable sharing of best practice and rapid redirection of resource, if required, into effective schemes.

It should be noted that the CCG took the opportunity to run a number of the proposed schemes in 2013/14 as part of the Winter Pressures monies received. These were performance monitored and have now been embedded as part of the BCF and therefore commissioners have been able to receive some assurance over their deliverability and impact. The governance and reporting arrangements described above will allow schemes not delivering to be rapidly identified and either changed, stopped or the funding redirected elsewhere. This should allow for some flexibility with regards to the availability of funds to cover some of the costs should the reduction in emergency admissions not take place as expected.

There is currently no formal risk share agreement in place between the Vale of York CCG, City of York Council or York Teaching Hospital NHS Foundation Trust. All organisations continue to explore a number of alternative models, but this is acknowledged as a priority action point.

As a part of the approach to develop a risk sharing agreement that will include the council, CCG and the provider, the intention will be to meet, as a minimum, the following:

- i) It is assumed that, aside from the P4P amounts, funds will transfer to the pool on a monthly "12ths" basis as required, and will be managed under a Section 75 agreement
- ii) Quantify pooled funding amount deemed to be 'at risk'
- iii) Calculation and modelling of risk amounts for the schemes and the 'payment for performance' (P4P)
- iv) Agreement of the principles for investment of released P4P funds
- v) Modelling of the impact on the wider system as a result of any failure to meet targets set within this plan
- vi) Mitigating actions defined for the risks identified above and contingency arrangements as required
- vii) Articulation of the approach to be taken to sharing the risks appropriately across the system

The high-level timeline in place to deliver this agreement is as follows:

Milestone	Date
Principles and scope agreed with partners	19 December 2014
Draft agreement developed	28 February 2015
Legal team review and edit process	6 March 2015
Final edits and incorporation to Section 75 Agreement	13 March 2015
Agreement reviewed and agreed	31 March 2015
Finalised and signed agreement	31 March 2015

This remains an area that we recognise we could benefit from support

With regards to any potential risk between the main acute provider and commissioners the position at the moment is that Payment by Results will apply and that the money will continue to follow the patient. The main acute provider is currently significantly above the 2008/09 activity level and therefore only receives payment at the Marginal rate of 30% of tariff for emergency activity. They are fully supportive of any scheme that will reduce non-elective admissions as it currently costs them more to provide this activity than they get paid, but they feel that in continuing to accept the application of the national payment mechanism in this area that this is their contribution to a risk share.

## 6) ALIGNMENT

# a) Please describe how these plans align with other initiatives related to care and support underway in your area

The BCF plans are completely embedded within the overarching VoY CCG Five year Strategic Plan and form a significant contribution towards the operational programmes of work within the Integrated Care and Urgent Care Strategic Initiatives for 2014/15 and 2015/16. The 5 year vision for the CCG to deliver an innovative Care Hub Model depends on the transformation of acute, community and primary care services into an

integrated model of health and social care delivery and the BCF plans form part of all the integration pilots currently being rolled out in support of the Care Hub model programme.

The BCF plans and the anticipated outcomes and improvements on health outcomes indicators including reductions in avoidable non-elective admissions and again the CCG has identified a local Ambition to reduce emergency admissions over five years by 14% and will provide assurance around this trajectory to NHS England quarterly. Additionally this trajectory contributes towards the CCG's Quality Premium. Most significantly the BCF plans and impact on reducing emergency admissions are critical to delivering the resilience required for the local system as part of the Operational Resilience Plans and to support the CCG in assuring the delivery of NHS Constitution access targets for patients by its providers.

The BCF plans are programme managed and performance managed by the VoY CCG Improvement & Innovation team, supported by a Programme Management Office and PMT Tool Covalent. Assurance around the BCF programmes is then reported to the CCG Governing Body, NHS England as part of the CCG Assurance Framework, as well as through the local Joint Delivery Group for BCF and the emerging System Resilience Group (SRG) for the VoY CCG footprint and its associated Unplanned Care Working Group (was the Urgent Care Working Group).

# b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Council is currently developing the next phase of its Transformation ("rewiring") Programme. The changes towards integrated working and the requirements of BCF implementation are in the process of being reflected within the following transformation work stream documents:

- Corporate customer service transformation
- Corporate ICT transformation (includes use of website and social media)
- Adults transformation communications and engagement strategy
- Adults transformation blueprint
- Adults ICT transformation strategy (including replacement of the care management system and implementation of mobile working)
- Adults Workforce Development strategy
- Adults commissioning strategy
- Adults procurement strategy

### c) Please describe how your BCF plans align with your plans for primary cocommissioning

 For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads. NHS Vale of York CCG submitted their proposal for co-commissioning primary care in parallel with the national timescales and were approved to be ready soon for co-commissioning primary care based on the expression of interest submitted (see below).



The CCG are currently awaiting invitation, after acceptance of the expression of interest request, to develop the proposal defined with the NHS England Local Area Team, which explicitly notes the alignment to the BCF.

The submission document details the timescales and areas for developing cocommissioning to be confirmed with the NHS England Local Area Team and notably the suggestion for joint governance arrangements to develop a co-commissioning programme.

The expression of interest also details the engagement and involvement of primary care and other stakeholders in developing the co-commissioning approach, utilising key local fora to communicate changes and support involvement, for example through;

- PPG steering group and patient groups through "let's talk health" events
- PPG Forum
- GP Forum
- Council of Representatives
- Primary Care Strategy Group
- Health and Wellbeing Boards and sub-groups thereof
- Stakeholder and provider engagement events

As is noted in the submission, primary care co-commissioning is well aligned to the better care fund plans through the following;

- Developing primary care to reduce variation in services, advance care integration, raise standards and quality of care, contribute to improving whole system outcomes and performance, and cut health inequalities.
- Planning, securing and monitoring primary care in parallel with the CCG's 5 year strategy and BCF aims and objectives, for example, through providing and monitoring primary care information related to health and social care quality, activity and spend, whilst supporting improvement.
- Ensuring primary care plays a central role in the development of the community care hub model as a defined BCF scheme which is central to BCF delivery; Primary care providers do, and will, also act in some instances as "accountable lead providers" for this model locally working together with other stakeholders and providers.
- Supporting innovation and improvement in primary care that facilitates transition of care from acute to primary and community settings including, for example, the development of new primary care pathways that support admission avoidance and related BCF outcomes.
- Recognising and co-ordinating inter-dependencies between primary care

contracting and enhanced services that will contribute to BCF delivery (e.g. the impact of the admission avoidance enhanced service). The CCG, as is defined through enhanced service guidance, is working directly with primary care providers to support achievement of these related schemes through their internal innovation and improvement team; A named CCG operational lead is assigned to each practice through practice groupings.

- Exploring opportunities co-commissioning brings in improving primary care quality, co-ordinating public and patient communications, engagement and involvement, increasing out-of-hospital capacity and exploring efficiencies in integrated funding arrangements.
- Working through joint governance arrangements with other commissioners, local authorities, providers and stakeholders to join up primary care commissioning and delivery with better care fund plans

The primary risk related to co-commissioning is the conflict of interest posed through GP CCG membership. NHS Vale of York CCG has a comprehensive Business Conduct and Management of Conflicts of Interest Policy, which includes the process for declaring conflicts of interests, the content of which would be applied to any relevant primary care commissioning or co-commissioning, whilst recognising the policies, procedures and processes of any co-commissioner.

It is anticipated that primary care co-commissioning will work within a governance framework that is complimentary to the Better Care Fund plans

## 7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

### a) Protecting social care services

 Please outline your agreed local definition of protecting adult social care services (not spending)

ii)

In common with councils across the country, the largest budget pressure on adult social care is in respect of meeting increased demographic demand and the increasing complexity, and therefore cost, of care packages for the ageing population.

In order to protect adult social care services we are placing the focus on people's health and wellbeing and how this can best be managed where people live, with only occasional admissions to acute hospital settings when community services are unable to respond appropriately. We need to ensure the full range of adult social care services are available, including those that enable people to navigate a simpler easier to access service model, accessible to all in various formats that people can use either for themselves or with assistance, without which the entire health and social care system will become unsustainable. Adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, first time. Protecting adult social care will allow the local health economy to deliver 'care closer to home' and, whenever possible, in people's own homes.

This protection of social care is against a backdrop of an ambitious transformation programme currently underway within the City of York Council 'Rewiring York'. The programme also involves corporate activity to strengthen local community resilience, invest in a digital media Customer Resolution Service, support self-help and increase the Council's ability to generate income via commercial solutions. The programme requires us to substantially change the way people receive information and advice and the ways in which they manage their own health and well-being. This will require substantial numbers of people to have their route through the social care system changed – for example, improving and promoting people's use of digital channels, reducing the number of long term placements to the lowest nationally and investing Public Health resources in Prevention schemes to ensure we can divert or delay demand.

Elements of the programme related to BCF and delivery of the Care Act 2014 within the Health and Adult Services directorate transformation programme are activities including:

- Reducing demand, investing in prevention and diverting people to self-help and community solutions;
- Promoting independence by improving reablement, integration with the NHS, extending the use of Assistive Technology and improving equipment services;
- Developing a wider range of accommodation and care options to support more groups of customers to live independently;
- Increasing current and future capacity within communities and the care market in general, developing our own and the independent sector workforce and prepare for greater public service integration.

It is clear that protecting Social Care is critical to ensuring that the wider systems changes can occur within a safe environment where support is available to those people who do not need acute care but do need support. Without this support Adult Social Care services would need to find additional savings which would have an effect on the whole system.

The recently published ONS Population Projections show that the 65-69 year old population of the City of York expanded by 18.9% (1,738 people) between 2011-2013, while the over 90 year old population expanded by 14.3% (337 people) in the same 2 years. Our JSNA highlights the demographic challenges our health economy faces in future with, in particular, the population aged 85 or over growing by 38% locally, compared with 20% regionally or 23% nationally.

Our local definition of protecting social care services is:

To *maintain* eligibility at "substantial" or "critical" levels Care Act has national eligibility levels as from 1<sup>st</sup> April 2015.

To *maintain* current (2013/14) levels of service provision through the plan period Specifically with respect to carers, we intend to:

- maintain the current level of support to informal carers in York, taking into account demographic growth
- to enable informal carers to receive care and support in line with statutory responsibilities in the Care Act 2014

to ensure those cared for have plans in place to avoid unnecessary admissions to

hospital, nursing care and/or residential care

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The main priority in protecting Adult Social Services recognises the severe pressure the department is under and the requirement to provide sufficient funding to support the transformation programme which aims to reduce and delay demand, focus on prevention, self-help, independence and improve performance on delayed transfers of care. The funds will be used to ensure that Social Services can respond to existing and new service users in the context of a known increase in older people and younger adults with very complex needs.

CYC and VoY CCG are committed to the following principles for how people should experience services:

- The promotion of a person's health and wellbeing
- Support is focussed and integrated around the person rather than organisations
- Community and home options are the main focus of care and services
- · Parity of Esteem within mental health
- No decision about me without me

Cuts in local authority funding mean that City of York Council has already made £14m savings in other areas of its adult social care budget in the last 5 years. A further £7m of savings need to be found in the next two years. These further savings represent around 1/7 of the total adult social care budget.

There is agreement therefore that it will require support from the Better Care Fund to protect the ability of the Council to meet the needs of those who can be cared for and supported in their own homes, both to avoid an unnecessary hospital admission and prevent avoidable re-admission.

Firstly the plan intends to support social care provision to maintain current eligibility levels and current service levels.

Secondly, and very much at the heart of our plans, is an objective to maintain current levels of prevention services that reduce demand on health and social care services and which specifically support intermediate care provision and our redesign within the plan period of that provision. Details of the protection of prevention services will be finalised through the Whole System Review.

In addition, both the CCG and the Council currently commission preventative reablement services that benefit the health and social care community through prevention of avoidable admissions and re-admissions to both hospitals and nursing/residential care. There will be a BCF contribution to the Council commissioned reablement service in 2014/15. In 2015/16 a similar level of expenditure, not necessarily pertaining to the continuation of the same service model, has been included within the category of NHS commissioned services. This is in line with our stated intention to reshape intermediate care services within the plan period.

Finally, the council is the current (2014/15) provider of a range of step-up and step-down beds, including specialist dementia beds, which divert people from hospital and nursing/residential care provision and permit early supported discharge from hospital for those who are ready to be discharged from an acute setting, but not yet ready to return to independent living at home. The future service model for these beds will be addressed

## through the Whole System Review.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

For 2014/15 it would not be possible, given the size of the fund, to secure the requirement for maintenance of adult social care services from BCF. The total underlying requirement for the Council to maintain existing levels of provision of the schemes in the BCF as illustrated in the document, is £5.672m, while the amount that it is possible to fund from BCF is £3.161m. Hence, the burden of maintaining eligibility and maintaining current service levels, within a situation of further funding cuts will predominantly fall upon the Council.

For 2015/16, the requirement from BCF to fund schemes that will contribute to the maintenance of adult social care services at 2013/14 levels is £6.460m, while £5.251m has been agreed as the local contribution.

In addition, the costs of implementing the Care Act (see below) have been calculated using the recommended "Lincolnshire" model. This shows that it will cost the Council £1,818k to implement the Act in 2015/16. Of this, £444k will be funded from BCF in 2015/16.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Care Act will mean enhancing general duties and universal provision around wellbeing, preventing, reducing and delaying needs, enhancing information and advice across the health and social care system, shaping the market and commissioning as well as managing provider failure and other service interruptions.

Specifically around first contact and identifying needs assessments will be available to everyone including carers and for the first time eligible need will be a statutory requirement. Self funders will be entitled to an assessment and we predict this will increase workloads significantly as people want to assess their costs of care pre reaching the ceiling. A national eligibility scheme will be in place with added requirements around portability. Independent advocacy services are enhanced. Charging will change and deferred payment agreements will need to be in place. The Act places new responsibilities on integration and partnership working not only across health and social care but with housing, employment, welfare and other services such as probation and prisons. The Act is coterminous with the Children's Act in relation to transition to adult care and support. The Care Act also puts Safeguarding Boards on a statutory footing. These changes are significant and will mean significant cultural change supported by learning and development for our workforce. IT systems will also need to be revised.

The implementation of the Care Act has been mainstreamed within the Council's Transformation (rewiring) programme. Services are being redesigned in a way that is Care Act compliant as follows:

• Our council customer services response, including elements of our customers

- centre, self-service and transactional facilities and e-correspondence
- Our advice and advocacy services so that information and sign-posting is consistent across the council, but also across partner agencies in the statutory and voluntary sectors
- Our transformation of financial services
- Our redesign of care management
- Our market management strategies, particularly in respect of provider failure
- The strengthening of our safeguarding Board
- Our workforce development strategies (internal and external)

Our ICT strategy and the planned replacement of our case management system as part of a joint approach with health partners.

## v) Please specify the level of resource that will be dedicated to carer-specific support

York has a relatively high number of informal carers. It also has above average demographic growth in its over 80's population an age group which includes many of these carers who themselves are at increased risk of age-related illnesses and accidents involving falls.

Carer breakdown can result in unplanned admissions to hospital and to nursing and residential care. BCF funding will be used to support carers and prevent carer breakdown.

All carers are currently entitled to request a carer's assessment which is enhanced from April 2015 under the Care Act and to receive care and support for eligible needs found – under the Care Act requirements this will inevitably increase demand for services accelerated through the changes in policy aligned to the introduction of this new legislation giving carers an equal footing and raising volumes of people requesting assessment.

CYC has however recently undertaken a stocktake of its existing provision and anticipated demand resulting from the Care Act. Using the LGA modelling tool, this identified 1,455 carers assessments required and 1,198 requiring information, advice and signposting. Estimated costs are £1,600k in 2015/16 of which £227k will be met by BCF in 2015/16.

York will enhance its assessment service to undertake assessments and its range of care and support services i.e. information and advice, self and supported assessment, support services including respite and help with employment.

The model will work on an integrated health and social care design. It will work to align coproduction principles with voluntary sector partners such as the York Carers Centre and Age UK and it will focus on all carers but will operate on a risk stratification tool to enable proportionate responses and focused interventions to those most vulnerable and in need enabling self-care and support wherever possible to promote staying at home for longer. Specific service elements will include:

- Information and advice
- Advocacy
- Short Breaks
- Emergency Breaks

- Personal Assistant
- Day Activities
- Lifeline Alarm
- Dementia Support through the use of Dementia Bracelets
- Training for carers
- Support for employment and education

York already places a very high priority on carer services and co-production with the voluntary sector in this respect. From a carer perspective, the BCF proposals represent a natural evolution of existing services.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The total of the schemes initially submitted as part of the financial plan for 2014/15 totalled £4.6m. These were supported by £3.3m funding from NHS England made up of NHS Transfer (£2.7m) and Integration Implementation Fund (£0.6m) plus an aspiration to use £1.3m held by the CCG made up of reablement (£0.9m) and Carers (£0.4m).

The resubmission shows schemes in 14/15 to be funded from the minimum pooled amount of £3.3m; £2.6m for the protection of social care and £0.7m for CCG led integration schemes.

Subsequent negotiations between the CCG and CYC concluded the reablement and Carers money could not be transferred in full in 14/15 and a stepped approach would have to be taken prior to the incorporation of the £1.3m into the BCF in 15/16. Transfers from the CCG to CYC for reablement and carers breaks were £150k in 12/13 and £300k in 13/14. The reablement and carers breaks transfer is no longer part of the 14/15 plan but £600k was agreed to be transferred by the Chief Executives of the CCG, formally confirmed on 18th September 2014 and will be transacted outside of the s256 transfer.

The level of protection of social care available from the BCF is dependent on the success of the schemes that release benefits from health. If the schemes don't release the planned benefits then the protection of social care, alongside other schemes within the BCF, will need to be subject to review. This incentivises both parties to ensure the integration schemes deliver the planned benefits.

The development of the s75 agreement will clearly outline how the financial risks are managed as we implement the Better Care Fund and both parties will work together to agree the parameters of any risk share arrangement.

## b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

VoY CCG is actively working with York Teaching Hospital NHS Foundation Trust, as its main acute provider, to fully understand the requirements and implications of 7 Day Working. For 2014/15 7 Day Working forms a specific element of the contractual agreement between both parties within the Service Development and Improvement Plan (SDIP).

The SDIP is used to detail any service changes or developments that will impact materially on the contract. Progress against the SDIP will be monitored via the Contract Management Board (CMB) as appropriate during the year with quarterly review the minimum expectation. The SDIP is a live document which will continue to be developed and jointly agreed between both parties.

The expected outputs and the consequences for not achieving these outputs will be agreed once the working groups are established. The default consequence is subject to General Condition 9 (Contract Management).

The working groups will be responsible for identifying and cross referencing schemes to the relevant national and local Key Performance Indicators, CQUIN schemes, and quality premium indicators for which achievement will be supported through implementation.

The SDIP includes the following contractual expectations:

A national condition of the Better Care Fund is the requirement to "provide 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends." The CCG wishes to work with the Trust, through the proposed Care Hub models, to identify where changes to current service delivery models are required to support this requirement. It is expected improvements will be required in (but not limited to) areas such as access to diagnostics (including interpretation and resulting care plans), clinical decision making at weekends to support admissions avoidance and discharge, increased liaison with social services and better overall discharge planning.

The progress towards the above and the impact of delivery/non delivery will be measured through the Partnership Delivery Board and existing contract management arrangements.

So far this progress has been made in establishing a working group with Trust and CCG representatives to agree implementation plan and milestones and identifying high priority services, specialties and diagnostics for 7 day working.

Further work is now underway as part of the System Resilience funding for winter 14/15. This consists of additional working hours and clinical lead activity within ED. As well as the developments being put in place to extend the working hours of the RATS (rapid assessment team) based in ED. This will provide increased therapeutic input and social work assessments within ED and ensure those who present at ED after normal working hours will be assessed, triaged and returned home with a package of support in place within 2 hours of their discharge if they do not require admission to an acute bed.

There are also plans in place to increase the number of step up/down beds available within residential and nursing homes in the York area. These will provide an opportunity for clinicians and therapists to carry out a more in depth assessment prior to the person returning to their own home with a reablement package of support.

This will also link to the UCP scheme and provide additional community support that can be called on to avoid unnecessary conveyance for an individual not requiring acute care but unable to be left at home without additional support. Assistive technology will also be deployed i.e. telecare and 'just checking' system to reduce risk and provide comfort to carers that the person is safe within their home environment.

We will evaluate the effectiveness of this initiative, between Jan 14 – Mar 15 learning from which will enable us to determine the right level and type of support people need in order to avoid admissions to acute bed services in the future. We will review the current schemes within BCF to ensure they are aligned with these requirements.

Proactive support planning will then be carried out with through the care hubs for those that are recognised may have further episodes or crisis that may result in admission to acute care, helping to reduce future demand by providing more proactive and efficient long term condition management

## c) Data sharing

# i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Partners in our unit of planning have a committed plan for the usage of the NHS number as the primary identifier for correspondence across all health and care services. To facilitate this, the following progress has been made to date:

<u>Identification of clients that do not currently hold an NHS number within CYC ASC clinical system.</u>

An initial audit has been taken to identify clients that do not hold an NHS number. Approximately 4,500 clients within CYC ASC clinical system do not currently possess an NHS number.

<u>Identification of unknown NHS numbers/ Business as usual: Identify how the usage of NHS number as primary indicator will be adhered to.</u>

City of York Council is in the process of procuring a connection to the NHS number tracing system; Demographic Batch Service (DBS). To access the DBS system CYC must attain HSCIC Level 2 IG attainment; work on the application is underway. It is anticipated that the IG toolkit will be completed and ready for review by the HSCIC by 31<sup>st</sup> December 2014. HSCIC will then need to review and authorise the IG Toolkit expected turnaround for this would be in the region of 2-3 weeks.

Once we have both the DBS system installed and the appropriate IG toolkit attainment, we shall then commence auditing our ASC system in relation to missing NHS numbers and identify them via the DBS system, then batch load them back into our ASC system accordingly.

In addition a review of missing NHS numbers will also be completed within the children's social care system working along the same timelines ensuring compliance across the LA.

Moving forwards we will work to ensure the NHS number is the primary identifier in

relation to all correspondence across health and care service. Through education and communication and using the NHS number on all our standard forms and documentation, the inclusion of the NHS number will become standard practice, however it is accepted there will be occasions where the NHS number is unknown and unattainable. On these occasions we will continue to utilise the DBS to identify those NHS numbers that are unknown to the service. By continuing to utilise the DBS as a method of identifying clients' NHS numbers on a routine basis, we will also simultaneously be checking the quality of NHS numbers that have been manually input. This process will provide the ability to ensure data quality and assurance by means of auditing existing data and identifying any duplicate/miscellaneous NHS numbers.

It is anticipated we will be in a position to complete the above actions and be using the NHS number as our primary indicator by the end of February 2015.

### Communication of change/necessity to adhere.

There is a clear need to ensure the communication of the requirements to identify the NHS number is understood by all those involved, including clients, carers and staff alike. A communication plan detailing strategy and approach will be produced ensuring all those affected are fully informed.

#### Impact

The practice of using the NHS number as the primary indicator will ensure an efficient and confident linking between primary and secondary care providers, with the provision of assurance that the correct patient has been identified.

#### Summary of key milestones and priorities

- 1. Identification and initiation of communication plan on-going
- 2. IG toolkit completed and ready for review by the HSCIC by 31 December 2014
- 3. Gain DBS connection to provide ability to audit NHS number within ASC system anticipated by 30 November 2014
- 4. HSCIC to review and authorise IG toolkit in view of level 2 attainment; + 2 weeks
- 5. Auditing ASC system in relation to missing NHS numbers + 3 weeks
- 6. Identify missing NHS numbers via the DBS system to enable ASC system to be updated accordingly + 3 weeks
- 7. Weekly on-going audit and associated updates of NHS numbers via DBS by data hub team as part of business operations
- 8. Any on-going communication, engagement and actions required of stakeholders in relation to NHS number use will be shared and actioned via the joint delivery group to ensure NHS number is embedded in business operations
- ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

City of York Council, York Teaching Hospital NHS Foundation Trust and NHS Vale of York Clinical Commissioning Group, amongst other local health and care partners, collaboratively agree there is a clear need to share relevant personal information and

data across organisational and professional boundaries in order to ensure effective coordination, integration and delivery of services for individuals. A large proportion of the information we need to share involves personal details about the people who use our agencies and their personal needs. By lawfully sharing this information we are able to work better collaboratively, offering a higher level of personalised, joined up care to the person.

Sharing records is a key part of each of the organisations' IT strategies and formal commitment has been given by all parties to investigate the most suitable method of sharing information.

We are currently reviewing our options with regard to interoperability considerations and shall be further completing a comprehensive review of options followed by a clear implementation plan. This includes the following plans and progress to date;

- Investigating the possible replacement options of our current Adult Social Care clinical software, with an integrated system that fully supports the 'one patient, one record' model of healthcare. The right system will be fully interoperable with; primary care, acute and community records. It is understood that SystmOne and EMIS already support Open API's and should this be the route we decide to take, we would work with other providers to ensure that their information systems are technically able to exchange data with other systems.
- A co-chaired CCG and Council group has been initiated with key stakeholders to ensure system interfaces are developed with stakeholders in a collaborative and effective manner; The group has met for the inaugural meeting on 2/10/14 (with the next meeting planned on 22 October 2014) and terms of reference are being developed to ensure accessibility in development of systems interface.
- A task and finish group reporting to the above has been initiated to identify a clear understanding of what information stakeholders wish to share, with whom and when, to develop this work against existing solutions and where these are not appropriate, to develop a pilot of inter-operability solution(s). It is expected that all relevant business functionality will be included in any potential open API solution that delivers against the joint stakeholder vision.
- The group will be investigating a number of potential integration platforms, that will provide a holistic shared electronic patient record; from a number of suppliers all of whom we understand have applied to be included in GPSoC Lot 3 (Cross Care Setting Interoperable Systems). This is notwithstanding the procurement obligations and responsibilities of commissioners that may apply in purchasing an open API solution for the purposes described. It is recognised that service user/carer involvement and input will also be a critical component in developing, for example, shared care plans. This need and the approach to address it will be met through the aforementioned group and any commissioning process of new systems

Whichever solution is pursued it will be with the ultimate goal of connecting those that provide a direct provision of care to a patient, enabling community care teams to support the effective coordination and delivery of care between multiple organisations across the health and social care community.

Increased data sharing across providers will reduce cost of service provision, whilst ensuring optimisation of the provision of care provided.

This vision is a shared vision and all parties are committed to working proactively and positively with partners to achieve these aims.

## Risks/Issues/Considerations

It is acknowledged that careful consideration needs to be given with regard to the importance of information governance and patient confidentiality, when considering the implementation of Open APIs. However it is felt the vision is substantially in line with the new 7<sup>th</sup> Caldicott principle:

"The duty to share information can be as important as the duty to protect patient confidentiality"

"Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies".

Challenges are anticipated in relation to; how we inform patients, provide opt-outs where appropriate, compliance with regard to Data Protection Principles such as-limited use, accuracy, reasonable retention etc however there is shared confidence and commitment that these issues although relevant are achievable.

With regard to intermediate solutions; work has progressed in respect of formalising information sharing and a collaborative Information Sharing Protocol that will provide a clear framework to assist the facilitation of information sharing between those signed to the Protocol has been produced. The Information Sharing Protocol is a joint collaboration between CYC, North Yorkshire Council, York Teaching Hospital NHS Foundation Trust, North Yorkshire Police and the local Fire Authority. The Protocol will be signed by partner SIROs week by 15 December 2014 and then shared wider with an identified group of further key partners inviting them to join the protocol.

Information Sharing agreements have been produced where information is proposed to be shared to as interim measures and the necessary explicit consent will be requested accordingly where appropriate, with the option to opt out at any point.

An application has been made for a Section 251 to enable the sharing of patient data for the purpose of commissioning, including patient segmentation, pathway analysis and risk analysis; This application has made with a group of commissioning organisations facilitated by Monitor and the Department of Health and the submission includes the following;

- Data control and processing arrangements and processes
- Data sources for utilisation of data linkage solutions
- Fair processing and patient objection processes
- Involvement of patients and use organisations in data sharing
- Policies relating to data retention and destruction from all partner organisations
- Data and physical security arrangements

Partners are happy to share this completed application proforma when requested.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Substantial progress has been made in relation to Information Governance and planned progress will continue, to ensure the appropriate IG controls will be in place and adhered to.

There is a clear City of York Council Information Governance action plan that is governed by the CYC Corporate Information Governance Group, that is continually developing and implementing appropriate IG controls.

Work is currently underway in relation to the production of a collaborative Information Sharing Protocol which has already detailed, will provide a clear framework to assist the facilitation of Information Sharing between those signed to the Protocol.

CYC have two HSCIC IG Toolkits; one of which is now fully compliant to level 2 (however only applies to Public Health) and the other (that covers the remainder of the Council) is in the process of being updated. There is commitment that the overarching City of York Council IG Toolkit will be completed by 31<sup>st</sup> December 2014. At this point it will be submitted to HSCIC for review in view of level 2 attainment. There will be a clear action plan identified as a result of the completion of the IG Toolkit with regard to any specific areas that require further work, with clear accountability and timescales identified.

City of York Council have two dedicated Caldicott Guardians; Director and Assistant Director level; adult and children services respectively. The Caldicott guardians work to improve confidentiality and security within the council, whilst ensuring the seven principles of Caldicott 2 are strictly adhered to. The council has a well-established corporate information governance group, following the public sector network data handling guidelines which are the core of its overall information governance strategy. Compliance with Caldicott 2 is entirely consistent with the guidelines and the strategy. Both Caldicott Guardians are members of the Corporate Information Governance Group; CIGG, which is chaired by the councils Senior Information Risk Owner (SIRO). Equally, the CCG has a nominated Caldicott guardian at executive level.

New updated online e-learning training with regard to Information Governance is planned for 2014 which all CYC will have to complete as mandatory where a mandatory training programme also exists through the CCG.

In relation to future procurement of Open APIs, a strategic review of IG requirements will be undertaken, including a privacy impact assessment, working in collaboration with the councils Information Governance Manager and associated individuals across partner organisations.

Irrespective of which option is pursued in relation to future interoperability solutions, function access controls will ensure that each partner has access to only those items of

each patient's data proper to its function, taking account of the constraints above and the data protection act. Functionality will allow for consent (or refusal) to open (or close) access to data items for each partner in individual cases.

Explicit consent where appropriate will be gained. Appropriate guidance, protocols and data sharing agreements will be produced in line with the Information Commissioners Office Data Sharing Code of Practice.

A training needs analysis will be completed and appropriate training will be made a mandatory compliance. Dependent on the level of interaction and function access required with the decided Open API, will be reflected in the level of training provided.

As stated privacy impact assessment will be completed to identify all risks related to failure to protect the privacy and confidences of patients, and incorporated into the project plan and risk log.

The principal risk mitigation is careful adherence to the data sharing code of practice which requires the all partners to agree the following:

- what public and individual benefits are expected and why there is not a less intrusive alternative
- what items of personal data are to be disclosed by whom to whom
- how consent is to be managed
- how security will be maintained

It is recognised that the NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care; The NHS standard contract will be used, as is required of NHS commissioners, in commissioning any healthcare services. The council and CCG recognise that where services are jointly commissioned that the appropriate contract will need to be used and agreed, recognising the current and any emerging legal and policy guidance in this area.

#### d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

At the end of June 2014 Vale of York CCG, working in partnership with North Yorkshire & Humber CSU and North of England CS, rolled out the RAIDR Primary Care Dashboard to all Vale of York Practices. This gives all Practices the ability to stratify their individual patient lists by risk of unplanned admission using the Combined Predictive Model Algorithm. Note that the rollout of this system to Practices was delayed due to national Information Governance restrictions pending approval of a Section 251 agreement allowing Hospital and GP data to be linked for the specific purpose of Risk Stratification.

In accordance with the 2014/15 GP Enhanced Service on avoiding unplanned admissions, Vale of York Practices have initially focused on identifying the top 2% of their patients who are at highest risk. Once the work around setting up care plans and supporting MDT meetings is in place to support these patients with their care plans, it is hoped that Practices will start to case find extended groups of patients who would benefit

from more proactive care planning.

# ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Currently, the unplanned admissions Enhanced Service gives GP's the responsibility of risk stratifying their patient lists – and there is an assumption that MDT meetings will involve a group of care professionals who are involved in providing care (health and/or social) to an individual. The majority of Practices will endeavour to involve representatives from Community Nursing, Social Care and Mental Health in their MDT reviews. Note that currently there is no legal basis for linking health and social care data to assess risk.

From a General Practice perspective, the GP Core contract requires every patient aged 75 and over to have a named, accountable GP, but any appropriate member of the Practice may be responsible for day to day coordination of care and delivery of care plans.

# iii) Please state what proportion of individuals at high risk already have a joint care plan in place

This is not a metric that is specifically measured via the Enhanced Service agreement, but the aspiration would be for care plans to address patients' holistic needs across health and social care. Through the Enhanced Service, 2% of each Practices' population should now have care plans, but some of these may not require social care input to meet the needs of the patient.

## 8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

"Our vision is based on what people have said is most important to them. Over the past 2 years, with the establishment of the CCG and the Health and Wellbeing Board and our first Joint Health and Wellbeing Strategy, both City of York Council and the CCG have engaged extensively with patients and carers, residents, and the workforce across the public, private and voluntary sectors on the vision and priorities for health and social care. York's Health and Wellbeing Board remains committed to this level of engagement and hosts at least two stakeholder events per year. There has been a high level of lay person input into both the initial JSNA and its refresh and this input will continue through the lifecycle of the plan".

Patients, carers and the public are at the heart of our services and we are committed to the philosophy of 'no decision about me – without me'. Delivering sustainable and successful health and social care services in our local area is a collective challenge and we work with our residents to put them at the centre of their care.

We are working closely with Healthwatch in our local area, (and those in adjoining units of planning). Healthwatch have held a number of joint engagement events on a wide

range of health issues and also hosted an engagement event specifically on BCF to raise awareness and encourage resident involvement. A lay member for the CCG Governing Body is currently being co-opted from Healthwatch to further strengthen our focus on empowering our citizens in all our delivery and governance. We are also in the process of adding a member of York CVS to the Joint Delivery Group (see section 4) which will strengthen the role and challenge the voluntary sector has in developing our BCF schemes and plans.

The CCG also has a robust programme of engagement and communications across the Vale of York population to ensure we continue to build on this momentum. We host the Patient and Public Engagement steering group which includes Health Watch and lay members, to ensure we can capture the voice of our patients and residents in our strategic and operational planning.

A number of our General Practices host patient participation groups and as a CCG we are committed to at least two wider open forums per year and a number of engagement events focused on specific projects, i.e. long term conditions.

The CCG have held a series of 'world café' events to work with residents to identify their priorities and their key messages. These events have focussed on how we can develop better together making sure we feedback to those involved and learn how we can improve our engagement programme.

We have also hosted a joint Public and Patient Engagement (PPE) event to focus solely on joining up services and what this means to individuals, their supporters and the wider community. People told us it was important to them to 'tell my story once' and 'to have a joined up system, they could move through easily'. We will continue to build on this as we take our joint plan forward. All the partner agencies have committed to joint communications and engagement events to maintain the focus on working together better. As part of this commitment we are developing a joint communications strategy, led by the H&WB Board, which will ensure we continue to engage and consult across our resident population.

Within York, there is an active voluntary and community sector with partner organisations such as University of York, St John's University and Joseph Rowntree Foundation based here. Such organisations can offer research and evidence that is very valuable to developing our plans for integration. We intend to build on our relationships with these organisations and develop a specific work stream to work on this.

The National Voices research provides us with information for continuing to develop our patient, service user and public engagement. Both the CCG and our partners are committed to doing this and to progress our vision towards joined up, person centred support.

We want to emphasise that our engagement with staff, residents and people who use our services is not a one-off event. We are committed to involving people in planning and designing health and wellbeing services and provision in the long term. Our aim is to 'coproduce' more health and wellbeing services and pathways to care and support. By coproduction we mean we want to work with people as equal partners to improve services and respond to challenges, making decisions together. We believe that the people most affected by a service are best placed to help design it. We also recognise that residents and communities already have a range of resources available, both intellectual and physical, and that bringing our resources together we can deliver services with rather than for people and their families. Early evidence suggests this approach is a more

effective way to delivering better outcomes and more sustainable services, often for less money<sup>5</sup>.

We must acknowledge that co-producing health and wellbeing services is challenging, but it is not impossible. We want to learn from others who have achieved this for example the improvements to health care and patient experience in Jonkoping, Sweden. In delivering this strategy we will take every opportunity to co-produce health and wellbeing services, enabling our residents and people who use our services to identify problems and propose solutions, rather than being passive recipients of services. We believe that programmes such as 'Think Local Act Personal' *Making it Real* will help us achieve this by focusing on the way communities can help support each other and by increasing the uptake of personalisation, which is central to communities and their health and wellbeing.

#### **Our Carers**

Integral within our BCF planning are informal carers, we have worked hard with partners to ascertain their views. An example from CYC was a review of commissioned services for carers in York in summer 2013. Carers commented on gaps in services especially those providing breaks and emotional support. There was a very clear message that all services need to be more coordinated and joined-up. Generally, carers told us they would like better coordination across organisational boundaries, less demand in terms of assessments and paperwork and a more holistic approach.

Examples of carers comments received:

"There should be better integrated working between adult, children's social services and health"

"Finding the right way into the system and services is the hardest thing"

"Carers still have to support someone with mental illhealth and do so without support themselves"

There are over 18,000 unpaid carers in York; 19% provide 50+ hours of care weekly - these carers are twice as likely to be in bad or very bad health as other members of the population.

To ensure a meaningful voice and influence for carers in the local health and wellbeing system, York Health and Wellbeing Board adopted 'York Carers Charter' in July 2013.

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<sup>&</sup>lt;sup>5</sup> Based on Nesta Lab and the New Economics Foundation co-production research

We will build on this through our care hubs by involving carers in co designing support options and ensuring their voice is heard.

### b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

#### i) NHS Foundation Trusts and NHS Trusts

All major providers and commissioners are already signed up to our vision for person centred, integrated health and social care at the highest level via York's Health and Wellbeing Board (H&WB). Our main providers sit on this board. Our integration plan proposed in this submission is absolutely consistent with this vision and the core principles set out in York's Joint Health and Wellbeing Strategy.

A Collaborative Transformation Board (a sub-committee of H&WB Board) has been running since May 2013, chaired by City of York Council (CYC) Deputy Chief Executive and attended by senior representatives from commissioner and provider organisations including NHS Vale of York CCG (VoY), York Teaching Hospitals Foundation Trust (YTHFT), Leeds York Partnership Foundation Trust (LYPFT) and CYC Adult Social Services and representatives from the voluntary sector and health watch. Neighbouring Local Authorities who link with the Vale of York CCG are also represented.

YTHFT is fully committed to our plans. As our main provider of acute and community services the Trust has supported our system wide reablement and winter schemes and is playing a strong role in shaping and resourcing our BCF schemes. The Trust is also committed to our vision by running a care hub pilot in Selby and sharing workforce with other 'hub' pilots as well as reshaping its provision to reflect changing demand as our proposed schemes start to take effect.

We have also prioritised improvements in mental health services (details of new schemes proposed as part of initial BCF plans are explained later in this submission) as a core part of reforming the care system and Leeds and York Partnership FT (LYPFT) are active partners in helping us re-design and deliver our models of care.

Our Joint Delivery Group (a CCG and CYC group which is responsible for driving the delivery of the BCF) meets monthly and is supported by 2 senior programme leads who work collaboratively across health and social care commissioners and providers; this collaborative approach, managed through our Joint Delivery Unit, has allowed significant progress to be made in building sustainable relationships which are translating into joint plans and agreed actions.

Our GPs are closely involved in developing our plans; we already have plans in place for one GP led care hub in York and another hub which will work across York and North Yorkshire is currently being developed. GPs sit on all of the project teams and also provide clinical input into the JDG.

We also have a number of existing programmes with a range of health and social care providers including our voluntary and community sector, and they too are fully engaged in the development of our plans.

By fully engaging with our health and social care providers we have jointly delivered our

reablement programme over the past two years and this engagement and co-design has been pivotal to the success of this year's sustainability plan over the winter period and our planning for substantial integration going forward.

## ii) Primary care providers

Almost every strategic initiative and improvement intervention we are working on has an impact on primary care or requires our GPs and practices to refer or deliver care in a different way in the future. This will require practices to consider extending and expanding the scope of their general and enhanced services and potentially partnering with a range of other stakeholder organisations in order to respond to new service tenders and opportunities such as Care Hubs. The CCG is working closely with primary care to ensure practices understand and can contribute to all transformational initiatives and is working to support any development needs which will help practices to use or deliver future services. Improvement and transformation support is being aligned to groups of practices through the establishment of Improvement Hubs which will support practices with understanding activity and data (see section 3), highlight any variation in practice and allow practices to test and implement new pathways of care. The development of providers and potential future partners to ensure there is sufficient capacity for market readiness is a significant enabler for delivering our integration programme. Ownership of new service models by our community of general practice is critical to the success of our transformation.

We are also working closely with the Area Team to deliver the transformational change programme for primary care reform. The CCG has clearly indicated its interest in co-commissioning primary care with NHS England from 2014-15, including opportunities around community dentistry, community pharmacy and ophthalmic services which would support the delivery of our joint Care Hub approach. This includes the workforce planning and estates infrastructure required to deliver primary care at a greater scale in the future.

Our GPs are closely involved in developing our plans; we already have plans in place for one GP led care hub in York and another hub which will work across York and North Yorkshire is currently being developed. GPs sit on all of the project teams and also provide clinical input into the JDG.

#### iii) social care and providers from the voluntary and community sector

Healthwatch York held initial discussions about the Better Care Fund with the programme leads in both City of York Council (CYC) and Vale of York Clinical Commissioning Group (CCG). We advertised and attended the Health & Wellbeing Event at Merchant Taylors Hall on Monday 10 March, the first event encouraging members of the public and voluntary sector organisations to get involved in shaping the Better Care Fund. Following on from the event, we discussed the Better Care Fund at our Healthwatch Assembly in April. The Assembly is attended by our volunteers, partner organisations from the Voluntary and Community Sector, and key stakeholders, including CYC and the CCG. At the Assembly, we agreed to hold a public meeting to raise awareness of the Better Care Fund and enable people to help shape local plans. We held an event in May, attended by over 50 people. Lots of excellent feedback was received, which has been shared through

the Collaborative Transformation Board and has shaped our delivery plans.

To reach more people, and help them stay involved with the process, we put an article about the Better Care Fund into our summer newsletter. This was posted to 129 organisations and 231 individuals, emailed to 215 organisations and 459 individuals, and tweeted to our 1,000 followers. We continue to use our place within the Collaborative Transformation Board and the Health and Wellbeing Board to share the views of local residents. We have also attended a stakeholder meeting for one of the schemes the Better Care Fund will support, the Care Hub led by Priory Medical Group. We will continue to support the on-going involvement of local people in shaping these local plans.

York CVS has had on-going dialogue with the sector around BCF developments. A number of consultation mechanisms have been used, although timescales have limited engagement processes. In the initial development of BCF, there was a discussion between CVS and the programme lead regarding the projects and their focus. Following this, a joint consultation event was held between Healthwatch and CVS forums for providers. CVS followed this up with informing the Voluntary Sector Forum Chairs and Elected Sector Representatives on the initial BCF submission. Through the Voluntary Sector Forums and the Partnership Boards, providers and elected sector representatives have been informed about BCF developments and this is on-going, with the Collaborative Transformation Board being a primary conduit for this.

## c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

We have been working closely with our acute providers throughout the development of our Better Care submission. Both York Hospital Teaching Hospitals Foundation Trust and Leeds and York Partnership Foundation Trust are key members of the York Health and Wellbeing Board and the Collaborative Transformation Board and its Joint Delivery Group. York Hospital is delivering a Better Care pilot in another unit of planning.

Please refer to Annex 2 for further detailed information and the table below which summarises the impact of our schemes:

	Street T	riage	Urgent (	Care Practitioners	St Leona	rds Hospice	Priory Ca	are Hub	Whole S	stems Review	Sitting Se	rvice	Total	
2014/15	York BC	F	York BCF		York BCF	:	York BCI	F	York BCF				York BCF	
	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£			Activity	£
Reduction in Non Elective (general														
and acute only)			813	307,314	120	66,770	39	22,090					972	396,175
Reduction in A&E attendances	886	96,166	1,436	155,863	120	13,060	197	21,386					2,639	286,476
		,		227,232										
Total		96,166		307,314		79,830		43,477						682,651
Total York Teaching Trust Contract with VOY CCG 14/15														175,147,000
% reduction on contract														0.39%
Impact on provider	Street T	riage	Urgent (	Care Practitioners	St Leona	rds Hospice	Priory Ca	are Hub	Whole S	stems Review	Sitting Se	rvice	Total	
2015/16	York BC	F	York BCF		York BCF	:	York BC	F	York BCF		York BCF		York BCF	
	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£	Activity	£
Reduction in Non Elective (general														
and acute only)			1,183	447,174	361	200,868	312	173,603			350	156,450	2,206	978,095
Reduction in length of stay									3,650	350,400			3,650	350,400
Reduction in A&E attendances	2,657	288,391	2,089	226,740	361	39,183	1,578	171,276	2,600	282,204	500	54,270	9,785	1,062,064
Reduction in Age attenuances	2,037	200,371	2,005	220,740	301	37,103	1,376	1/1,2/0	2,000	202,204	300	34,270	9,700	1,002,004
Total		288,391		673,914		240,051		344,879		632,604		210,720		2,390,559
Total York Teaching Trust Contract														
with VOY CCG @ 14/15 contract value														175,147,000
% reduction on contract														1.36%

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

## **ANNEX A – Detailed Scheme Description**

For more detail on how to complete this template, please refer to the Technical Guidance

#### Scheme ref no.

#### Scheme name

Community Care Hub – Priory Medical Group

## What is the strategic objective of this scheme?

Strategic objective:

The community care hub will be a proactive and responsive care model for a population of around 100,000 or more that seeks to continually improve health and care outcomes whilst reducing local health and care economy cost per head.

## Strategic Aims:

- To put service users at the centre of hub delivery
- To improve defined population-based health and care outcomes, focussing particularly on those most at risk
- To reduce population-based healthcare costs, social care costs and associated costs by providing alternatives to hospital admission
- To improve the quality and equity of health and care services for the hub population as measured through defined information/outcomes
- To provide proactive and preventative healthcare and health promotion through, for example, self-care and measures of patient independence

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?
- How will this scheme support/link to move to 7 day working?

In parallel with local joint strategic needs and plans, and the better care fund strategy and objectives, the CCG and local providers have committed to a "community care hub" model that provides proactive and community-centred care for populations of around 100,000 or more. The community hub model combines all resources from the public sector, the independent sector and existing community assets to deliver joined-up care and improved outcomes for the population it serves.

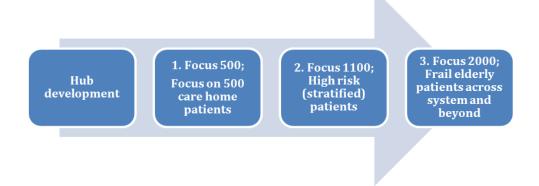
Priory Medical Group are the provider lead for the City of York Community Care Hub and will work with partners to develop the community hub model for their practice population of around 53,000 patients initially, with the potential for working with other practices and providers locally to expand this population reach with time. Phase 2 of this scheme, to incorporate a further three practices and increase the reach of this work up to around 115,000 patients locally, will commence in January 2015. This will initially include the same patient cohorts, with the same MDT model.

The community care hub model is seen as essential to reducing acute care demand, increasing and improving primary and community care capacity, and improving health

and care outcomes locally whilst reducing cost to the overall health and care economy.

#### Model of care and care cohort

The approach will be first to develop the hub structure, primary care-led multidisciplinary team and governance framework, and then focussing care hub attention and delivery on a progressively increasing patient cohort. The below approach and focus areas are anticipated to be delivered over a 24 month period and beyond in line with the BCF development. As demonstrated the model intends to identify vulnerable population cohorts and proactively manage their care through multidisciplinary working in the community setting.



The first three phases highlighted above represent a cohort focus of around 1-4% of the primary care practice population, including those in care homes, many members of which will be receiving multiple health and care related interventions. The cohorts defined above occupy a proportionately higher activity volume and spend of acute care based on data modelling completed prior to scheme initiation. The system benefits of improving care co-ordination and reducing acute demand from cohorts defined has been recognised. Throughout implementation the schemes will flex as there are changes in GP working patterns due to national and local pressures. Phase 2 commencing in January 2015 will encourage horizontal integrated patterns and allow a test of the logistics of working with an expanded team.

The model of care will be scaled in time to include other practices focussing on 5-10% of the patients most at risk of hospital admission or high care utilisation in terms of activity and cost. The model uses principles of:

- Clinical leadership and ownership through an accountable primary care provider
- Risk stratification and daily acute care data alerts for hub patients attending, admitted to, and discharged from hospital. This supports admission avoidance, early discharge and prevention of re-admission
- Daily multi-disciplinary team meetings including health and care professionals through provider agreements
- Care planning and case management supported through technology e.g. electronic care records
- Single point of access for care delivery and management
- Development of new primary care and community care pathways to include voluntary sector support and enhanced sign-posting via existing community facilitators, particularly focussing on alternatives to hospital admission and

- admission avoidance
- Monthly monitoring and reporting through defined better care fund programme governance
- Robust evaluation and adaptation of model responding to impact
- To use principles of communication, co-operation, co-ordination and control as the basis for the hub delivery

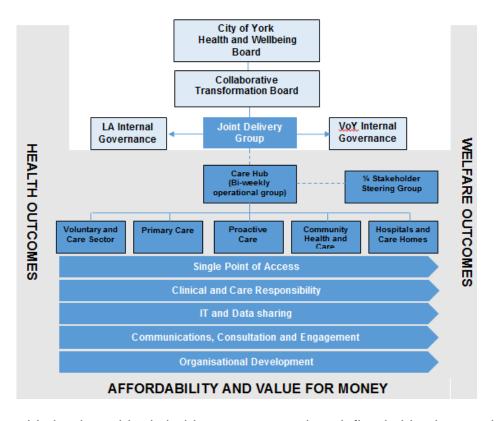
## The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of the community care hub, initially as a pilot. The accountable lead provider, Priory Medical Group, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner) and Priory Medical Group (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local acute services and council provider services, for example.

Governance arrangements for the hub are represented diagrammatically below;



The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider

innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics are reported monthly. The KPI's are matched against those for other areas within Vale of York CCG that are testing variations of the care hub model. They are also discussed locally and nationally with other networks that are testing out new models of care. Initial data around the effectiveness of the various interventions on-going, and the measures to report them are just starting to be available for analysis.

#### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In relation to selection and design of the scheme, health and social care data was gained for the c. 53, 000 practice population including activity and spend in acute and social care, with more specific understanding and breakdown of areas of opportunity based on population spend and activity broken down by demographic, gender, age, place of residence, disease area, condition-specific activity and other areas. Similar work is ongoing for the practices in Phase 2. This helped to identify patient cohorts and patient characteristics representing a higher proportion of activity and spend in the health system and work since has helped to repeat the process across social care. Additionally, retrospective data on activity and growth has been modelled in addition to formal data modelling supported provided to the CCG and local authority to understand potential impacts further. Subsequent incremental improvement to the schemes objectives is being reviewed to assess if further modelling is required.

Joint strategic needs assessments and public health data has also been available to help prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives.

The care hub model also utilises evidence from elsewhere, whilst recognising the need for effective local adaptation, delivery and implementation, the latter being particularly important. The model builds on good experience locally and draws on evidence from national and international exemplars, for example, the Canterbury experience in New Zealand, Caremore and 'Extensivists' in California and 'Polysystems' in London. Additionally, the CCG are linking up with other local and national organisations and networks that are trialling new models of care, to share learning and ideas.

It is recognised, for example through the evaluation of community and integration models through the Nuffield Trust (2013), that models such as those proposed require time and scale. Supply-induced demand can often limit the impact of such models on reducing emergency admissions. It can equally be difficult to prove a negative of avoidable admissions. Where cashable savings are required, commissioners often have to use effectiveness of new models to decommission services not providing value for money which is a dependency to demonstrate cost reduction. However, the model adopted intends to create alternatives to admission and evidence-based delivery, such as risk profiling to target care appropriately to support reducing admissions.

References and an evidence-base being used to inform the model and above statements are highlighted below.

#### References

- Cochrane Effective Practice and Organisation of Care Group (2014). http://epoc.cochrane.org/ (Community service reviews)
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   361/dh\_127719.pdf
- Health Education England (2014);
   <a href="https://www.eoedeanery.nhs.uk/page.php?page\_id=2776">https://www.eoedeanery.nhs.uk/page.php?page\_id=2776</a>
- Health Foundation, The (2011). Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community. London. The Health Foundation.
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- King's Fund, The (2014). Community services: How they can transform care. London. The King's Fund.
- Nuffield Trust, The (2012). The anatomy of health spending. London. The Nuffield Trust.
- Nuffield Trust, The (2013). Evaluating integrated and community-based care.
   London. The Nuffield Trust.
- University of York (2012).
   http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12011006375#.U8kq4rnjjI

## **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

The following overview costings for 14/15 for the care hub are:

Cost (£)	Summary
£88.4k	Senior GP accountable clinical lead and Managing Partner
£45k	Central resource for care planning and navigation
£45k	Central resource for direct health and care in home environment
£25k	Single point of access and care planning administration
£48k	Remote technology/ devices and electronic care plan software
£10k	Developing community/care teams to support admission
	avoidance skills and pathways
	£88.4k £45k £45k £25k £48k

Total	£261.4k

The Care Hub expansion plan for 15/16 indicates significant growth across groups of general practices and patient groups. Indicative funding for this growth has been budgeted at £500,000.

## Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The impact of this scheme is currently being measured by a dashboard of quantitative data as below;

## 2014-15

Benefit	Organisation	Activity	Unit price	Total saving	Saving value calc.	Monitored
Reduction in permanent residential admissions	Local Authority	5	£6,625	£32,860	64% based on CYC population, of a 6% reduction and an average cost of £250 and an average length of stay of 26.5 weeks	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in delayed transfers of care	NHS Commissioner	89	£96	£8,527	64% based on CYC population of VoY, of a reduction of 554 XBDs on a weighted average cost of £96.20	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in non-elective admissions	NHS Commissioner	39	£556	£21,700	4% reduction 156 non-elective admissions using local average NEL cost when applying 30% marginal tariff	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in ED attendance	NHS Commissioner	197	£109	£21,410	Reduction of 789 A&E attendances pro rata for final quarter at local average A&E attendance cost	Through the Joint Delivery Group and Collaborative Transformation Board

## 2015-16

Benefit	Organisation	Activity	Unit price	Total saving	Saving value calc.	Monitored
Reduction in permanent residential admissions	Local Authority	40	£6,625	£262,880	64% based on CYC population, of a 6% reduction and an average cost of £250 and an average length of stay of 26.5 weeks. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in delayed transfers of care	NHS Commissioner	709	£96	£68,217	64% based on CYC population of VoY, of a reduction of 554 XBDs on a weighted average cost of £96.20. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board

Reduction in non-elective admissions	NHS Commissioner	312	£556	£173,603	4% reduction 156 non- elective admissions using local average NEL cost when applying 30% marginal tariff. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board
Reduction in ED attendance	NHS Commissioner	1578	£109	£171, 276	Reduction of 789 A&E attendances pro rata for final quarter at local average A&E attendance cost. Project will have doubled in size.	Through the Joint Delivery Group and Collaborative Transformation Board

## Current data delivered to date (October 2014):

Metric	2013/14 Monthly Average	Pre-Scheme Monthly Average (Preceding 12m)	Post-Scheme Monthly Average – YTD (06/14)
1. Acute spend total	£1,953,522	£1, 930, 876	£2,003,702
2. A+E Attendances (GP-ref)*	1322 (56)	1306 (53)	1373 (49)
3. IP Non-Elective Admissions* (Care homes)	434 (35)	432 (36)	413 (30)
4. Total New Outpatient Attendances	1068	1059	969
5. 28-Day care-home Re-admissions	9	9	7
6. Over 65-Falls Related Injuries	17	24	21
7. Avoidable emergency admissions	T.B.C	T.B.C	69
8. DTOCs per 100,000	17.8	17.8	T.B.C
9. Avoided admissions**			T.B.C
10. D/C contacted (within 72 hours)			38
11. Number of patients on case management reg.			833
12. Patient Contacts			872
13. MDTs held (MDT patient reviews)			21 (239)
14. Number of shared care records			831

<sup>\*</sup>Growth has been subtracted in at (the following rates) 3.0% based on last 12 months and acute uplift for 14/15 at x%

Meetings are underway in December 2014 to align the performance metrics across the schemes currently being implemented in Vale of York CCG.

## Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand

<sup>\*\*</sup>As determined by the use of the hub as opposed to attendance at hospital (audit t.b.c) Note: Metrics 9-14 reported as in-month actuals (scheme started from June 2014) Additionally a patient satisfaction survey is underway at present, and initial results will be available from January 2015.

## what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Informal regular bi-weekly action-focussed operational development meetings between the core team supporting hub development, progress, challenges, opportunities and delivery
- Formal monthly data evaluation against agreed system wide KPI's: using health and social care data across a range of activity and spend and reported through the joint delivery group
- Formal evaluation through an academic partner is currently being investigated for formal, quantitative and qualitative evaluation to understand what is working well. Local and national research bodies have been asked to provide a specification for this work and the aim is to provide evidence that evaluates current impact and informs development

## What are the key success factors for implementation of this scheme?

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to;

- On-going provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes
- Monitoring and adapting scheme delivery, throughout different phases, though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery)
- To ensure sustainability of the scheme through on-going adaptation and learning

## **ANNEX 1B – Urgent Care Practitioners**

For more detail on how to complete this template, please refer to the Technical Guidance

#### Scheme ref no.

#### Scheme name

**Urgent Care Practitioners** 

## What is the strategic objective of this scheme?

#### Strategic objective:

The CCG's Integrated Operational Plan 2013/14 has three local priorities, underpinned by a clear strategic intent "to improve systems for assessing the urgency of care, ensuring an appropriate and prompt response to patient need". The aim for all three is to proactively manage conditions as close to the patients' home as possible thus reducing unnecessary A&E attendances and unplanned hospital admissions.

The first and the third priorities come within the Urgent Care Programme and focus on:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Reduction in emergency admissions for acute conditions that should not usually require hospital admissions

With this in mind, it has been decided within the NHS Vale of York CCG boundaries to change the name of an Emergency Care Practitioner to that of an Urgent Care Practitioner (UCP) so they are able to support the delivery of these priorities in avoiding further growth in admissions, which will reflect a considerable achievement from the 2012/13 experience of 16% increase in unplanned admissions

Commissioning the UCP Service will also feed into the vision for health and care services (as set out at the start of this document) by ensuring individuals are able to access the right level of care and support in community based settings to help avoid unnecessary admissions to hospital and in doing so will contribute towards the reduction of emergency hospital admissions.

In achieving this it will almost certainly iincrease the proportion of people having a positive experience of care outside of hospital, in general practice and in the community.

With the introduction of NHS 111, which is managed by Yorkshire Ambulance Service (YAS) across Yorkshire and the Humber, there are strong links and potential benefits associated with the commissioning of an UCP service delivered by YAS. NHS 111 supports patients with urgent care needs to access the right care, in the right place, first time, which will, if appropriate, involve referral to the UCP Service. Evidence suggests that this form of signposting appears to have the advantage of reducing immediate medical workload through the substitution of telephone consultations and alternative use of clinical skills. Furthermore, this has the potential to reduce costs. (*Leibowitz, (2003)*)

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

As part of the 2013 /14 winter pressures projects four members of staff from the Yorkshire Ambulance Service were employed to work alongside regular ambulance crews to attend falls, faints and minor injuries.

The success of this project enabled the CCG to continue and expand the service with funding from the York and North Yorkshire BCF.

They are working on a roving basis around the Vale of York and are called to both emergency calls to improve response times and to less urgent calls where they have appropriate skills. This service aims to see, treat and where required refer onwards individuals in the home or at the scene instead of providing conveyance to hospital.

The use of Urgent Care Practitioners Service that YAS provides for Vale of York CCG is to respond to 999 calls and to accept referrals from paramedics, nursing homes, community matrons and nurses. These referrals include, but are not limited to, falls, COPD, catheter problems, and wound care. UCPs, as independent advanced practitioners, are able to assess patients in their own home and make referrals to the most appropriate agency resulting in reduced ambulance conveyance rates to hospital.

Building on the success of this scheme will be the development of alternative pathways and integration into the community services that offer an alternative to hospital care. This additional funding for UCPs will increase the capacity and coverage of the Vale of York. Also in the rural areas of the locality this enables UCPs to be embedded within general practice. Although their primary role will still be that of an advanced paramedic practitioner responding to 999 calls, their skills and knowledge will be used to manage urgent demand which may be identified within primary care. This will support the move to Primary Care 7 day working.

The CCG have committed to fund this project through the York and North Yorkshire BCF and winter resilience monies and have committed to extend this service.

In 14/15, 4 UCPs are funded non-recurrently through system resilience monies. Recurrently an additional 4 UCPs are funded through North Yorkshire BCF and 4 through York BCF. In 15/16 4 UCPs will be funded recurrently through North Yorkshire BCF and 8 through York BCF. This gives a total of 12 UCPs in each year.

## The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG, with partner organisations and stakeholders, have been working together to manage urgent care. With the national introduction of an Urgent Care Programme the focus has been placed on transformation, improvement of urgent care pathways, integration of existing and new services and close working with care homes. The Systems Resilience Group has been established that underpins the importance of working with key stakeholders to develop ideas, oversee implementation of urgent care plans and monitor the A&E recovery and improvement plans. The approach spans pre-hospital, hospital and post-hospital care.

Following the development of a joint UCP service specification, this has now been

fed into a new contract agreement between the CCG and YAS.

YAS, as the main provider of the UCP service will be responsible for the delivery and implementation of the scheme working closely with the CCG as the contract commences. Currently a strategic meeting is held monthly to review the current levels of activity and address any issues with the scheme. It is anticipated that this will move to a contract management board (CMB) arrangement where YAS will be held account against a defined set of objectives and metrics.

#### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

#### **Current Scheme Activity Across North Yorkshire & York.**

Below are the latest activity figures for the current service with only 4 UCPs. The additional 8 posts will be in place by December 14. Costs have been estimated against non-conveyance rates, ED attendances and reduction in admissions.

	Total calls to UCP service	No of pts not conveyed to hospital	% of non- conv	1. Non- Conv costs £62	2. ED Atten costs £108	3. 50% reduct in admiss (£1258) at 30% (due to marginal rate effect)	Total
Apr-14	88	50	57%	£3,100	£5,000	£9,425	
May-14	147	57	39%	£3,534	£5,700	£10,933	
Jun-14	100	50	50%	£3,100	£5,000	£9,425	
Jul-14	122	82	67%	£5,084	£8,200	£15,457	
Aug-14	164	91	55%	£5,642	£9,100	£17,342	
Sep-14	210	120	57%	£7,440	£12,000	£22,620	
Oct-14	182	96	53%	£5,952	£9,600	£18,096	
Totals	1013	546	54%	£33,852	£54,600	£103,298	£191,750

#### NB:

- 1. Ambulance costs are based on a basic two man vehicle at £62 per journey. There are four categories of conveyance costs. YAS car booking if mobility permits £28, Basic two man vehicle £62, Fully kitted vehicle, two man support £288, Frontline 999 ambulance £288. Based on the patients seen by the UCPs the majority of patients will not require frontline, fully kitted vehicle. Therefore the cost of transport is based on a two man vehicle for most patient seen by the UCP who require ambulance conveyance to ED.
- 2. Attendance savings are based on 2012/13 data. Number of patients attending A&E divided by the actual cost x by the target reduction of % non-attendance. This is averaging £108 per attendance.
- 3. Admissions reductions are 50% of the patients attending ED conveyed by ambulance. The percentage conversion from attendance to admission has been identified through YAS experience in other areas. The costs are based on 2012/13 data for emergency admissions that met the criteria discussed above.

## Forecast savings

No	Month	Total	Non	%	1. Non	2. ED	3. Reduct	
of		calls	convey	based	convey	Attend	in admiss	
UCPs			,		£62	£108	(incl 30%	
							marginal	
							rate)	
4	Apr-14	88	50	57%	£3,100	£5,000	£9,450	Actual
4	May-14	147	57	39%	£3,534	£5,700	£10,773	activity
4	Jun-14	100	50	50%	£3,100	£5,000	£9,450	]
4	Jul-14	122	82	67%	£5,084	£8,200	£15,498	
4	Aug-14	164	91	55%	£5,642	£9,100	£17,199	
4	Sep-14	210	120	57%	£7,440	£12,000	£22,680	]
4	Oct-14	182	96	53%	£5,952	£9,600	£18,096	
4	Nov-14	210	141	67%	£8,723	£15,196	£26,592	Forecast
12	Dec-14	315	211	67%	£13,085	£22,793	£39,888	]
12	Jan-15	540	362	67%	£22,444	£39,096	£68,418	]
12	Feb-15	720	482	67%	£29,884	£52,056	£91,098	
12	Mar-15	720	504	70%	£31,248	£54,432	£95,256	]
							£424,447	£806,224
ı I	Total	3,518	2,246	67%	£139,237	£242,541	1,123	
	Target						£461,160	£676,560
	2014/15		2,154			£233,795	1,220	
	Target						£670,572	£983,872
	2015/16		3,133			£340,056	1,774	

References and an evidence-base have been used to inform the development of this model further.

#### References

There have been a number of studies that support the implementation of Urgent (was Emergency) Care Practitioners roles. The references below provide an overview of these studies.

Transforming urgent and emergency care services in England First published: November 2013

Urgent and Emergency Care Review, End of Phase 1 Report.

http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

 The challenges facing our urgent and emergency care system are clear, as are the opportunities for improvement. We now need to take action. The report sets out the proposals for the future of urgent and emergency care services in England. There are five key elements summarised in the report, one of which is to provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E

#### Sheffield PCT 2012

• The Sheffield ECP service has a primary role of seeing and treating people at scene, thus ensuring patients do not have to be transported by ambulance to A&E, when this is not the most suitable pathway for them. The service typically sees about 25 patients a day, many of whom have fallen. The service has been successful in reducing the need for people to be taken to A&E for treatment as patients can be treated on scene by an advanced practitioner.

## Journal of Paramedic Practice, Vol. 2, Iss. 4, 21 Apr 2010, pp 158 - 168

- The aim of the literature review was to identify and appraise studies that have compared the effectiveness and decision-making of emergency care practitioners with other health professionals.
- Out of the twenty-nine publications, ten studies were analysed in further detail and three main themes identified: non-conveyance rates, decision-making and admission avoidance.
- The decision-making of ECPs compares favorably with other health professionals when deciding whether a patient can be treated at home, or requires ED attendance or hospital admission.

# Measuring the Benefits of the Emergency Care Practitioner: Skills for Health 2007.

 70% of patients ECPs treated, discharged or referred patients away from hospital

Paramedic Practitioner Older People's Support Trial (PPOPS): A Cluster Randomised Controlled Trial. British Medical Journal, Nov 3;335(7626):919, 2007 (Mason, 2007)

 Controlled study of ECPs in three service settings showed high rates (72.2%) of patients discharged without referral on to other provider

Collaborative practices in unscheduled emergency care. The role and impact of the Emergency Care Practitioner (ECP). Cooper S. et al University of Plymouth (UK) October 2006

 70% of patients were seen 'in-hours'; 62% were not conveyed; 38% were referred, mainly to A&E

## AACE (2014) Future Clinical Priorities for Ambulance Services in England

The Association of Ambulance Chief Executives (AACE) has identified Urgent Care as one of their seven clinical care priorities. AACE recognise a shift from traditional ambulance service delivery ('see and convey') to an increased model of 'see and treat'. This model requires an increase in advanced paramedics and / or nurses equipped with enhanced skills to assess and either treat patients on scene, or refer the patient onwards to appropriate health and social care services.

#### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

#### Investment for 14/15 and 15/16

a. Investment required:

Proposed costs per UCP: £52k pay, £10k equipment, £10k travel and associated costs (£72k)

Year one 14/15:

Four UCPs for 12 months -4X£72,000 = £288,000

Two UCPs for 6 months -2X£36,000 = £72,000

Two UCPs for 3 months -2x£18,000 = £36,000

## Total BCF = £396,000

Of which £198,000 is funded from the York BCF.

Year one 14/15:

Four UCPs for 4 months – 4X£24,000

Total SRG = £96,000

Year two 15/16:

12 UCPs for 12 months - 12X£72,000 = £864,000

Total = £864,000

Of which £564,000 is funded from the York BCF in 15/16

### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	14/15 Activity	14/15 Saving (£K)	15/16 Activity	15/16 Saving (£K)
Reduction in emergency admissions	813	307	1183	447
Reduction in A&E attendances	1436	154	2089	223

NB: The above figures are for York BCF only.

#### Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods:

- Formal strategic monthly meetings with Yorkshire Ambulance Service and its membership includes CCG and YAS staff from contracting, finance, service improvement and front line clinicians.
- Formal monthly and quarterly data evaluation has been put in place using agreed performance metrics (as per the approved service specification)

#### What are the key success factors for implementation of this scheme?

It is anticipated that an increase in the number of UCP's commissioned by Vale of York CCG will achieve the following key success factors:

- Increased levels of appropriate non-conveyance due to the enhanced clinical skills of UCPs allowing them to assess and treat, assess and refer and assess and convey to alternative care sites (when clinically appropriate)
- Provide an integrated service, which supports a coordinated approach from health and social care professionals
- Reduction in attendance at A&E for specific patients
- Provide direct referrals to the most appropriate pathway for the patient
- Increased management of palliative care patients at home or at the place they choose to end their life

## **ANNEX 1C – Hospice at Home**

For more detail on how to complete this template, please refer to the Technical Guidance

#### Scheme ref no.

#### Scheme name

St Leonard's 'Hospice at Home' Scheme

## What is the strategic objective of this scheme?

## Strategic objective:

The extended hours operation of the Hospice at Home will be a proactive and responsive care model for the identified population of the Vale of York which seeks to continually improve integrated health and care provision closer to or at service users usual place of residence whilst reducing per head local health and care economy cost. The "identified population" of 2,700 is based on the challenge to primary colleagues from the National Council for Palliative Care to "Find their 1%" of patients aged 18 and over who would be expected to die within the next 12 months.

## Strategic Aims:

- To put service users at the centre of care delivery
- To improve access to home-based care and support services to enable more people to die at home or place which has become their home, with dignity
- To reduce population-based healthcare costs, social care costs and associated costs through providing alternatives to hospital admission
- To improve the quality and equity of access to health and care services for palliative and end of life care service users within the Vale of York.

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

In parallel with local joint strategic needs and plans, and the better care fund strategy and objectives, the CCG and local providers have committed to an extended hours hospice at home service that provides proactive and community-centred care for the Vale of York population. The hospice at home model combines resources from St Leonard's Hospice in conjunction with Marie Curie Nursing Services team, York Teaching Hospital Foundation Trust Community Services team and other care providers to deliver joined-up care and improved outcomes for the population it serves both during the working week and also at weekends.

The Hospice at Home extended hours service model is seen as essential to reducing acute care demand, increasing and improving primary and community care capacity, and improving health and care outcomes locally whilst reducing cost to the overall health and care economy.

#### Model of care and care cohort

The approach will be first to look to recruit the additional team members to deliver the extended hours service as there is a pressing requirement for this service given the overwhelming evidence from the Winter Pressures pilot. The recruitment phase should be complete within three months. Primary care colleagues continue their work to identify their palliative care patient population as part of the national "Find your 1%" challenge. These patient cohorts should be proactively managed within primary and community care teams with referrals to the 'hospice at home' service being co-ordinated via St Leonard's Hospice. The referral pathway will be communicated widely as part of the roll-out.

The model of care will be scaled in time to include other practices focussing on the most 5-10% at risk patients of hospital admission or high care utilisation in terms of activity and cost. The model uses principles of;

- Clinical leadership and ownership through St Leonard's Hospice
- Daily multi-disciplinary team meetings including health and care professionals through provider agreements
- Where practicable, care planning and case management supported through technology e.g. Electronic care records
- Single point of access for care delivery and management
- Development of new primary care and community care pathways to include voluntary sector support and sign-posting, particularly focussing on alternatives to hospital admission and admission avoidance
- Monthly monitoring and reporting through defined better care fund programme governance
- Robust evaluation and adaptation of model responding to impact
- To use principles of *communication, collaboration, co-operation, co-ordination and control* as the basis for the service delivery

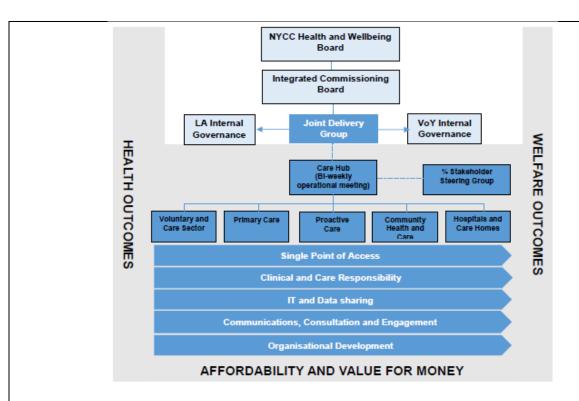
## The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A Service Level Agreement (SLA), in parallel with commissioning governance and assurance, will support the definition of the delivery chain and demonstrate the collaborative working approach.

The accountable lead provider, St Leonard's Hospice, is commissioned through the better care fund partners and process (invoicing monthly against a submitted business plan and budget), monitored through a joint health and social care delivery group. The SLA defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner), North Yorkshire County Council (commissioner) and St Leonard's Hospice (provider). The accountable lead provider however works with multiple other providers and stakeholders to deliver the care hub aims, objectives and deliverables, including local acute services and council provider services, for example.

Governance arrangements for the hub are represented diagrammatically below:



The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Acute and social care utilisation and metrics are reported monthly.

## The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

From the 'Finding your 1%' initiative around 2,700 adults in the Vale of York will have a palliative care diagnosis. This scheme will work towards reducing the national metric of 25% of all inpatients at any one time in acute hospitals that will die. Similarly from the National End of Life Care Strategy (2008) over 70% of people wished to die at home yet over 50% actually died in acute hospital settings.

Joint strategic needs assessments and public health data has also been available to help prioritise the wider strategy for models and plans, in addition to prior public communications and engagement exercises, and a number of provider market engagement events relating to community services and admission alternatives. It is hoped that this service will wrap around the developing better care fund community care hubs.

References and an evidence-base being used to inform the model and above statements are highlighted below.

#### References

National End of Life Care Strategy (2008)

- Health Education England (2014);
   https://www.eoedeanery.nhs.uk/page.php?page\_id=2776
- Health Foundation, The (2011). Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community. London. The Health Foundation.
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- King's Fund, The (2012). Pick 'n' mix: an introduction to choosing and using indicators. London. The King's Fund.
- King's Fund, The (2013). South Devon and Torbay. Proactive case management using the community virtual ward and the Devon Predictive Model. London. The King's Fund.
- King's Fund, The (2014). Community services: How they can transform care. London. The King's Fund.
- Nuffield Trust, The (2012). The anatomy of health spending. London. The Nuffield Trust.
- Nuffield Trust, The (2013). Evaluating integrated and community-based care.
   London. The Nuffield Trust.
- University of York (2012).
   http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12011006375#.U8kq4rnjjI

# **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total Investment Required: 14/15 - £135,000, 15/16 - £170,000

This funding comprises staffing costs as well as the costs of recruitment, staff development and travel for the extended hours (6pm until midnight) peripatetic service across the whole of the Vale of York.

The increased levels of staffing comprise: 4 registered nurses, 4 health care assistants, 1 part-time admin officer and an additional management/supervisory resource.

Based on 30% tariff and an average of 7 referrals per week, the total forecast savings would be as follows:

14/15

NEL Admissions reduction - £67k A&E attendances avoided - £13k

15/16

NEL Admissions reduction - £201k A&E attendances avoided - £39k

There is a further anticipated saving against ambulance conveyance cost, but as this is on a block contract further work is required to realise this benefit.

# Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

	14/15	14/15	15/16	15/16
	Activity	Saving (£K)	Activity	Saving (£K)
Reduction in emergency admissions	120	67	361	201
Reduction in A&E attendances	120	13	361	39

# Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Regular monthly action-focussed operational development meetings supporting hub development, progress, challenges, opportunities and delivery
- Formal monthly data evaluation using health and social care data across a range of activity and spend reported through the joint delivery group
- Formal evaluation through an academic partner currently being developed for formal, mixed methods (quantitative and qualitative) evaluation to understand what is working well, evidence that could inform development and evaluation of impact

# What are the key success factors for implementation of this scheme?

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and approach for implementation.

Specifically related to the defined scheme and in examining the publications previously referenced key success factors relate to;

- Successfully recruiting sufficient staff resources to safely operate the service
- On-going provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence around integration schemes specifically, for schemes to realise material reductions in admissions and other stated outcomes
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- Utilising decision-making processes to, for example, decommission services in line with increased scheme delivery (to reduce supply-led demand and realise material cost reductions and transfer of care delivery)
- To ensure sustainability of the scheme through on-going adaptation and learning

# **ANNEX 1D – Mental Health Street Triage**

#### Scheme ref no.

# Scheme name

Street Triage

What is the strategic objective of this scheme?

The proposed Mental Health Street Triage Scheme is intended to enable timely and appropriate interventions to individuals at their point of contact with police. It has been successfully trialled in Leicestershire and Cleveland, and other pilots are currently being rolled-out across the country. Leeds Street Triage service has been operational since December 2013 and has seen significant results in relation to increased patient experience and reduced detentions under the Mental Health Act 1983.

Working in partnership with the police, community mental health services, City of York Council and the Third Sector to offer an assertive outreach and follow up service to those difficult to engage following initial contact with the police

# Key Objectives -

- Reduce the burden on Crisis Teams, police and health staff, and hence reducing costs
- Mitigate risk and reduce the potential for vulnerable people escalating into crisis
- Significantly enhance inter-agency working in addressing the issues of vulnerable people at the earliest opportunity, with the lowest level of intervention
- Improve the outcomes for those who are detained and also those who are dealt with in the community
- Increased accessibility to Mental Health Service staff beyond normal working hours, seven days a week.
- Reduce the number of inappropriate detentions to both hospital and custody
- Support North Yorkshire Police experiential learning through multi-agency teamwork, leading to greater understanding of the roles of other professionals within mental health service and a greater understanding of mental illness and pathways to support vulnerable people
- Reduce the number of expensive call-outs for Forensic Medical Examiners and Approved Mental Health Professionals within police custody
- Actively contribute to reducing future demand upon services through pre-emptive engagement and action
- Reduce S136 detentions, evidence around the UK with other Pilots is a minimum 25%-30% reduction
- Reduced Emergency Department (ED) admissions (no figures available however above reductions could be replicated with mental health presentations through the ED).

The scheme will achieve this by adding skilled mental health professionals into the existing Crisis Assessment Service in York, the service that currently manages the Cities Health-Based Place of Safety for Section 136 detentions under the Mental Health Act. The team will be available to be deployed by the police to provide an initial assessment of the individual. With various interventions the Mental Health professionals will provide officers with advice, signposting to relevant support packages of care. It will also facilitate information-sharing between agencies at the interface of mental health and service provision, and help to address the subjects issues that lead to the revolving-door cycle of service use. By effective intervention and advice, the scheme will complement the recent investment in the creation of a Health-Based Place of Safety (HBPoS) for MHA detainees in York, and help avoid unnecessary detentions under the Act, thereby improving the patient experience for these individuals and achieving a substantial cost saving for those services.

It is envisaged that the Street Triage Team will see a Registered Mental Nurse (RMN) or an equivalent trained Allied Health Professional and a nursing assistant, on duty between 14:00hrs and 0.00hrs, 7 days a week. Following the model developed for implementation in Scarborough, it is proposed that they will utilise an unmarked vehicle suitable for the discreet assessment of vulnerable people at the scene of incidents in support of the police.

The focus of the service will be directed towards improving the patient experience, with an emphasis on providing a prompt, effective and efficient response to the Police. While not in itself a panacea, the scheme will assist in providing the lowest appropriate level of intervention at the earliest possible juncture.

#### **Purpose of Street Triage**

This Service is open and accessible to people of all ages, where it is believed that they may have a mental illness, learning disability, personality disorder or misuse substances, who come into contact with the police outside of custody. The team assesses their mental state in a face to face contact and advises if detention under the Mental Health Act is necessary. The object being to divert people from the Criminal Justice System when appropriate and provide access to community based services thereby ensuring that their health and social care needs are known and provided for by appropriate services.

If the person does need to be detained in a place of safety then the team follows the vehicle being used to transport the person, and once at the place of safety ensures that their health needs are known by staff at the receiving point. The team also where appropriate, provides signposting for all other persons who do not meet the criteria for detention.

The focus of the service is very much towards the front end of the criminal justice pathway, with an emphasis on providing a prompt response to incidents.

The team offers advice, assessment and access to services. They achieve this by offering advice and support to Criminal Justice Staff, checking where appropriate whether someone is known to mental health services and offering advice and signposting to other services.

A face to face triage screening assessment is carried out on persons outside of a custodial setting and risk assessments are completed on all persons seen.

The team also facilitate access to appropriate services in the community where this is appropriate.

# Philosophy of Care

The Street Triage team seeks to provide an inclusive service to ensure that persons coming into contact with the criminal justice system receive a high quality, competent and effective range of interventions. The service delivery includes liaison, prevention and ultimately if needed, equitable access to mental health services across the trust.

The service promotes social inclusion and acceptance of service users within mental health provision who may have offended, or are likely to offend or re-offend to enable them to live a more productive, positive and fulfilling life.

The Street Triage service is an integrated part of mainstream services ensuring access to mental health assessment and advice, and creating robust multi-agency working.

The Street Triage service promotes prevention and reduction of offending by working in a flexible, mobile and timely manner with all agencies in the locality.

The street triage team completes follow-up work to promote mental wellbeing and encourage access to appropriate services and offer support.

The street triage team works in partnership with Cleveland Police to provide mental health advice and guidance in an effort to assist the police in their decision making process around managing risk.

#### The services values are:

To recognise that mentally disordered persons who may also be offenders have the same right to assessment and treatment as any other person. Each person will be treated as a unique individual with dignity and mutual respect, whilst promoting a non-discriminatory service to all. The service will strive to be flexible and responsive to individual needs, responding to requests in a timely manner. Our aim is to establish a therapeutic relationship built on trust and respect. Confidentiality will be maintained within the boundaries of our environment. The service will integrate with the individual's existing systems of support.

# Service Definitions

The service is open to persons of all ages with recognition that it will only provide triage screening. There are agreed referral pathways to Child and Adolescent Mental Health Services for persons under 18 years of age and for adults and older adults via the agreed pathways for Adult Services and Mental Health Services for Older People.

If during the triage process a learning disability is suspected then although the team do not have specialist skills in this area they do have a general awareness and would signpost to the most appropriate service.

As part of the triage process Drug and Alcohol Issues will be screened for and help and advice on what services are available will be offered.

The service ensures that the care they provide is culturally sensitive and recognises that cultural differences will not exclude anyone from the service.

# The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A memorandum of understanding, in parallel with commissioning governance and assurance, supports definition of the delivery chain.

An accountable lead provider model has been adopted for the development of Street Triage, initially as a pilot. The accountable lead provider, Leeds and York Partnership NHS Foundation Trust (LYPFT), is commissioned through the better care fund partners and process, monitored through a joint health and social care delivery group. The memorandum of understanding defines the overall engagement and principles of this arrangement between NHS Vale of York CCG (commissioner), City of York Council (commissioner) and LYPFT (provider). The lead provider is accountable for the effective delivery of the Pilot however LYPFT works with North Yorkshire Police and other stakeholders to deliver all the objectives and deliverables.

Well-established LYPFT Clinical Governance structures will support Street Triage and existing supervision within the Crisis and Access Service will ensure continued delivery of safe and effective high quality Mental Health care to all patients seen on Street Triage.

The accountable lead provider is held to account against defined objectives and metrics and a defined plan for the agreed budget, however, there is flexibility for provider innovation and adaptation to ensure the model is as effective as possible in delivering the aims and objectives sought.

Street Triage development, progress and metrics are reported monthly.

# The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Existing schemes around the UK have been consulted; findings are consistent with reports highlighting their impact on reduced Section 136 Mental Health Act 1983 detentions by Police. There are also reports highlighting the reduced attendance of mental health presentations in custody areas.

Anecdotal reports highlight increased patient experience and describe improvements in working relationships between Health providers and Police Constabularies.

# **Investment Requirements**

Financial resource required to recruit to the following posts: (The following costs are based on a 12 month secondment or temporary contract)

2.31 Whole Time Equivalents (WTE) Band 6 Mental Health professional working 7 days a week between the hours of

14.00 and Midnight: £100,809.22

2.31 WTE Band 3 Health Support Worker working 7 days a week between the hours of

14.00 and Midnight: £60,358.27

# Staffing total resource

£161,167.49

Financial resource other:

#### Vehicle:

£4,000 Qty 1 Vauxhall Zafira people carrier, with privacy glass and annualised running costs (tax, insurance) for 12 months

£1500 fuel for above

£237 Qty 1 SRH Cradle Car Kit

£20 Qty 1 T Bar Radio Antenna

£17 Qty 1 Fist Mic

£160 Qty 1 Bury 9068 Blue Tooth Kit

£590 Qty 2 days Installation / Resource Costs. (Install of original S Max plus De Install and Re Install into new Zafira @ £295 per day )

Total: £6524

#### Hand Held:

£1116.20 Qty 2 SRH3900 GPS Radio including all Ancillaries @ £558.10 per radio £450 Qty 1 Radio Battery Charger

£210 Qty 6 additional Batteries

Total: £1776.20

# Security:

£650 Qty 1 CPNI Approved Airwave Radio Safe £85 Qty 1 Safe Delivery

Total £735

# **Airwave Access Agreements Revenue:**

£2628.32 Qty 2 per year @ £1314.16 each terminal per year

Total £2628.32 per year

Accessories:

£26.80 x4 duty belts £7.18 First Aid vehicle kit

Total £33.98

Other financial costs

£11,697.50

Margin £25930.00

Total Costs for 12 month Pilot £198,795

# Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

n/a

# Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Daily Police meetings are planned to support feedback and enable growth in the service
- The pilot will collect data following each Street Triage intervention, this will support the completion of the Department of Health's Incident Pro-forma (see below)
- Formal monthly data evaluation will be sent to all parties including the joint delivery group

# Mental Health Triage Pilot Incident Pro-forma

Date of encounter	DD/MM/YYYY	
Response officer time		
on incident prior to		
triage	HH / MM	
Start time of triage		
involvement	HH / MM	
Ref number for		
individual		
Location of encounter		
<u>Location of choodings</u>		
What type of issue lead to triage	involvement	
What type of issue lead to thage	involvement	I
Nature of triage		
Nature of triage		
engagement		

encountered Age of person encounte		
- ·		
Date of birth	DD/MM/YYYY	
Ethnisia of a second	to no d	
Ethnicity of person enco	buntered	
What montal boolth issu	up triggored trigge involvement? (tick as many as	
appropriate)	ue triggered triage involvement? (tick as many as	
αρριοριιαίο)		
	if unusual behaviour, please elaborate in open	
First souts at with this as	box below	
First contact with triage car		
Cai		
Action taken by triage		
Conveyed to <b>1st</b> place		
of safety by  If other, please		
specify		
Detainee taken to		
Length of time		
detained in 1st place		
of safety	HH / MM	
If taken to 2nd place of	<del></del>	
safety, conveyed by		
If other, please		
specify		
Detained taken to		
Detainee taken to		
a de la companya de		
Length of time		
detained in <b>2nd</b> place of safety	HH / MM	

If taken to 3rd place of		
safety, conveyed by		
If other, please		
specify		
Detainee taken to		
Length of time		
detained in 3rd place		
of safety	HH / MM	
Clinical assessment		
started within what		
length of time since	1111 / 8484	
start of encounter	HH / MM	
End time of encounter	HH / MM	
Previous conviction		
Known to mental		
health services		
Known to CAMHS		
Active care plan		
Open to services		
Previously detained under S136		
Engagement with and		
uptake of services		
Subsequently		
sectioned under		
Mental Health Act		
Subsequent informal		
admission		
Diagon note any		
Please note any		
problems, obstacles, observations or other		
outcomes (Please		
capture here any		
feedback/user		
experience)		
олрененое)		

# What are the key success factors for implementation of this scheme?

A range of broad and recognised factors consistent with any programme delivery are recognised, such as addressing barriers to change and ensuring a clear structure and

approach for implementation.

Specifically related to findings in other Street Triage services and the National Pilot the defined scheme key success factors relate to;

- On-going provider engagement in delivery
- Allowing time (for model development and scale amongst other areas), in parallel with the evidence from other Street Triage schemes.
- Monitoring and adapting scheme delivery though real-time and scheme-sensitive metrics (recognising external influences such as population growth, demographic changes and other influences on change)
- To ensure sustainability of the scheme through on-going adaptation and learning

# **Data and Analysis**

The service commenced operating on 10<sup>th</sup> October 2014.

It started off slow with only 39 interventions carried out in October.

In November there were 82 interventions.

At the end of the referral form there is a question asking officers what would they have done if Street triage had not been available, this question was only asked 47 times out of the 121 interventions however the comments highlight the impact the service is already having across pathways –

12 interventions stopped and ED attendance

6 interventions stopped an attendance into custody

- 24 interventions stopped a S136 detention
- 3 felt they would not have done anything but send the individual on their way
- 2 would have sought mental health advice.

The service receives regular positive feedback from officers, examples of these are -

Supportive, professionals who are able to relay correct clinical information about service users.

Enhancing the knowledge of response officers around mental health presentations, Officers feel more confident around supporting regular repeat attenders.

Joint risk management allows previous detentions to be supported on different pathways. Regular attendance to daily briefings and Force Control Rooms allow familiarity to the service which is demonstrated in the increased activity as the service has developed. Scenario based examples shared in these meetings allow further learning and a better approach to individuals in a mental health crisis.

# **ANNEX 1E – Pathways Together**

For more detail on how to complete this template, please refer to the Technical Guidance

# Scheme ref no.

#### Scheme name

Pathways Together: York

# What is the strategic objective of this scheme?

Objectives allied to the Better Care Fund priorities:

- Empowerment of patients to lead their own care and design services to meet their needs
- More integrated models of care and better data sharing across agencies
- Ensure a joint approach to planning and care and that individuals have a named keyworker
  - Reduction in emergency service use among target cohort
- Reduction in preventable use of acute hospital beds among the target cohort
- Better identification of mental health needs within emergency service responses
- Improved and coordinated responses to mental distress and complex needs by emergency, primary and secondary care, and voluntary services
- Increased confidence and competence among agencies coming into contact with individuals experiencing mental distress, in engaging and signposting individuals experiencing distress and complex needs, appropriately
- Increased community engagement and access among the target cohort (eg into health, employment, informal networks of support, secondary care where appropriate)
- Increased wellbeing, psychological and relationship resilience across the target cohort

# Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Pathways project has attracted enough funding to be operational 7 days a week from the outset. It is intended that this service will be operational at least 8 hours a day and this will correspond with service user need and times correlated with high demand. Discussions around co-location have kept this at the forefront of decisions and we intend on co-locating with a service provider who is open 'out of hours', 7 days a week.

#### The target cohorts will be:

- Those experiencing distress at first contact with emergency services, or at risk of contact with emergency services, aiming to preventatively divert individuals into appropriate resources and strengthen networks, coping and relating skills before problems become entrenched, with referrals by GPs, ASB Units, Safer Neighbourhood Teams, Emergency Care Practitioners, A&E, and the Mental Health Street Triage Team
- Those frequently in contact with emergency services who may have longstanding

difficulties, referred by Police, Ambulance, A&E, Fire, Psychiatric Liaison teams, and the Street Triage Team. Individuals experiencing distress in contact with emergency services will also be able to self-refer.

Although the target cohort are individuals with a diverse range of resources, difficulties and presentations, an example may be found in the case study given by the North Yorkshire Police, below.

"Brian first came to attention reporting he had lost his wallet. His contact with the police steadily increased, coming to police attention 21 times to the end of 2011, either calling (services) himself to threaten self harm or suicide, (reporting the loss of his wallet a further three times), or being reported by other concerned people for behaviour including head butting walls and walking through the streets ranting.

Brian was usually inebriated when making or being subject of these calls. In 2012 police received fifty reports from Brian stating that he was lonely, wanted a chat, or threatening self harm and suicide. A number of calls were received from other public services such as Ambulance, requesting police attendance at calls for help he had made to them. Brian's number has been blocked by the Samaritans who have refused to deal with him due to the volume of calls he has made to them.

In 2013 Brian made 137 calls for police service, all similar in nature to those above. Many incidents involve multiple calls to the control room. Brian has already instigated 15 police incidents this year (again losing his wallet). Brian has been detained in police cells 5 times using \$136 powers."

Classification	Cost per incident*	Number of incidents over 3 years	Estimated total cost over 3 years
Ambulance	£214	20	£4,280
Police attendance (no further action)	£35	30	£1,050
Police – action taken	£500	4	£2,000
s.136 MHA in custody	£2,500	5	£12,500
Calls to call centre	Unknown	241	Unknown
A&E attendance	£214	8	£1,712
Alcohol dependence cost to NHS <sup>‡</sup>	£1800	N/A	£5,400
Employment and Support Allowance (ESA) per annum per individual <sup>‡</sup>	£8,632	N/A	£25,896
•		Minimum total cost of emergency service use	£21,542 (3 years) (£7, 180 per annum)
*Marcus, Cox and Morris, [New Economy; 2013]		Minimum total cost (including ESA and NHS/ Alcohol)	47,438 (3 years) (15,812 per annum)

The Pathways Together© approach was designed specifically to tackle mental distress in the context of 'complex or multiple needs', for example, people who have experienced mental distress alongside a range of other factors, such as trauma, intergenerational exclusion, drug and alcohol misuse, forensic histories and risks, homelessness and learning difficulties.

Frequently, a lengthy statutory service intervention is not actually what would be most helpful to this group. Our psychologically informed approach takes expertise in understanding of psychological processes and presentations, out of clinics and hospitals, applying it flexibly to people who may never access formal treatment settings, who may have multiple needs, or who may have numerous sub-threshold needs. We pay particular attention to the establishment and maintenance of relational safety<sup>6</sup>, in order to effectively engage and support this group. We provide agencies (such as police, mental health services, ambulance and homelessness services) and the people we support, with tools to understand and ameliorate entrenched problematic coping and relating styles — helping address the factors that keep people excluded from networks, communities and services. We use our knowledge to inform and develop interagency information-sharing, working and strategic planning.

We know from our own experience that, although painful, crisis, or times of deep distress, can be starting points for extraordinary journeys of growth, learning, change and discovery – with the right support. Because of this, we aim to facilitate journeys of learning and discovery, about self, others, internal processes, and the world, as well as supporting people to deal with practical problems. This emphasis on learning, planning, understanding and reflecting, is the vital component of our psychologically informed approach.

What is unique about the pathways approach?

- Aimed at people who experience mental distress alongside a range of needs (eg homelessness, substance misuse, relationship problems, worklessness and financial difficulties) that brings them into contact with emergency services and/or the criminal justice system, or leave them at risk of this contact.
- Skilled support workers lead and managed by a clinician (OT, psychotherapist, social worker, CPN, psychologist).
- Robust governance: monthly clinical supervision; clinician led model; on-going specialist consultation, ad vice and training from Together's award winning Criminal Justice Management Team.
- Specialist training in the unique therapeutic support approach.
- Underpinned by a 'learning' approach informed by the rapeutic practice: it is as

The term 'relational safety' refers to:- I) recognition of the importance of relationships to individuals with significant emotional disturbance II) recognition of the potentially highly charged and challenging nature of relationships for many individuals who experience significant emotional disturbance; III) understanding that many individuals experiencing significant emotional disturbance have experienced relational traumas such as abuse or neglect, and that these experiences may inform future relationships, and understanding of how this may present; IV) using the support relationship as a primary tool to support individuals to repair trust, hope, emotional regulation, and agency, which may include using warmth, nurturance, playfulness, laughter, firmness, setting and reflecting on limits and boundaries, self-disclosure [c.f Young, 2003; 177].

The need for attention to relationships is well established for groups deemed by agencies traditionally challenging: for example, NOMS 'Segmentation: Needs and Evidence Tables for Commissioning 2013-14' [November 2012] finds 'positive staff interactions and pro-social modelling' to be the only evidence-based criminal justice intervention reliable for every offence, and every level of risk of harm and reoffending.

- important for our workers and the people they support, to *learn about problems,* what makes them worse and what makes them better, as it is to tackle the problems themselves.
- Wholly person-centred tackling individuals' identified 3 biggest problems on the basis that by alleviating the hardest things, the 'crisis' element of the individual's experience will be eliminated – while not institutionalising people by continuing to offer generic support indefinitely.
- Flexible discharges as part of road mapping discharge, the service and the client will agree to proactively check in at agreed intervals to ensure things are going smoothly and problems are troubleshot before they become crises.
- Identifying and addressing not just the symptom of the problem (worklessness, distress, homelessness, financial distress) but the causes of problems, for example – relating difficulties, problems managing anger, assertiveness, complex family situations).
- Uses the 'Three Hardest Things' tool a therapeutic support tool that names the 3 biggest problems explicitly, while reorientating individuals towards values and goals, and identifies and uses individuals' own motivation to effect positive psychosocial change.
- Road mapping discharge: document that tracks what the problem was, what
  caused the problem, what skills the person will bring to the problem in future, how
  the person will know if the problem is re-emerging, and what to do about it.
- Services designed in consultation with the people who use them and people who
  use the services collaborate at continuous development and improvement at every
  level during key working sessions, attending team meetings, and sitting on or
  attending Strategic Boards, whichever they prefer.
- Sees the person within the context of their network learns from Multisystemic approaches by shadowing and building links with local teams, while applying the learning to young adults and adults.

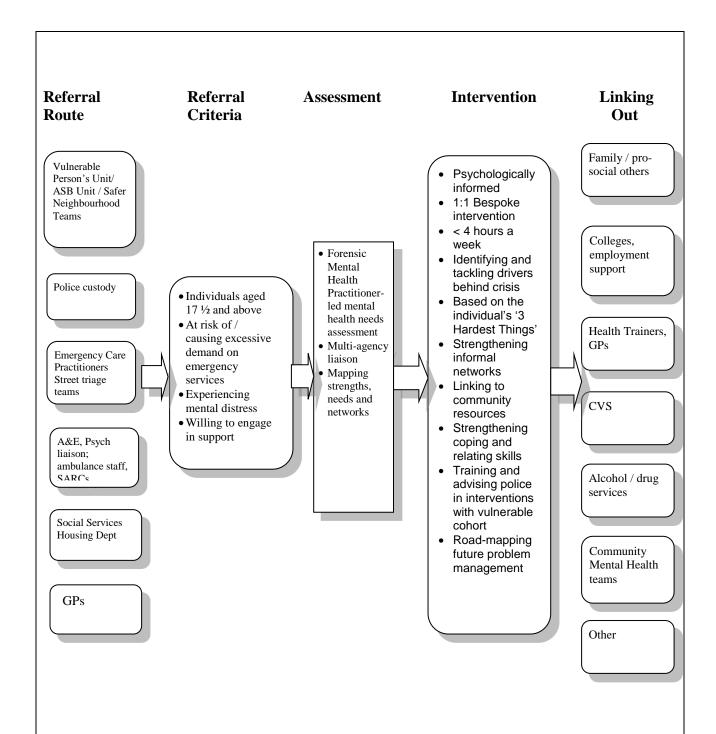
Our unique approach blends rigorous interagency and intercommissioning strategic governance with robust clinical governance, to target the 5 key factors in inadequate responses to 'complex' individuals, resulting in costly use of emergency services and preventable crises becoming acute, severe, chronic and intergenerational.

- i) 'Individual has too many needs' / 'Individuals' needs lie outside service criteria'
  - Practical support based on each individual's identified '3 Hardest Things' –
    unique triggers of individuals' unique crisis; working with and strengthening
    individuals' own motivation holistically
  - Support not simply based on triaging into services, but also up skilling individuals and families to manage their own wellbeing and relationships in line with individuals' own priorities.
  - Facilitating community reintegration and reducing distress and risks through activities such as increasing uptake of education, training and employment; increasing and building family and friendship links, engagement with drug or alcohol treatment.
- ii) 'Individual does not meet criteria for secondary care services'/ individuals unable to access services to which they are entitled
  - Clinical expertise to identify and triage needs appropriately
  - Strategic partnerships (eg with mental health trusts and police) that facilitate

pathways into appropriate services

# iii) 'Individual does not engage'

- Psychologically informed approach
- Use of individuals' own motivation to elicit change
- Blending psychological interventions with practical support
- Clinical supervision facilitates practitioners' continual reflective practice, so practitioners continue to intervene with individuals holistically, from a resource, resilience and responsibility-based perspective.
- Relationship, network and carer interventions: Working with and understanding the whole network around the individual, working with individuals and their networks to maintain more effective and prosocial relationships.
- Psychological Interventions: Developing resilience, confidence and competence in emotional regulation, interpersonal effectiveness, managing anger and mood management, so that, having been linked into community resources and networks, individuals have skills emotional regulation, mood management and relationships that will enable them to maintain these links.
- Traditional 'non engagement' behaviour (eg non-attendance, lying, challenging behaviours) used as service feedback, individuals are supported to articulate these verbally rather than behaviourally, and this feedback used to develop and improve systems, service and intervention.
- iv) Services lack expertise in understanding and engaging the individual and therefore individuals 'fall out' of services
  - Up skilling professionals around the individual: Increasing understanding and effective working with this group across agencies, through providing assessment, training and case consultation around the mental health needs and effective engagement of this client group.
- v) Because individuals' needs fall into a range of categories (eg drugs, alcohol, mental health, housing, family, employment) and services and systems are designed to meet single, acute, severe needs (eg mental health), individuals' needs are neither holistically captured nor met, resulting in repeat presentations, worsening health outcomes, and lack of awareness.
  - Increased interagency and intercommissioning liaison, collaboration, planning and information sharing for this group, through Senior Project Board, comprised of senior decision makers within agencies including Police, Mental Health Trusts, CCG, and Healthwatch, providing strategic and project oversight.
  - Working within the Better Care Fund structures, oversight by Joint Delivery Group
  - Using demographic information from Project Evaluation and monitoring data to inform the Strategic Board
  - Use of service users' feedback to inform systems and system change, including through attendance at Strategic Board meetings and in trainings.
  - Use of strategic governance to feed into system development and inform commissioning and interagency liaison and planning.
  - Increasing data sharing through sharing best practice from achievements within other areas, engaging in existing multiagency forums, and through the use of the Strategic Board.



# The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG will act as the commissioners of the service with additional funding from the Better Care Fund and Lankelly Chase (external grant giving organisation). Additional referring agencies and partners are detailed below:

- North Yorkshire Police (NYP)
- City of York Council including the anti-social behavioural hub
- Yorkshire Ambulance Service
- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- North Yorkshire Fire and Rescue Service (NYFRS)

- Priory Medical Group
- York Centre for Voluntary Service
- York Healthwatch

All the above stakeholders have been invited to join the Strategic Board.

- Increased interagency and intercommissioning liaison, collaboration, planning and information sharing for this group, through Senior Project Board, comprised of senior decision makers within agencies including Police, Mental Health Trusts, CCG, and Healthwatch, providing strategic and project oversight.
- Working within the Better Care Fund structures, oversight by Joint Delivery Group
- Using demographic information from Project Evaluation and monitoring data to inform the Strategic Board
- Use of service users' feedback to inform systems and system change, including through attendance at Strategic Board meetings and in trainings.
- Use of strategic governance to feed into system development and inform commissioning and interagency liaison and planning.
- Increasing data sharing through sharing best practice from achievements within other areas, engaging in existing multiagency forums, and through the use of the Strategic Board.

#### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In a study describing care and support for people who experience complex needs, The Journal of Integrated Care [2009] notes the importance of both 'highly individualised solutions', and 'interventions which maximise individuals' opportunities for exercising control' [8: 2009; Henwood and Hudson]. They note that 'much assessment and care planning remains deficit-based and focused on what people are unable to do rather than understanding individuals with a range of strengths and qualities'. Moreover, a 'model that focuses on individual pathology...does not always provide the best foundation for longer-term, non-acute conditions, or for promoting social inclusion.'

While highly individualised solutions, which maximise opportunities for exercising control, and view people from a resource, responsibility and resilience-based perspective, should be the blueprint for all interventions, too often this approach is lost when it comes to those who are experiencing the most complex difficulties, because staff and agencies encountering people who experience multiple or entrenched difficulties can start to feel inadequately resourced, helpless, de-skilled or impatient [Journal for Integrated Care [2009]. At these times, people 'fall out' of services (seen in the case study).

The project has consulted with a number of key stakeholders in the development of this bid to-date, including :

- head of Mental Health Crisis and Street Triage services in York
- lead consultant for York A&E
- mental health lead for the Yorkshire Ambulance Service
- a service-user whose case is detailed below ("Anne")
- City of York Council

- The Priory GP surgeries
- Healthwatch
- Ark light

Identified needs include:-

The North Yorkshire Police note from a desktop analysis of mental health recording in police callouts that 2/3 of incidents recording self harm and suicide did not flag mental health as a factor in the callout, indicating a low level of confidence and awareness in identification and response.

Healthwatch notes the need for 'initial support for anyone that's experiencing issues, before problems become acute or severe', alongside 'support for people who have more complex issues. People don't understand being told they do not qualify for services although they are absolutely desperate. The system is not sufficiently resourced to give people help when they need it so crises occur.'

The Priory Group GPs note a need for interventions 'which will not turn people away because they do not meet service criteria, even though they are really distressed and struggling.'

The lead consultant for York A&E notes, "Historically the ED (A&E) staff often struggle to provide patients with mental health problems with appropriate care which leads to a feeling of frustration for the patient and helplessness / failure for the staff. The problem is addressing the Mental Health care needs of those that tend to fall in between agency support and the ED staff's feeling that there is 'nothing out there' that we can realistically offer the patient: that is where this proposal will help."

One high-volume service-user consulted during the development of the proposal ("Anne") stated: "You don't just fall into crisis and then when 'the immediate crisis [e.g. Section 136, A&E] is over, everything's OK. When services just stop once the crisis is over, you're back there. Back in whatever it was that put you in crisis in the first place. Nothing's changed. You've taken time getting into crisis and it takes time and support to move on. You've got real problems. And if you don't get help to address the underlying problems, you'll be back there. Everyone's unique. And everyone needs a unique approach to get better."

Stakeholders have expressed willingness to support and contribute to the project in a range of ways: offering views and feedback to support development, sitting on the project Strategic Board, or contribution of resources such as office space or mutual agency collaboration and learning.

# **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

This scheme is funded through both the North Yorkshire and the York Better Care Fund. Funding 14/15 £50k to also include set up costs 15/16 £50k

# Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme underpins the other BCF schemes and is closely aligned with the Street Triage Scheme therefore the benefits have not been shown separately to avoid possible

double counting of benefits.

# Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We use a range of outcome measures, Data is collated and disseminated quarterly for our commissioners and key Strategic partners.

- Together's Assessment and Outcome Measure, which is used in all interventions, at treatment start, review and discharge, which measures psychosocial wellbeing, coping, relating, hopefulness, and mood, as well as intermediate factors leading to offending.
- Together's Network and Carers measure, which audits confidence and wellbeing among carers and networks where involved
- Information will feed into monthly team meetings, and into the quarterly Strategic Board via monthly Evaluation and Monitoring returns, and narrative reports, and summaries of this information will be escalated to the Delivery Group (comprised of senior membership from Health, Police, the CCG, the HWB, the Local Authority etc).
- The cost benefit analysis will also be used to measure the impact on service users' lives through analysing changing patterns of emergency service use.
- Key participants at the Strategic Board will be able to use the forum to monitor and report on impacts on services (eg Police, A&E) as a consequence of the Project, and to advise ameliorative action where required.
- Service users' feedback will also be gleaned through a variety of mechanisms unique to the Pathways Approach©. Our approach to feedback is that it is vital to shape our service, and supporting individuals to feedback verbally rather than through challenging or offending behaviours, is an essential component of our work.
- Service users will attend the Strategic Board and input directly to training.
- Service user feedback will be gleaned through key working sessions, discharge and feedback questionnaires, and, most importantly for this client group, nonverbal (challenging behaviour, lying, disengagement) and demographic feedback (eg which populations are not accessing the service, or disengage quickly) will be used to continuously shape service delivery and interventions. For example, For example, a Pathways service user became verbally aggressive at the end of an assessment when the worker tried to forward plan. The incident was explored in supervision, and a decision taken to cease forward planning and spend more time taking pleasure in building mutual interaction before moving forward, with good effect. This was brought to the team meeting, reflected on in correlation with other disengagements, and used as a valuable lesson in slowing down and practising acceptance of the people we support in a variety of ways, before moving towards practical goals. This lesson exponentially increased positive engagement across our cohort of usually deemed 'hard-to-reach'. We fed back to the individual what we had learned from him and reflected on what had happened together, empowering the individual to articulate his values and concerns explicitly (verbally) rather than implicitly (through aggression). The individual has subsequently advised the Strategic Board.

# What are the key success factors for implementation of this scheme?

# Resulting in positive change for service users

Together: York will use the activities and service model, working closely with partners in

health, the voluntary sector and police described above, to achieve this.

Success will be measured through:

- Together's Assessment and Outcome Measure, which is used in all interventions, at treatment start, review and discharge, which measures psychosocial wellbeing as well as intermediate factors leading to offending
- Together's Network and Carers measure, which audits confidence and wellbeing among carers and networks where involved
- Information will feed into monthly team meetings, and into the quarterly Strategic Board via monthly Evaluation and Monitoring returns, and narrative reports, and summaries of this information will be escalated to the Delivery Group (comprised of senior membership from Health, Police, the CCG, the HWB, the Local Authority etc).
- The cost benefit analysis will also be used to measure the impact on service users' lives through analysing changing patterns of emergency service use.
- Service users' feedback will also be gleaned through a variety of mechanisms (described below).

Involving service-users and being service-user led. Supporting involvement in different ways, at different levels and times.

Principle monitoring mechanisms are:

- Monthly monitoring and evaluation;
- Together's internal auditing and business planning processes.
- The Strategic Board (comprised of Police, local authority, mental health trust, the Yorkshire Ambulance Service (TBC)), and Together: for Mental Wellbeing;
- The Joint Delivery Group.

Service user input will be collated on a monthly basis as part of service evaluation and monitoring. Service users' ideas, feedback and suggestions will be reviewed and monitored by the Project Strategic Board with recommendations for service development incorporated and reviewed on a quarterly basis. Service users will sit on the Project Strategic Board and help to hold the project accountable for its involvement and leadership, as well as for its vision of truly meeting needs responsively. This information feeds into wider business planning and staff appraisals and is reviewed by Together's Head of Criminal Justice Services, helping to feed into Together's wider Criminal Justice Strategy. The Joint Delivery Group will ultimately hold the project to account locally for meeting its aims and objectives with regards service user involvement and leadership.

#### Remaining strategically and locally relevant.

Principle monitoring and measurement tools are:

- Independent cost benefit analysis of service efficacy to determine impact on cohort and wider local community, and the strategic viability of service intervention for this cohort
- Together's wider organisational business planning objectives and review processes
- Annual stakeholder questionnaires as to where the service is performing well and

how it can be improved, which feed into the Strategic Board and Delivery Group described above

- Service Level Agreements between key partners (e.g. police and health) and quarterly meetings to review joint relationships
- Local and national funders' individual contract monitoring processes.

The cost benefit analysis will identify whether the service has had an impact on local pressures and difficulties and this information will feed into funders and local community planning. Demographical data is collected on a monthly basis within Evaluation and Monitoring processes held in Together. This information, and stakeholder feedback, will be shared and reviewed by the Strategic Board and delivery group and this will be compared with local demographical data (eg found in the JSNA) and action taken to address issues where required. Project data including stakeholder feedback, is reviewed by project managers within Together and is ultimately accountable to service directors. This information feeds into both business and project planning and into individual staff appraisals. Service level agreements and regular review meetings with key partners such as the police and health will ensure that issues arising will be identified and managed within a structured relationship.

# **ANNEX 1F – Psychiatric Liaison**

For more detail on how to complete this template, please refer to the Technical Guidance

#### Scheme ref no.

#### Scheme name

Psychiatric Liaison – Emergency Department Liaison Service

What is the strategic objective of this scheme?

Strategic objective:

To provide a 24/7 Psychiatric Liaison service within the Emergency Department (ED) at York Hospital to manage patients presenting with psychiatric requirements safely and effectively.

# Strategic Aims:

- 1. To provide rapid bio-psychosocial and risk assessment of individuals who present to the ED with deliberate self-harm and acute mental health problems.
- 2. To collaborate with York Teaching Hospital Foundation Trust (YTHFT) colleagues to facilitate prompt assessment avoiding duplicate contacts ensuring fluent and timely progression through the care pathway.
- 3. To screen referrals and prioritise them according to urgency.
- 4. To provide an advocacy role for the service user and carers within the general hospital.
- 5. Discussing treatment and management options with the service user and safely signposting them to the most appropriate service(s) to meet their individual needs.
- 6. To facilitate prompt access to mental health intervention for those individuals who have an identified mental illness working closely with the acute care pathway to access inpatient psychiatric admission and intensive community services.
- 7. To facilitate prompt access to appropriate physical health/emergency intervention for service users where it is identified they have compromised their physical health.
- 8. To liaise with other services in York, including GP's and primary care workers, community mental health teams, specialist mental health teams, addiction services, crisis services and voluntary organisations.
- 9. To provide a resource to general hospital colleagues for information and advice on mental health issues.
- 10. To positively promote mental health in York Hospital.
- 11. To collaborate with YTHFT in adhering to the Emergency Care standard and auditing adherence outcomes against targets.
- 12. To provide education and training to the ED with specific objectives to :
  - Promote an understanding of the roles of mental health services in York and the

- roles of mental health services that interface with York Hospital.
- Promote an understanding of common mental health problems and the nature of psychosocial crisis and distress.
- Promote an understanding of suicidal ideation and behaviour and self-harm in the context of tension relief.
- Provide an insight into mental health risk assessment and risk management.
- Develop communication skills within the ED in asking questions pertaining to an individual's mental health.
- Develop skills in identifying mental health problems in service users who may have presented with a physical disorder.

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Individuals attend the ED of York Hospital with mental health difficulties and following acts of self-harm. They present with a diverse range of issues and presentation. The Emergency Department Liaison Service (EDLS) team will provide a comprehensive bio-psychosocial assessment.

The EDLS will work in close collaboration with YTHFT on building established working relationships through the Crisis and Access Service (CAS) and link into wider mental health services provided by Leeds and York Partnership Foundation Trust (LYFPT) as the gatekeepers of the mental health acute care pathway.

This interface is seamless in respect of shared assessment format. To manage the transition in implementing the ED service, staff from the CAS will be rotated into the EDLS team. This is to optimise the clinical expertise of the ED team and support the induction of the newly appointed staff.

Service users will be provided with a thorough bio-psychosocial assessment. This assessment should take place within three hours of arriving in the ED of York Hospital for the initial six months of the service. From 1 April 2015 the assessment should take place within two hours. Once their assessment is completed, they will be signposted to the most appropriate service to manage their current mental health and bio-psychosocial difficulties.

There will be an improved patient experience through the ambulatory care pathway for service users with a mental health difficulty or following an episode of self-harm.

#### Service user groups covered

The service provides mental health and self-harm assessment to individuals age 18 and over who present to the ED department of York Hospital. Service users with mild to moderate learning difficulties can access the services if it is thought that they may benefit from doing so. It may be necessary, to work jointly with Learning Disability or Adult Mental Health Services, on occasions to ensure the best outcomes for the service user.

#### **Exclusion criteria**

- Service users under the influence of alcohol or illicit substances should be referred when sober enough to effectively and safely engage in the assessment process. The EDLS team should be informed of these service users at the earliest appropriate time to allow planning of the assessment at the earliest opportunity.
- Service users who are not medically fit for assessment.
- Service users detained under Section 136 of the Mental Health Act.

# The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The driver to provide the EDLS is to improve the quality of service to people who present to the ED with mental health problems, and to reduce the number of admissions to the Acute Medical Unit (AMU) within York Hospital.

From April 2013 – February 2014 there were 1,057 mental health attendance (based on a primary diagnosis of anxiety, bipolar affective disorder, depression, overdose, personality disorder, psychiatric/behavioural, psychosis or schizophrenia).

14% of these attendances breached the 4 hour target, suggesting that mental health related attendances are more likely to breach than attendances for a physical health problem. We expect the rate of ED breaches for patients with a mental health need to reduce as a result of this service.

The table below shows the volumes and costs of non-elective admissions to York Hospital in 2013/14 relating to serious and enduring mental illnesses (SMIs), common mental health disorders (CMDs) and self-harm admissions:

Category	Primary Diagnosis Spells	Final £	Secondary Diagnosis Spells	Final £	Total Spells	Total Final £
SMIs	56	£101,394	261	£422,970	317	£524,364
CMDs	61	£121,197	1,010	£1,961,674	1,071	£2,082,871
Self Harm	767	£445,710	143	£345,244	910	£790,954
Grand Total	884	£668,301	1,414	£2,729,888	2,298	£3,398,189

It is anticipated that these figures will fall as a result of the introduction of the EDLS.

The EDLS will be operational 24/7 seven days a week providing a mental health assessment to the ED department. The target group are service users who have presented with self-harm and acute medical management and interventions are not indicated. It is also anticipated that the service model will provide more timely assessment of those admitted to medical inpatient area of York Hospital, a consequence of which will be a reduced length of stay.

The EDLS will advise YTHFT colleagues on the management of individuals with mental health difficulties who frequently present to the ED. This, where appropriate, will include working with both LYPFT and YTHFT colleagues to devise individually tailored care plans, for implementation to the ED. This is aimed at supporting this group of service users with a consistent approach.

These individuals could be suffering from the range of mental health conditions, commonly described as common mental health disorders and serious mental illnesses. Effective liaison has been shown to be successful in significantly reducing repeat attendances from individuals within these groups by promptly signposting patients to the most appropriate services. Evidence and data will be recorded to ensure the EDLS is meeting the needs of these groups.

The EDLS, as part of CAS, will have well established relationships with a range of community services including home treatment, Community Mental Health Teams (CMHTs) and Section 136 services. They also regularly link with and refer to Social Services, GPs and other voluntary and

statutory services, including housing, employment and education agencies.

#### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The report 'Managing Urgent Health Care In The Acute Trust', 2008, is a guide developed by practitioners for managers and commissioners in England and Wales. This report was prepared by the Royal College of Psychiatrists, working in partnership with representatives from the Royal College of Physicians of London, the Royal College of Nursing and the College of Emergency Medicine.

The executive summary highlights that the current provision of mental health services to people attending the emergency departments of general hospitals are extremely variable across the country. These departments have high levels of activity and encounter some of the most seriously ill people at greatest risk. The summary describes this variability in service provision situation as unacceptable.

The summary of the report recommends that liaison services should coordinate the front line responses for psychiatric support to the emergency department and acute wards. This would mean acute trusts working in partnership with mental health services to provide 24/7 services.

This report and the report 'High Quality for all', (Department of Health, 2008) both send a strong message about developing care pathways that are easily accessible, and provide timely assessment and high quality care. This translates into a clear single point of access for emergency department staff to refer to mental health services 24/7, seven days a week.

This is also supported within the document 'Healthy Ambitions' (NHS Yorkshire and Humber) describing of critical importance is single point of access to services which are accessible 24/7.

The need for mental health nurses in emergency departments (ED) is highlighted in the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine report *CR118* (February 2004). This report recommends that '...mental health nurses should provide the first point of contact from mental health services. Where such professionals are employed they generally develop a close working relationship with the A&E department, and have a role in training and staff support.'

The National Service Framework for Mental Health (Department of Health 1999) does acknowledge that EDs can make a valuable contribution when providing access to mental health services particularly for service users who have self-harmed, rough sleepers and those who have not registered with a GP.

The RAID model, first introduced into the City Hospital, Birmingham, has shown the benefits of incorporating psychiatric liaison into a general hospital setting. The service offers consultation and liaison to the ED, the medical assessment unit and the medical maternity and surgical wards with response targets of 1 hour for the ED and 24 hours for inpatients. RAID builds on existing liaison services adding health and social care capacity to the liaison team plus specialist skills in older adults and addictions – as such it is a complete, all age mental health service with an acute trust. As there has been no Psychiatric Liaison service in Vale of York the RAID model is a long term aspirational goal and this initial scheme is part of the pathway to progress to this.

The London School of Economics have recently published an independent economic evaluation of this service, based mainly on a critical scrutiny and re-analysis of data collected by the hospital. The publication concludes that the service generates significant cost savings and is

excellent value for money. The incremental cost was £0.8m versus the incremental benefit, based on conservative assumptions, of £3.55m. These savings relate to a reduction in acute inpatient bed days in terms of reductions in length of stay (LOS) (1.5m), admission avoidance (0.3m) and reduction in readmissions (1.5m). LOS cost savings are derived from annual bed day savings multiplied by the cost of a bed day, purported to be £200.

Admission avoidance and readmission savings multiply the avoided admissions by the marginal rate of an acute admission. The savings are therefore both provider and commissioner related and the London School of Economics report has demonstrated that it can achieve the following outcomes, over and above traditional liaison services:

- Reduce admissions, leading to a reduction in daily bed requirement
- Reduce discharges to institutional care for elderly people by 50%
- Produce a cost-to-return ratio of £1 to £4
- Good service user feedback on holistic care in acute settings
- Staff feedback of improved confidence and capacity in managing service users with mental health issues with improved staff morale
- Waiting times for service users time in A & E has reduced by 70%

The Emergency Department Liaison Service pilot will be used to inform the development of a future psychiatric liaison service. It is envisaged that the service will eventually form part of the wider mental health contracts held by Vale of York CCG if successful at this stage.

References and an evidence-base being used to inform the model and above statements are highlighted below.

# References

# Applicable national standards (e.g. NICE)

 NICE CG16. Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care

# Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- RCPsych report, CR158, 2010: Self-harm, suicide and risk: helping people who self-harm
- CEM report 6883, 2013, *Mental health in Emergency Department*

# **Associated policy documents**

- Department of Health (2012) Preventing suicide in England a cross-government outcomes strategy to save lives.
- Department of Health (2011) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.

#### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

North Yorkshire BCF and York BCF are each providing £25,000 to fund the pilot in 2014/15. 15/16 to be part of the new mental health tender.

#### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is anticipated that the EDLS will improve the level of service provided to patients presenting to ED with a mental health need, and reduce the proportion of patients that breach the 4 hour ED target from this cohort.

When the service is fully running we expect it, in conjunction with the other BCF schemes, to enable more efficient management of patients with a mental health need, providing effective alternatives to ED attendances and in-patient admissions.

This scheme is a whole system enabler and is supporting the BCF schemes, therefore no benefits have been specifically identified against this scheme. It is anticipated that as part of the mental health tender in 15/16 this service will be embedded.

#### Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service is being launched in a phased approach, and the first shifts were introduced into the Emergency Department of York Hospital in October 2014.

Outcomes of the scheme are measured and/or to be measured through the following methods;

- Regular informal discussion between stakeholders from the three main organisations: LYPFT, YTHFT and Vale of York CCG.
- Formal monthly data evaluation using agreed metrics against agreed KPI's, reported to main stakeholders and the Partnership Commissioning Unit.
- Formal evaluation through an academic partner currently being developed for formal, mixed methods (quantitative and qualitative) evaluation to understand what is working well, staff and service user evaluation, evidence that could inform development and evaluation of impact.

# What are the key success factors for implementation of this scheme?

# **NHS Outcomes Framework Domains & Indicators:**

Domain 4	Ensuring people have a positive experience of care	Х
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Х

#### Reporting specific to this scheme:

Info id	Information to be reported	Frequency of reporting
1.	Number of people referred to EDLS	Monthly
2.	Number of people assessed by EDLS	Monthly
3.	Time taken from booking into ED reception to referral to EDLS	Monthly
4.	<ul> <li>a) Number of people assessed by EDLS within the set target.</li> <li>b) Number of people assessed by EDLS outside of the set target. When the target has been missed, reasons should be recorded.</li> </ul>	Monthly
5.	Number of EDLS assessments delayed because the service user was intoxicated from alcohol or illicit substance misuse	Monthly

6.	Number of people assessed requiring MHA assessment	Monthly		
7.	Number of people referred to EDLS who meet the 4 hour ED target	Monthly		
8.	Number of people referred who self-discharge prior to assessment  Monthly			
9.	Number of people assessed who self-discharge prior to completion of EDLS involvement	Monthly		
10.	Destination following assessment and treatment. Number of people assessed who are:  Admitted to AMU Admitted to inpatient bed within York Hospital Admitted to inpatient bed within LYPFT Referred to community based MH services Referred to primary care Discharged back home Self-discharge	Monthly		
11.	Number of patients who attend community based mental health services when referred from ED	Monthly		
12.	Length of stay for patients:  Admitted to AMU Admitted to inpatient bed within York Hospital	Monthly		
13.	Number and % of re-attendance within:  7 days 28 days	Monthly		
14.	Number of ED staff who have received appropriate training to equip them to understand and care for people who have self-harmed or who present with mental health needs	Monthly		
15.	Service User Experience data	TBC		
		1		

# **Key performance indicators (KPI)**

KPIs should be reported on a monthly basis from the full launch of the pilot service. Levies as a consequence of a breach will not be enforced for the first 6 months of the pilot.

KPI	Requirement	Threshold	Method of	Trust
id			measurement*	responsible
1.	% of appropriate patients being referred to the EDLS team within target	Target is 2 hours between 1 <sup>st</sup> Oct 2014 – 31 <sup>st</sup> Mar 2015, and 1 hour between 1 <sup>st</sup> Apr – 30 <sup>th</sup> Sep 2015	N – number of patients referred to EDLS team within 1 hour D – number of patients referred to EDLS team	YTHFT
2.	% of EDLS assessments carried out within target	Target is 3 hours between 1 <sup>st</sup> Oct 2014 – 31 <sup>st</sup> Mar 2015, and 2 hours between 1 <sup>st</sup> Apr – 30 <sup>th</sup> Sep 2015	N- number of EDLS assessments carried out within target D – number of EDLS assessments carried out	LYPFT

3.	Reduction in the	Use Q1 data to set	N – number of	To be	
3.		baseline		established	
	% of patients	Daseillie	patients who attend	established	
	attending the ED	Current breach is 14%	ED with MH problem		
	with a mental	Current breach is 14%	and meet 4 hour		
	health (MH)		target		
	problem, who		D - number of		
	breach the 4 hour		patients who attend		
	target		ED with MH problem		
4.	% of patients who	Use Q1 data to set	N - number of	LYPFT	
	attend when	baseline	patients referred to		
	referred to		CMS, and attend		
	community based		services		
	MH services		D - number of		
	(CMS)		patients referred to		
			CMS		
5.	Reduce the	Use Q1 data to set	To be agreed	LYPFT	
	number of	baseline			
	patients who re-				
	attend to EDLS				
	within 28 days of				
	previous				
	attendance				
6.	Increase levels of	Use Q1& Q2 data to	To be agreed	LYPFT	
	service user	set baseline			
	satisfaction				
7.	Increase levels of	Use pre service	To be agreed	LYPFT	
	staff satisfaction	evaluation to set			ļ
	TBC	baseline			
	1				

# **ANNEX 1G – Sitting & Crisis Hours Service**

For more detail on how to complete this template, please refer to the Technical Guidance

#### Scheme ref no.

#### Scheme name:

Sitting & Crisis Hours Service

# What is the strategic objective of this scheme?

To prevent unnecessary conveyance to hospital of York residents who are assessed by ambulance service personnel, UCP's, the Lifting Service, the social care out-of-hours emergency duty team *or* GP's as not being fit to be left on their own immediately after a crisis, e.g. a bad fall, but do not have a medical need to be conveyed to hospital and admitted, as well as supporting other elements of the transitional care and support pathway such as the RATS & hospital discharge teams to ensure there is always care available to get people home safely, and to provide a strictly time limited (72 hours maximum) domiciliary support service providing adult social care as necessary.

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

It is widely accepted that many people are conveyed to hospital or subject to a GP referral for admission, because, immediately following a crisis it is not safe to leave that person, (usually a frail older person), on their own however, often, there is no service to which such individuals can be referred and therefore they are admitted to hospital.

This service would be part of a coordinated and integrated transitional care and support pathway to provide a rapid response care and support offer to those in crisis in their own homes but who do not have a medical need to be conveyed/admitted to hospital.

Referrals would be taken by the sitting and crisis hours service control room and sitters/carers dispatched within a target response time of 1 hour. They would then either sit with the person until 8 am in the morning, for an overnight call, or for up to 6 hours for a daytime call-out, or they will offer an appropriate number of visits to provide care and support over a period of up to 72 hours.

The tasks that the sitter or care provider carried out would vary in response to individual need but as a core would comprise one or more of the following:

- Reassurance
- Assistance with hydration and nutrition
- Support with hygiene
- Personal care provision
- Making contact with family/friends
- Providing a comprehensive list of key phone numbers they might need in the future, including all local alternatives to 999.
- Advice with regard to maintaining safety

There is a commitment between health and social care to work this scheme up in more detail over the coming weeks.

# The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This would be an NHS commissioned service provided by the existing provider of out of hours response services as well as an appropriate registered domiciliary provider agency..

# The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This service forms a part of a wider system of interlinked schemes to deliver a transitional care and support pathway from low level prevention and early intervention, to more specialised and intense services designed to prevent hospital admission, coupled with a joint reablement and support offer to engage with those coming out of hospital or recovering from an illness, accident or fall etc. There will be a very strong links with services such as Urgent Care Practitioners and the Care Hubs. This is due to the fact that when an individual is seen by a UCP following a fall, and the UCP feels the person, although medically stable is not quite ready to be left alone, then the UCP can call on the sitting or crisis hours service (depending on the level of need) to provide support, care and reassurance etc. There is evidence that an integrated approach to prevention and re-ablement can significantly improve the health and wellbeing of the person accessing the services.

http://www.scie.org.uk/publications/guides/guide49/
from the Social Care Institute of Excellence (SCIE) gives an overview of the benefits of reablement & early interventions in social care..

https://www.nice.org.uk/guidance/cg161/chapter/1-recommendations lays out NICE guidelines on falls prevention and management in older people.

https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/366104/43 380 23902777 Care Act Book.pdf Outlines the Care Act 2014 and the duty of Local Authorities and their health partners to Prevent, Delay and Reduce the need for on-going care and support.

# **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

# Cost:

Sitting & Crisis Hours Service		
Sitting Service	£70,000	
Crisis Response Service	£94,000	
Total	£164,000	

#### Benefit:

Sitting & Crisis Hours Service Benefits			
Area of activity	Number reduced	Unit cost	Total
	by		
Ambulance Conveyance	500	£154	£77,000
ED Attendances	500	£109	£54,500
Non Elective Admissions	350	£447	£156,450
	Total Savings for Scheme		£287,950

#### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

A small team of sitters would need to be recruited by "Be Independent". Payment would be on a "per episode" basis. There would also need to be a dedicated care response team employed by the domiciliary care agency provider who takes on the "crisis hours" element of the service. There would be an expectation that the care agency would need at least some of the care hours guaranteed to ensure that there is care staff time available when required.

Be Independent would recruit a team of relief staff who would agree to be called at short notice to provide overnight or short term support. These staff would only be paid as and when they were called to work.

The outcome that we would seek is to ensure elderly customers who have suffered a fall or experienced a similar episode at home to have access to low level reassurance and support to help them regain their confidence at home.

The provision of information regarding services to contact rather than the NHS services will also reduce the pressure on out of hours GP services and the ambulance service.

The deliverable benefits of this scheme include at least 1 non elective acute admission per day (365 annually).

#### Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

To ensure that the outcomes of this service are actually helping to reduce the need for admissions to acute and short term residential/ nursing care, we will agree a complete suite of management monitoring data that will include, but not be limited to:

- Details of service users (Name, Address, Date of Birth, NHS No)
- Dates & times of activations.
- No & type of service activations (i.e. sitting or crisis hours).
- Amount of hours used per incident
- Referral source
- Presenting needs
- No of staff employed on each incident
- Outcome at the end of service

# Referrals onto which other services

# What are the key success factors for implementation of this scheme?

Clear eligibility criteria.

Awareness of all referrers of the service and how to access it.

Good coordination between ambulance control room/social care out-of ours service/GP out of hours service, Be Independent control room out-of-hours & care providers supervisors/ managers..

Good coordination between proposed new single point of access, "Crisis Hours" care provider(s) and Be Independent control room in normal daytime hours.

Clarity about 7-day working arrangements.

Very clear arrangements for liaison with social care to ensure that assessment can be prioritised for any of these residents who appear to be in need of on-going social care, including those not currently in receipt of such care.

Further reduction in the number of non- elective admissions to acute care. An increase in number of people who can have their presenting crisis dealt with by an early intervention with long term social & health care &/or support either prevented all together, delayed or reduced.

Demand management processes to ensure scheme is used appropriately and costs do not escalate.

# **Annex H - Whole Systems Review**

For more detail on how to complete this template, please refer to the Technical Guidance

#### Scheme name:

Whole Systems Review of Community Health & Social Care Services

What is the strategic objective of this scheme?

To carry out a joint review on the community based services that are at present commissioned by the Vale of York CCG and the City of York Health & Wellbeing Directorate.

Working within an integrated Health & Social Care commissioning structure we will design the structures needed to provide a truly joined up transitional care and support pathway that provides support and care commensurate with the needs of the individual with identified needs, as well as their carers, delivered as close to home as possible.

As well as joining up and integrating community services to reflect the aims & objectives of the Better Care Fund, the services included in this review will be designed to conform with the aims of Prevent, Delay and Reduce (the need for care and support services) laid out in the Care Act 2014.

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Whole System Review will be carried out in an integrated way to ensure that the community services across health, social care and social housing are joined in a way that provides a coherent transitional care & support pathway for the patient/ service user, that is efficient, effective and avoids duplication of any elements of the pathway. The scope of the review will include:

- Reablement: National evidence (CSED, SCIE, and DoH) demonstrates that
  well delivered reablement services do improve health and wellbeing and have
  the potential to reduce the size and cost of long term packages of care
  through promoting independence and the regaining of skills needs to carry out
  tasks associated with daily living. we need to develop an integrated
  reablement service that can help to;
  - reduce delayed transfers of care,
  - prevent or reduce the need for social care packages,
  - provide therapy and reablement assistant/carer support as part of the same package.
  - reduce the incidence of readmission to acute care

- reduce the number of admissions to long term residential/nursing care.
- **Dementia Step Up & Step Down Beds**: There will be an increasing need to provide elements of the transitional care & support pathway that are appropriate and needed by people with dementia and their carer(s). The step up and down beds are a way to support a person with dementia and/or their carer(s) during a short term crisis episode in order to:
  - Avoid the need for an admission to acute care. Non dementia specific
    hospitals can be confusing to someone with dementia, so exacerbating
    the episode of crisis. There is also the real possibility of the person
    with dementia disrupting the smooth running of an acute ward, as well
    as disturbing other patients.
  - Support the carer(s) in times of crisis, or during difficult periods, when
    they feel unable to cope. Research has shown that carers that feel
    supported and able to access respite and "sitting" type services feel
    able to carry on providing the support required to keep the cared for
    person in the community for longer.
  - To support early supported discharge from acute beds and prevent delayed transfers of care episodes due to lack of dementia appropriate care being available in a community setting.
- Step up & Step Down Beds; As part of any transitional care & support pathway there must be an availability of short term residential beds that can work in a re-enabling way in order to:
  - Support people (without a medical need to be in hospital) being stepped down from an acute bed, who are not quite ready to return home for whatever reason.
  - Help people regain confidence to carry on living in their own homes by regaining the skills and activities of daily living, such as food preparation, washing, dressing, moving etc.
  - Reduce the number of admissions to acute care by allowing the stepping up to a residential bed when there is no medical need for admission to a hospital bed.
- Falls & Lifting Service; falls are by far the largest reason for people over 65 years to be conveyed and admitted to hospital. Falls also have a detrimental effect on the general health and wellbeing of a large number of older people,

eroding confidence in their own ability to remain independent and in their own homes, as well as being the leading cause of fractures (especially hip) in those over 60. NICE Guidance 161 states that all people over 65 have a 30% chance of falling each year, this rises to a 50% chance of a fall each year in those over 80. In order to make a positive difference to the older population of York we need to ensure that there is an integrated vision and adequate services in place to prevent falls and to limit the damage caused by falls wherever possible. An integrated falls management service coupled with a dedicated lifting service is recommended in the NICE guidelines in order to;

- Reduce the number, as well as the damaging effects of falls in older people. By adopting a multi factorial risk assessment and implementing appropriate prevention and protection measures.
- Reduce the number of emergency ambulance call outs attending older people who fall through the use of a dedicated falls lifting & assessment service. Supporting the UCPs to deal with older fallers.
- Reduce the number of older fallers who are conveyed to accident and emergency departments, as well as reducing the number of older people admitted to hospital following a fall.
- Safely Home Service: Older and vulnerable adults, especially those over 85 that are discharged directly to their own homes from hospital are at a greater than average risk of readmission to an acute setting through a variety of factors such as, falls, non-compliance with medicine treatment regimes and the temporary loss of daily living skills often brought about by the inactivity inherent in a hospital stay. The Safely Home Service is designed to;
  - Engage with the potential service user whilst they are still in the acute bed to explain the services they offer. If the patient/service user is suitable and wishes to engage with the services then they can begin to be familiarised with appropriate pieces of technology such as automatic medication dispensers prior to discharge. Experience has shown that familiarity with the equipment aids the safe transition home and into sustainable routines.
  - Reduce the incidence of delayed discharges, and delayed transfers of care from acute hospital beds.
  - Ensure that the home environment is safe and suitable for the service user to remain with an appropriate level of care and technological support. This will be done by initial visits on discharge as well as follow up phone calls/ visits, at the 3 days, 1 week, 2 weeks, 4 weeks & 6 week post discharge points.

- Community Equipment Provision; Low level and simple equipment known as Simple Aids to Daily Living (SADLs) such as walking aids, bath boards, grab rails and raised toilet seats are vital elements in ensuring the continued independence and safety of a large number of older people both with and without mainstream packages of health or social care. The larger and generally more expensive Complex Aids to Daily Living (CADLs) include more specialist items such as bespoke seating solutions and mobile hoists etc. The effective and efficient provision of community equipment is vital to the safe discharge of patients from hospital as well as being a main cornerstone of any effective offering of prevention services within a community setting. The Community Equipment Service will:
  - Support the prevention agenda.
  - Aid safe and timely hospital discharge through the speedy provision of equipment available 7 days a week.
  - Support the journey through the transitional care and support pathway both upwards from the community through step up to acute care, and down from acute through reablement beds and domiciliary based reablement services onto independent living or the minimum support needed to remain independent.
  - Operate in an efficient manner, ensuring that procurement of equipment and service is carried out in a manner that represents best value for money
  - Have the facility to provide SADLs such as walking aids etc direct to the public as required.
- enabling them to remain independent and living in the community. The adaptations provided range from relatively simple and inexpensive items such as grab rails and bannister rails, through to more complex and expensive projects such as level access wet rooms and rising ramps to raised front doors etc. The original funding for these adaptations comes to the council from the Disabled Facilities Grant (DFG). The amount of DFG has not matched the growing demand both in the higher numbers of older people, but more specifically the increasing number of people that are choosing to remain in their own homes with serious and limiting long term conditions. In order to ensure that the adaptations service can continue to deliver services in an acceptable time frame without developing long waiting lists, City of York Council have instigated a top up to the DFG grant to allow the service to keep

pace with growing demand.

- **Telecare & Assistive Technology**; The DoH Whole Systems Demonstrator study has provided evidence that Telecare when properly used and integrated with other "hands on" health and social care support and services, can deliver;
  - Reductions in non-elective admissions to acute care.
  - Delay admission to long term residential/nursing care.
  - Reduce the number and size of domiciliary care packages.
  - Support informal carers to carry the caring role for longer.
  - Increase the health & wellbeing of the service user.
  - Reduce the number of and negative consequences of falls.

CYC presently commission a Telecare service with Be Independent.

This service provides community alarm "pendant "services to approximately 2,900 older people in the city. Of these around 300 also have wider Telecare equipment packages such as, heat detectors, door monitors, automated pill dispensers, bed occupancy monitors etc. Arguably the most important aspect of the Telecare service is the response once an alarm is activated. The York be independent service operates a 24 visiting response service that can reach any service user within 1 hour of the alarm being received.

- ED Diversion Service; In order to provide the nationally mandated 7 day working across the health and social care economy in York, we have arranged extra capacity within the existing Rapid Assessment Team (RATS) based in the York Teaching Hospital Foundation Trust (YTHFT) building. The RATS team is multi-disciplinary and includes Social Workers as well as Occupational and Physiotherapists. They presently work 08.30 to 18.00 hours Monday to Friday only. The extension of the hours under this scheme will see the service operate from 08:00 hours to 20:00 hours 7 days a week. The social worker will work from 11:00 to 20:00 hours on Saturdays and Sundays. The main function of the RATS team is to take people from the Emergency Department that have no real medical need to be admitted to an acute bed, but who are likely to require some support to return home safely. The RATS team are capable of carrying out a basic assessment of needs and then referring the person into a service appropriate to their needs (home care, reablement etc). The service supports several outcomes and KPIs including:
  - Reducing the number of non- elective admissions to hospital
  - Maintaining a smooth patient flow through ED

#### The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Currently the majority of the projects above are commissioned by the City of York Health and Wellbeing directorate. There is also significant funding from the Vale of York CCG to support the community services offer.

Taking these schemes forward there will be an integrated commissioning approach over the medium to longer term with VoY CCG and CYC planning, commissioning and delivering these services jointly to provide the best community support and care offer possible for the people of York.

#### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence in favour of reablement including positive impact on hospital admissions/readmissions (from policy and performance).

**Local:** Study commissioned by Social Policy Research Unit from University of York Home Care Reablement Services: Investigating the longer-term impacts

here: http://php.york.ac.uk/inst/spru/pubs/1882/

as well as at SCIE here; <a href="http://www.scie.org.uk/publications/ataglance/ataglance52.asp">http://www.scie.org.uk/publications/ataglance/ataglance52.asp</a>

http://www.scie.org.uk/publications/briefings/files/briefing36.pdf

Detail on the rise in dementia diagnosis & the efficacy of specialist dementia intermediate care services can be found at:

.

Quality Outcomes Framework, Recorded Dementia Diagnoses - 2013-14. :http://www.rcn.org.uk/development/practice/dementia

Step Up Step down beds are discussed in the National Audit of Intermediate Care Services here:

http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care.php

Real benefits of a lifting service for older people can be found on page 7 of:

http://www.vitaline.org.uk/Annual%20Report%202013.pdf

The NICE guidance for falls management & pathways is at:

https://www.nice.org.uk/guidance/cg161

Evidence on the effectiveness of Safely Home type Services can be found here: <a href="http://www.housinglin.org.uk/\_library/Resources/Housing/H2H/H2Hfactsheet1.pdf">http://www.housinglin.org.uk/\_library/Resources/Housing/H2H/H2Hfactsheet1.pdf</a>

#### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

#### Expenditure Plan

Whole Systems Review Costs				
	2014/15	2015/16		
	£577,000	£4,313,000		

#### Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Area of activity	Number reduced by
Ambulance Conveyance	2,600
ED Attendances	2,600
Length of Stay (Days)	3,650
Delayed Transfers of	3,232
Care(Days)	

#### Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcome of this scheme will be measured primarily in how effectively we can integrate the services described above between health and social care, and how we can agree joint targets that can support the longer term integration agenda.

Specific success measures and KPIs will of course be jointly identified for each of the different projects/ services.

#### What are the key success factors for implementation of this scheme?

This scheme will be considered successful if we can demonstrate an integrated and truly joined up vision, planning and delivery process for the above projects. Working together and with partners to ensure the best possible transitional care and support pathway across the City of York that is effective in ensuring access to the right support and services as close to home as possible, whilst avoiding unnecessary duplication of any service elements.



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## **Glossary**

BCF - Better Care Fund

CCG - NHS Vale of York Clinical Commissioning Group

CTB - Collaborative Transformation Board

CYC - City of York Council

HWB - Health and Wellbeing Board

JCE – Joint Commissioning Executive

JDG – Joint Delivery Group

NEL - Non-Elective Admission

PfP - Payments for Performance





#### **Health and Wellbeing Board**

15 July 2015

Report of the Director of Adult Social Care

#### **Performance Update July 2015**

#### **Summary**

1. This report asks the members of the Health and Wellbeing Board to note the latest available performance figures for the indicators agreed in December 2014.

#### **Background**

- 2. As part of the refresh of the Joint Health and Wellbeing Strategy a scorecard of representative indicators was agreed at the December 2014 meeting of the Health and Wellbeing. The data attached at Annex A represent the latest published data for these indicators.
- 3. For the adult social care data that forms part of the national Adult Social Care Outcomes Framework (ASCOF) framework, the year-end figures for 2014-15 are awaiting validation from the Health and Social Care Information Centre (HSCIC) and therefore we have used 2013-14 figures until final validated figures are available. This is likely to be towards the end of this year, when national and regional comparator figures will also become available.

#### Consultation

4. Not applicable.

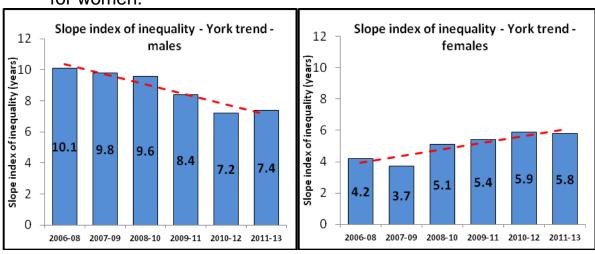
## **Options**

5. There are no specific options for board members to consider.

## **Analysis**

6. Analysis of the data shows that York has better outcomes compared with the national average for the following indicators:

- A higher level of satisfaction with care and support amongst those using services
- A higher proportion of adults in contact with secondary mental health services living independently.
- Fewer children in reception year who are obese
- Fewer children in year 6 who are obese.
- 7. York has worse outcomes than the national average for the following indicators.
  - A higher rate of permanent admissions (65+) to residential care
  - A higher rate of delayed transfers of care from hospital
  - A higher rate of bed days in secondary mental health care hospitals and a lower rate of referrals to Improving Access to Psychological Therapies (IAPT) services.
  - A lower proportion of adults with a learning disability who have had a health check.
- 8. For the remainder of the indicators York has similar outcomes to the national average. For indicators relating to inequalities e.g. the gap in life expectancy between the most and least deprived residents in York, benchmarking against the national average is not always meaningful. The intention of these indicators is to monitor progress made towards reducing inequalities within York over a period of time.
- 9. The charts below show that the gap in life expectancy in York is higher for men; however the general trend over the last seven years is that the gap is getting smaller for men but slightly bigger for women.



#### Council Plan 2011-15

10. This report is directly linked to the Council Plan 2011-15 priority entitled "Protect vulnerable people".

## **Implications**

11. **Financial** – There are no financial implications attached to the monitoring of the latest performance information.

**Equalities** – The attached annex and the report is intended to promote awareness of health inequalities.

Other - There are no other known implications.

#### **Risk Management**

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

#### Recommendations

13. Members of the Health and Wellbeing Board are asked to note the latest performance data for the suite of indicators agreed.

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

#### **Contact Details**

Author:	Chief Officer Responsible for the report:			
Helena Nowell Strategic Support Manager (Adults and Public Health)	Guy van Dichele			
01904 551746				
	Report Date 30.06.2015 Approved			
Specialist Implications Offi	icer(s) None.			
Wards Affected: List wards	s or tick box to indicate all $\overline{\qquad}$			
For further information ple	ase contact the author of the report			
Background Papers:	сельно по синно се инстерент			
None				
Annovoe				

Annex A – Health and Wellbeing Board Scorecard July 2015



ANNEX A - Health and Wellbeing Board Scorecard July 2015

Category	No.	Indicator name	York No.	York Value	England average	Time period	York Benchmark v England
Older People/ Better Care Fund 4	1	Permanent admissions (65+) to residential care per 100,000.	275	768	651	2013/14	worse
	2	% of 65+ at home 91 days after discharge into re-ablement / rehab	55	81.0%	82.5%	2013/14	similar
	3	Delayed transfers of care (days) from hospital per 100,000. 18+	29	17.6	9.6	2013/14	worse
	4	Overall satisfaction of people who use services with their care & support	3175	67.4%	64.8%	2013/14	better
	5	Injuries due to falls (65+) per 100,000	779	1,983	2,064	2013-14	similar

	6	Emergency admissions for acute conditions not normally requiring admission, per 100,000	4,242	1,231	1,181	2014-15 Q2	similar
	7	Slope index of inequality in life expectancy at birth - males	n/a	7.4	9.1	2011-13	n/a
	8	Slope index of inequality in life expectancy at birth - females	n/a	5.8	6.9	2011-13	n/a
Tackling Deprivation & Health Inequalities	9	Potential years of life lost from causes amenable to healthcare per 100,000.	3,746 yrs	2,672	2,809	2013	similar
	10	Gap in smoking prevalence between most and least deprived GP practices		16.1%	n/a	2013-14	n/a

	11	No. of bed days in secondary mental health care hospitals per 100,000	18,605	6,567	5,007	2014-15 Q3	worse
	12	Gap in employment rate for mental health clients and the overall rate	n/a	62.9%	64.7%	2013-14	similar
Mental Health & Learning Disabilities	13	% of adults with a learning disability having a GP health check	343	34.6%	44.2%	2013-14	worse
	14	IAPT Referrals	705	249	740	2014-15 Q3	worse
	15	IAPT reliable recovery rate	125	61.0%	62.5%	2014-15 Q3	similar
	16	% of adults using secondary mental health services living independently	n/a	68.7%	60.8%	2013-14	better
Children &	17	% school children in reception classified as obese	150	7.82%	9.48%	2013-14	better
Young People	18	% school children in year 6 classified as obese	257	15.35%	19.09%	2013-14	better

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	Under 18					
19	conception	64	21.6	24.3	2013	simila
	rate					
	Hospital					
	admissions as					
20	a result of self	189	401.2	412.1	2013-14	simila
	harm (10-24					
	years)					
	% of young					
	people not in					
21	education,	260	4.7%	4.7%	2014	simila
	employment					
	or training					
	Child					
22	mortality rate	4	10.8	11.9	2011-13	simila
	(1-17 years)					

## Glossary

ASCOF – Adult Social Care Outcomes Framework

HSCIC - Health and Social Care Information Centre

IAPT- Improving Access to Psychological Therapies





#### **Health and Wellbeing Board**

15 July 2015

Report of the Health and Wellbeing Partnerships Co-ordinator

#### Joint Health and Wellbeing Strategy Refresh

#### **Summary**

 This report asks the Health and Wellbeing Board to approve the process and timescales for the Joint Health and Wellbeing Strategy Refresh.

#### **Background**

- 2. The current Joint Health and Wellbeing Strategy was approved by the Health and Wellbeing Board in April 2013; it runs until 2016.
- 3. It contains five key themes namely:
  - Making York a great place for older people to live
  - Reducing health inequalities
  - Improving mental health and intervening early
  - Enabling all children and young people to have the best start in life
  - Creating a financially sustainable local health and wellbeing system
- 4. In addition to the above there were also a number of cross-cutting actions. Over the past two and a half years work has been progressing against delivery of the Strategy and the Health and Wellbeing Board have received update reports from their substructure boards detailing progress made.
- 5. The Board will be receiving the Health and Wellbeing Board (HWB) Annual Report as part of the October 2015 meeting which will detail a final summary of progress made against the current Strategy.

#### Main/Key Issues to be Considered

- 6. It would be fair to say that the current Joint Health and Wellbeing strategy is aspirational, wide reaching and still very pertinent to health and wellbeing issues in York. The Strategy was lightly refreshed at the end of 2014 to remove completed actions and to reflect changes to the national and broader health picture (such as those around the Better Care Fund and the Care Act). Any new Strategy will need to be mindful and responsive to the fluidity of the health and wellbeing agenda.
- 7. Whilst progress has been made against the current Joint Health and Wellbeing Strategy, recent findings from a series of 1-2-1 meetings with Health and Wellbeing Board members have highlighted the feeling that measurable progress against delivery has been slow.
- 8. There is a general feeling through the 1-2-1 interviews that the Board needs to renew its focus on the Strategy and the HWBB sub-structures to support delivery.

#### **Themes**

- 9. From all the Health and Wellbeing Board members that took part in the 1-2-1 interviews, three distinct but broad themes have been identified as the key challenges going forward for the Board; these are:
  - Finance
  - Integration of heath and social care (and wider wellbeing)
  - Prevention and Early Intervention
- 10. These are quite clearly work streams that impact on the whole system and are believed to be, by the Board members interviewed, those that are of the most strategic importance. At a national level these are reflected in the NHS Five Year Forward View<sup>1</sup> and the Association of Directors of Adult Social Services (ADASS) Distinctive, Valued Personal<sup>2</sup> report.
- 11. The Strategy refresh will also need to use the evidence contained within the Joint Strategic Needs Assessment (JSNA).

<sup>1</sup> http://www.england.nhs.uk/ourwork/futurenhs/

<sup>&</sup>lt;sup>2</sup> http://www.adass.org.uk/adass-paper-distinctive-valued-personal-why-social-care-matters/

Some of the key themes emerging from the JSNA are set out below and fit well with the themes identified above.

#### What is the JSNA telling us?

- 12. <u>An increasingly aging population -</u> The population growth of doubling of the over 75s we are about to experience. Not an issue if they are fit and well, but an issue if they have multiple health needs.
- 13. The large numbers of fit and healthy and sexually active young adult They bring a health dividend to the city, with higher levels of physical activity, but also some risk taking too. We therefore need to support their wiser choices and make it more difficult to make poor choices.
- 14. <u>Differences in life expectancy</u> The 'tale of two cities', where the bottom 20% have different life experiences and outcomes from the remaining 80% i.e. premature mortality. We therefore need to put in extra efforts at helping the poorest to catch-up.
- 15. In order to address these there will be a need:
  - further integration across all information systems where this improves outcomes for people
  - to encourage to take greater responsibility for their health throughout life and before reaching older age by being more active, more alert, engaged and contributing to society
  - to aspire to get equal outcomes for all elements of society i.e. address the "inverse care law".
  - to accept the limits of the effectiveness of modern medicine, and move to a more self-care and self-management model of partnership and co-production

#### Process and timescales

16. Dependent on the option chosen by the Board there is likely to be a period of extensive engagement and consultation around the formulation of the new Joint Health and Wellbeing Strategy.

This will involve opportunities for a wide range of stakeholders and the public to give their views on what should be included and how it should be delivered. The following skeleton timetable is put forward to manage this process:

- July –August 2015: Preparation of consultation/engagement materials; including a desktop exercise on learning from what other local authorities are doing
- September October 2015: Consultation and engagement with a wide range of stakeholders and members of the public. This is likely to include a number of events such as visits to individual groups and organisations, presentations, surveys and at least one public event hosted by the Health and Wellbeing Board
- November 2015: Collation and interpretation of the information received from the various events and meetings
- December 2015: Preparation of first draft of the new Joint Health and Wellbeing Strategy
- January 2016 -Draft Strategy presented to the Board
- February 2016: Amendments and revisions to the Draft Strategy
- March/April 2016 Final Strategy presented to the Board for approval

#### Consultation

17. An extensive consultation and engagement programme will take place as part of three of the four options put forward in the paragraphs below.

#### **Options**

- 18. Option A Retain the current strategy themes but re-engage and consult on the specific actions that need to sit underneath each of these; including how these should be delivered;
- 19. **Option B** Develop a more streamlined Joint Health and Wellbeing Strategy using the broad headings of the three themes identified above (finance, integration, prevention and early intervention)

- 20. **Option C –** Extend the current strategy for another 3 years without making any further changes
- 21. **Option D** Develop a new set of themes for consultation and engagement
- 22. In addition to this the Board are asked to nominate a lead to work with officers on Strategy development and to champion this work.

#### **Analysis**

- 23. **Option A** this would still require an extensive programme of engagement and consultation with stakeholders and the public but it may not lead to many new/changed actions emerging. However it could lead to identification of a new way of delivering against those actions.
- 24. Option B- this would be the preferred option as members of the Board have already, through their 1-2-1 interviews, identified the three themes as being the challenges that the Board need to concentrate on. It is therefore suggested that these are used as a basis for consultation and engagement to help shape the next Joint Health and Wellbeing Strategy from 2016. In comparison to the current Strategy which predominantly focuses on specific communities/service areas (older people, children, mental health) the themes sets out above encompass and impact on <u>all</u> services and communities across the city.
- 25. Using these broad themes as headings it is likely that a more streamlined Strategy will be produced, but a Strategy that would readily allow for either existing or new strategies and action plans to dovetail into it including the children and young people's plan (currently under development for 2016) and other appropriate operational plans.
- 26. Option C Whilst this would be the least resource intensive of the options it is not clear how it would address some of the challenges that Board members have raised via their 1-2-1 interviews or how it would respond to whole system change and some of the bigger themes the health and social care system will need to consider over the coming years.
- 27. **Option D** If the currently identified themes are not considered suitable for consultation and engagement the Board will need to meet to discuss appropriate strategic priorities to form the basis of

a new Strategy. This will lead to a delay in the outlined timetable for this work.

#### **Strategic/Operational Plans**

28. This item represents the revision of the statutory Joint Health and Wellbeing Strategy.

#### **Implications**

29. As part of the Strategy refresh process actions chosen for inclusion will be individually assessed for impact once they are known and these will be reported to the Health and Wellbeing Board at that time.

#### **Risk Management**

30. There is a risk associated with not having a current Joint Health and Wellbeing Strategy as this is a statutory duty for the Board set out in the Health and Social Care Act 2012.

#### Recommendations

- 31. The Health and Wellbeing Board are asked to consider:
  - Approving Option B to allow the refresh process to start immediately
  - Identifying a lead Board Member to work with officers and to champion this work

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

#### **Contact Details**

Author: Chief Officer Responsible for the

report:

Tracy Wallis Guy Van Dichele

Health and Wellbeing Partnerships Co-ordinator

Interim Director of Adult Social Care

Partnerships Co-ordinator Tel: 01904 551714

Report Approved **Date** 30.06.2015

Specialist Implications Officer(s) None

Wards Affected:

All 🔽

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

Joint Strategic Needs Assessment <a href="http://www.healthyork.org/">http://www.healthyork.org/</a>

#### **Annexes**

None



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## Glossary

ADASS - Association of Directors of Adult Social Services

HWB - Health and Wellbeing Board

JSNA – Joint Strategic Needs Assessment





#### **Health and Wellbeing Board**

15 July 2015

Report of the Chair of the Health and Wellbeing Board

# Governance Arrangements for the Heath and Wellbeing Board Summary

1. This report is for information only and provides members of the Health and Wellbeing Board with an update and a reminder around their current governance arrangements.

#### **Background**

- 2. The Health and Wellbeing Board was formally established as a statutory committee of the council in April 2013, in accordance with the legislation passed as the Health and Social Care Act 2012.
  - 3. The purpose of the Health and Wellbeing Board is to:
    - Improve health and wellbeing of the locality via strategic influence over commissioning decisions across health, public health and social care
    - Ensure stronger democratic legitimacy and involvement
    - Strengthen working relationships between health and social care, and
    - Encourage the development of more integrated commissioning of services

#### And to produce:

- A Joint Health and Wellbeing Strategy
- The Joint Strategic Needs Assessment
- A Pharmaceutical Needs Assessment (from April 2015)

#### Main/Key Issues to be Considered

- 4. Under the Terms of Reference for the Board the Chair of the Health and Wellbeing Boards is 'required to hold a named delegate list for board representatives including deputies'.
- 5. It is a requirement for all Board members and their substitutes to have been formally appointed by Council and to have all completed a register of interest form. Partnership members are reminded that they may only send one of their nominated and formally appointed deputies, as these are the ones where Democratic Services have a recorded register of interest form completed and publically available.
- 6. Board members are asked to notify either Democratic Services or the Health and Wellbeing Partnership Co-ordinator if they wish to make any changes to their deputies.

#### **Executive Functions**

- 7. Currently the Health and Wellbeing Board only has the remit to set the vision and direction of travel for health, wellbeing and social care in the City. In order for the Board to fulfil some of its commitments around pooled budgets and integrated commissioning it will be necessary to request that Executive delegate some further functions to the Board.
- 8. Work will commence on how this will be done within the next few months with a view to taking a paper to Executive before the end of the year. Board members will be kept fully informed of progress against this.

#### Consultation

9. As there have been no changes to the Terms of Reference no consultation has been required. Consultation on delegating any required Executive functions to the Board will take place later in the year.

#### **Options**

10. This report is for information only and as such there are no specific options for the Board to consider.

#### **Analysis**

11. Not applicable.

#### **Strategic/Operational Plans**

12. There is a legal requirement for the Health and Wellbeing Board to have a robust Terms of Reference in place.

#### **Implications**

13. There are no known implications associated with the recommendations in this report.

#### **Risk Management**

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

#### Recommendations

15. Members of the Board are asked to note this report.

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

#### **Contact Details**

Author:	Chief Officer Resport:	onsible for the
Tracy Wallis	Guy Van Dichele	
Health and Wellbeing Partnership Co-ordinator	Interim Director of A	dult Social Care
Tel: 01904 551714	Report Approved	<b>Date</b> 6 July 2015
<b>Specialist Implications Off Wards Affected:</b>	icer(s) None	All 🔽

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

Health and Wellbeing Board Terms of Reference <a href="https://www.york.gov.uk/downloads/file/857/health\_and\_wellbeing\_board">https://www.york.gov.uk/downloads/file/857/health\_and\_wellbeing\_board terms of reference</a>

#### Annexes

None





#### **Health and Wellbeing Board**

15 July 2015

Report of the Health and Wellbeing Board Healthwatch York Representative

#### **Healthwatch York Reports**

#### Summary

- 1. This report asks Health and Wellbeing Board members to receive two new reports from Healthwatch York namely:
  - Who's Who in Health and Social Care? (Annex A)
  - Consistency and Confidence in Patient Led Assessments of the Care Environment (Annex B)

#### **Background**

- 2. Healthwatch York produce several reports a year arising from work undertaken as part of their annual work programme. These reports are presented to the Health and Wellbeing Board for consideration.
- 3. The usual protocol adopted for Health and Wellbeing Board is to receive these reports initially and then at a future meeting discuss the recommendations within them in more detail.
- 4. A further report will be presented to the Board in relation to the two reports detailed above at the October 2015 meeting.

## Main/Key Issues to be Considered

5. For each of the reports listed above there will be a summary of work being undertaken to respond to the recommendations within them and this will be presented at the October meeting.

#### Consultation

6. There has been no consultation needed to produce this information report for the Board.

Healthwatch York has consulted extensively to produce the reports and details of this are included within each of their reports at Annexes A and B.

#### **Options**

7. This report is for information only and as such there are no specific options for members of the Board to consider.

#### **Analysis**

8. Not applicable.

#### Strategic/Operational Plans

9. The work from Healthwatch contributes towards a number of the themes, priorities and actions contained within the current Joint Health and Wellbeing Strategy.

#### **Implications**

10. There are no implications associated with the recommendations set out within this report. However there may be implications associated with the recommendations in the two Healthwatch York reports presented today. information regarding these will be included within the report to the Board in October 2015.

#### **Risk Management**

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

#### Recommendations

12. Health and Wellbeing Board are asked to receive the reports from Healthwatch York.

Reason: To keep members of the Board up to date regarding the work of Healthwatch York.

#### **Contact Details**

Author:	Chief Officer Responsible for the
Tue en Mallie	report:
Tracy Wallis	Guy Van Dichele
Health and Wellbeing	Interim Director of Adult Social Services
Partnerships Co-ordinator	
Tel: 01904 551714	Report Date 6 July 2015 Approved

**Specialist Implications Officer(s)** None *Tel No.* 

Wards Affected: All

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

None

#### **Annexes**

Annex A - Who's Who in Health and Social Care

**Annex B** - Consistency and Confidence in Patient Led Assessments of the Care Environment





# Who's Who in Health and Social Care



**April 2015** 

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#### Who's Who in Health and Social Care

This report looks at how people navigate the health and social care system in York. It sets out how we identified this as an area to investigate and what we have done in response. It makes recommendations about how to address identified issues and highlights examples of good practice.

## Why Healthwatch York decided to look at this issue

There have been many changes to health and social care over the past few years. The Health and Social Care Act 2012 made a number of changes to the way that the NHS in England is organised. The most radical changes were:

- Primary Care Trusts, which had commissioned (planned and bought) health services, were replaced by Clinical Commissioning Groups (CCGs). CCGs now control the majority of the NHS budget including acute hospital services and mental health services.
- NHS England was set up to commission primary care services (GPs, dentists, opticians, pharmacists and NHS 111).and specialist services (for conditions which affect relatively small numbers of people such as complex heart services, rare conditions and burn care).
- Public Health England and local Health and Wellbeing Boards were set up to protect and improve health and wellbeing and to address health inequalities.

In Healthwatch York's 2013 work plan survey (see Appendix 1) people were asked to tell us what should be on our work plan. The survey also asked questions to find out:

- How aware people in York are of the recent changes in health and social care and how much these matter
- How much people know about making complaints, raising concerns, making comments and compliments

 Attitudes to health and wellbeing – how people feel about taking care of their own health

The responses to these questions are summarised in Appendix 2, together with the comments people made.

People were asked whether Healthwatch York should do anything to help explain who's who in health and social care and who does what since the Health and Social Care Act came into force.

Of the ninety six people who responded to our survey, sixty eight (70%) told us that it was important for Healthwatch York to help explain who's who and who does what. Responses showed that, following all the recent changes to health and social care, the majority of the people who responded to the survey felt it important to know:

- Which organisations are involved in commissioning and providing services
- What services are available
- How they can access services
- Who to complain to if things don't go well

The survey responses showed that sometimes people really don't know where to go for help. There is a lot of information available – both online and in paper form, but it can be bewildering.

So many changes have led to a great deal of confusion and a lot of people just switch off

We need information in a language and style we can understand

For a lot of people finding out what services are on offer is the hardest part



I can't keep up with the constant changes in every field



In addition to the responses to our survey, Healthwatch York received a number of comments and questions from the public which indicated that people don't always have the information they need. Here are some examples:

- Are there still well woman clinics in York? Do all GPs have them?
- How do I find an NHS dentist in York?
- Where do you go for a pharmacy 'out of hours'?
- When do I ring 111?
- Does PALS (Patient and Advice Liaison Service) still exist at York Hospital? Has the name changed?
- My child has autism where do I go for additional support?
- I went to A & E with a minor health issue. I knew I shouldn't go there but there is no choice there is no walk in centre in York.
- What local services are available to disabled people? I feel my GP should be able to give me details of these.

Healthwatch York is aware there is ongoing work both locally and nationally to 'map' services and provide information about health and social care services. We wanted to find out more about what information resources are available, how useful these are to people, and where there are gaps in the information available. We also wanted to find out whether information is communicated in ways which are easily understandable to everyone.



#### What we did to find out more

#### We looked at some of the resources available

When people are trying to navigate through the health and social care system there are a variety of ways people can find information about the services available. A number of factors influence how people get information and where they get it from: whether they have internet access, whether they are able to use the internet effectively, their level of literacy, places they go where leaflets and directories might be available.

We looked at some of the available resources and collected examples of the following to show to people and get feedback from them:

- Online resources
- Directories and A to Z lists
- Leaflets/factsheets

#### **Online resources**

## (1) The King's Fund animation

The King's Fund is an independent charity working to improve health and health care in England. One of its aims is to promote understanding of the health and social care system. Following the changes which took place as a result of the Health and Social Care Act 2012, the King's Fund produced an animation called 'An alternative guide to the new NHS in England'. This animation is on the King's Fund website:

<u>www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england</u>

## (2) Connected York

We reviewed the Connected York website which was set up in 2011 by York CVS. It was funded through a Local Area Agreement grant from City of York Council as part of the Better Together for York project. The website is a directory of forums, networks and partnership groups that



are active in York. Connected York was designed to show relationships between groups, as well as details of these groups. Clickable links show that a group has a relationship with another group (or organisation) listed in Connected York:

#### www.connectedyork.org.uk

Connected York has eight themes, one of which is health. We updated the entries in the Health theme to reflect recent changes such as the Vale of York Clinical Commissioning Group, the Health and Wellbeing Board and Healthwatch York.

#### **Directories and A to Z lists**

#### (1) Healthwatch York Health and Social Care Directory

The first issue of the Healthwatch York Health and Social Care Directory was published in December 2013. 11,800 paper copies were distributed throughout York via libraries, GP surgeries and community centres as well as via Healthwatch York. It was also available to download from the Healthwatch York website. By April 2014 we had already received very positive feedback about the directory but we wanted to find out specifically what people had found useful about the directory and whether any information was missing from it, before the second issue was produced. The second issue was published and distributed in January 2015 and is available to download from the Healthwatch York website, or from the Healthwatch York office.

## (2) A to Z listings

York Carers Centre created an A to Z listing of useful groups and an A to Z listing of useful groups for older people. Healthwatch York adapted these listings with the permission of the Carers Centre.

#### Leaflets/factsheets

We gathered together existing examples of leaflets and factsheets from the local area and other areas of the country. These included information produced by organisations who provide and commission (buy) services



as well as organisations who provide advice and support to people who use the services.

We also produced some sample fact sheets as examples of what could be produced.

The full list of all the resources we collected can be found in Appendix 3.

## Focus groups

We decided to hold focus groups to:

- 1) Show people some of the resources currently available
- 2) Capture peoples' views on what information and what format is most useful
- 3) Find out if people felt anything was missing from the information currently available

We held two focus groups at the Priory Street Centre in York. They took place on 9th April 2014 5pm-7pm and 15th April 2014 10am – 12 noon. Four people attended the focus group on 9th April, twelve people attended on 15th April. The groups were led by Healthwatch York staff team members.

## What we found out

We began each of the focus groups with a discussion about what people feel they need to know. People told us they want to know how to:

- Get information, advice and support
- Find services
- Complain / be supported to complain
- Get involved in shaping the design, delivery and review of services
- Go to places where strategic decision making happens
- Be heard

We then asked the focus groups whether the resources we showed them (listed in Appendix 3) were helpful. People looked at all the



resources and their feedback about the resources which generated most comments are summarised below.

#### Feedback on online resources

- (1) King's Fund animation
  - This is a good place to start but it just maps the system. It doesn't help people to navigate their way through it
  - It's useful in spelling out what each organisation does
  - Visual images such as flowcharts and bubble diagrams are very helpful to provide an overview

#### (2) Connected York website

- This kind of website is ideal but it does need to be kept up to date
- I'm really impressed with this.It's useful to see the whole picture
- This should be available via a link from other websites such as City of York Council, NHS Vale of York Clinical Commissioning Group, York Hospital
- It needs updating and keeping up to date
- Where do you go for this information if you aren't online?

#### Feedback on directories and A to Z lists

- (1) Healthwatch York Health and Social Care Directory issue 1, 2014
  - It's excellent as a first level
  - Page numbers would be good
  - How about a CD version?
  - It would be useful to have a page on how to access public meetings and how to navigate the system of public meetings – e.g. can you just turn up, speak, ask questions?
  - Links to useful websites would be helpful
  - It's a very useful document
  - The paper version is useful because not everyone has access to the internet
  - What about including information about organisations, including contact details, possibly in a separate 'pullout'?

- We need an easy read version with symbols to help people understand the information
- It would be useful to include a section on mental health services
- It would be good to have information about how to complain

#### (2) A to Z listings

- These are a good place for people to start.
- Could they be made more visually interesting?
- It's important not to duplicate what's already been done

#### Feedback on leaflets/factsheets

Focus group attendees chose to comment in detail on the following leaflets/factsheets:

- 1) Yorkshire Ambulance Service Choose Well leaflet
  - There is no mention of York Hospital is this leaflet just for North Yorkshire?
  - It should say 'York & North Yorkshire' if it covers the whole area, not just 'North Yorkshire'. Is it supposed to be for York?
  - I'd assume this is not actually for York patients. I'd ask for the leaflet for York
  - I would not know what to do if I was unwell
  - It feels incomplete
  - It's not very accessible
  - This is no use for people who can't drive all the minor injuries units listed are a drive away
  - People end up using A&E as an entry point to services, or for signposting, because it's too hard to get into the system elsewhere
  - Pharmacies could be used to get the 'choose well' message to people. They should have a poster in their window
  - GP surgeries should also have 'Choose Well' information clearly visible when the surgery is closed so you can see what to do
  - The problem is, if you can't get in to see your GP, then you will go to A&E
  - There's nowhere else to go in York. GPs are not accessible 24/7 there is no cover for weekends and evenings
  - After the walk-in centre closed messages were not clear enough –
    is the urgent care centre at the hospital a walk in centre or not?

- This doesn't make it clear when you should go to A&E. It doesn't suggest you can go with broken bones, for example
- Where is mental health in this? What about sexual health?
- Mental health support line no longer covers night. Closure of night support means mental health service users will have to tell their whole tale again as people won't have access to your files (NB: This line has not closed but, due to staffing difficulties, an answer machine message has been used on several occasions)
- We need to know more about what happens if someone is displaying signs of a serious mental health issues. How do staff refer in? What should a concerned member of the public do?
- 2) Guide to Local Health Services in Worcestershire

This leaflet was produced by the three NHS Clinical Commissioning Groups in Worcestershire 2013/14.

- This is really good as it gives some specific examples such as sprain, minor burn, illness or injury that won't go away
- This makes it clear where to go
- There is no mention of mental health
- Good pictorial stuff
- The layout is good, with 6 boxes one for each option
- It includes dental services and sexual health services, which is good
- Something like this should go to every household people could keep it until they need to refer to it

## 3) Fact sheets

- The organisation facts sheets are good what is a CCG etc
- For City of York Council there are lots of agencies within the organisation – adult social care, children's services, public health – do we need a separate factsheet for each?
- 4) Department of Health: NHS Dental Services in England
  - This is a useful leaflet for explaining about treatment costs
  - A national NHS England phone number (03003112233) is given for people having difficulty finding an NHS dentist, as well as the NHS Choices website www.nhs.uk
  - This leaflet does not mention community dental services, who treat people who are unable to get to the surgery because of a disability

or physical or mental health condition. This service is mentioned in the Age UK factsheet 5 Dental Care, but there are no details about how to access the service.

- 5) Maternity and new mum useful information (produced by Healthwatch York)
  - Do the Family Information Service (FIS) have all this information?
  - It needs to have details of support groups for new mums with depression
  - Add Mytime York Support Group <a href="mailto:MyTimeYork@gmail.com">MyTimeYork@gmail.com</a>

## Common themes from the focus groups

#### Deciding which services to use and finding services

When people are deciding which service to use it helps to have real life, practical examples. 'What do I do if?' scenarios are helpful to illustrate what services people need to access. For example:

- What should I do? My baby is ill in the night and I don't have a car. My 5 year old is at home with us both and is fine but my partner is working in Spain this week so I'm home alone with them both.
- What should I do about my mother? She called but really didn't sound like herself and I live a long way away.
- What should I do about my teenager? He's got a long standing mental health condition and seems to be going through an episode of ill health but he thinks he's fine.

Having decided which service to use, people need to know how to find the services easily and quickly. A clear path is needed.



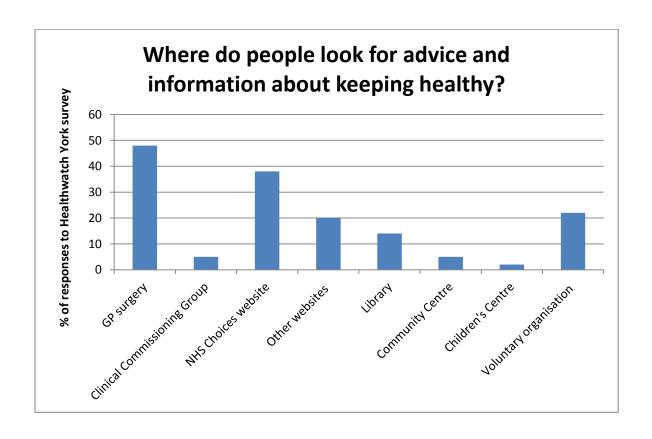
#### Access to information at the right time

People need to find out about services when they really need them – if they have developed worrying symptoms, their child has an excessively high temperature in the middle of the night, a family member's mental health has suddenly declined.

#### Where do people look for information?

For a lot of people the internet is the first place they look but not everyone can do this. Many people see their GP as a gateway to services and want their GP to provide information about voluntary groups and support services.

This response from our focus groups is consistent with the responses to our survey question 'Where do people look for advice and information about keeping healthy?'



#### Picking up leaflets

People are more likely to pick up a leaflet if they feel it is useful and relevant to them. Some leaflets provide more general 'background' information.

For example, while people who have a specific interest in health and social care might find it interesting to read general information about the Care Quality Commission (CQC), most people would just want to know how the organisation could be helpful to them. They might just need to know that they can contact the CQC if they want to give feedback about a service or read the latest inspection report.

#### **Making information accessible**

All leaflets need to be accessible – use as big a font size as possible and use Arial or Century Gothic. Short, clear sentences should be used and jargon and acronyms should be avoided.

## **Public meetings**

People felt they needed more information about public meetings – what they do and how people can get involved. Most people at the focus groups were aware that details of City of York Council's public meetings are available online but not whether they are available elsewhere. There used to be a list of Council meetings outside the Guildhall – is there one outside West Offices now?

People are aware that they can be added to the agenda circulation lists for City of York Council meetings. However, this relies on the public knowing you can do this and people being on email. Although it is possible to pick up copies of papers at meetings, this means people won't have read them in advance. Most of the people who attended the focus groups felt that the Council papers are not accessible – they are too long and too wordy.



#### What information is missing?

People attending the focus groups felt that there is not enough information available about the following topics:

- How to access respite care
- Information about personal health budgets what they are and how to get one
- Information about routes into mental health services
- Complaints processes particularly when more than one organisation is involved. There is no overarching complaints system. Maybe some kind of diagram or flowchart could help?
- How to choose complementary health options such osteopaths, chiropractors, acupuncture.

## Conclusion

This work has revealed that although there are a lot of information resources available people can't always access the information they need. Common problems faced by people trying to access information:

- Information is only available via the internet
- Printed information uses small fonts or fonts which are not easy to read
- Both online and printed information uses language which is not easy to understand such as 'high level' English, acronyms and jargon

Information needs to be communicated in ways which are easily understandable to everyone.

There is a lack of clear practical information to help people decide which service they need and how to access that service. Information is presented in 'categories' such as dental services, mental health services, GP services and hospital services. There is no single definitive source of information which people can refer to in times of illness or crisis.



We know that there are a number of pieces of work going on to 'map' services and we want to work with partners to make sure that information is communicated in ways which are easily understandable to everyone.

There are some examples of good practice which our focus groups praised. These include:

- NHS North Yorkshire and York Community and Mental Health Services: Visiting the dentist if you have Autism
- Worcestershire NHS Clinical Commissioning Groups: Your Guide to Local Health Services in Worcestershire. Is A&E for me?
- York Health and Social Care Directory Issue 1

#### Recommendations

Healthwatch York have made a number of recommendations, based on the feedback we have received.

Recommendation	Recommended to
Make a commitment to developing and maintaining Connected York. Add a link to the Connected York website from the websites of statutory organisations	<ul> <li>Healthwatch York</li> <li>City of York Council</li> <li>NHS Vale of York Commissioning Group</li> <li>York Hospital</li> </ul>
Develop primary care services (GPs, pharmacies, dentists, opticians) as resource centres	<ul><li>NHS Vale of York Clinical Commissioning Group</li><li>NHS England</li></ul>
Make all written information (leaflets, meeting papers etc) as understandable and accessible as possible. Use Healthwatch York's readability group to review leaflets and websites before they are finalised.	All statutory and voluntary organisations



Make an an descript to the Healthwest St. Vand	II. di . d. I. W. I
Make amendments to the Healthwatch York	<ul> <li>Healthwatch York</li> </ul>
Health and Social Care Directory Issue 2 to	(completed January 2015)
include information about mental health	
services and information about how to	
complain.	
Produce a directory as a guide to mental	<ul> <li>Healthwatch York</li> </ul>
health services and support in York.	(completed March 2015)
Review the way(s) in which information is	City of York Council
provided about meetings which are open to	<ul> <li>NHS Vale of York</li> </ul>
the public. This should take into account	Commissioning Group
people who do not have internet access.	<ul> <li>York Hospital</li> </ul>
People need to know what the meeting is,	<ul> <li>Leeds and York</li> </ul>
what the purpose of the meeting is and how	Partnership NHS
the public can be involved.	Foundation Trust
	<ul> <li>Yorkshire Ambulance</li> </ul>
	Service
	<ul> <li>NHS England</li> </ul>
Collectively promote a single 'Choose	NHS Vale of York
Well/is A&E for me' leaflet for York. This	Commissioning Group
leaflet should contain both practical	<ul> <li>Yorkshire Ambulance</li> </ul>
examples and contact details for services.	Service
The leaflet should be delivered to every	
household in the city.	
· ·	

# **Appendices**

Appendix 1	Healthwatch	York workp	lan surve	y 2013

Appendix 2 Summary of survey responses

Appendix 3 Materials taken to focus groups



# Appendix 1 Healthwatch York workplan survey 2013

Dec	ciding our we	orkplan		
Please note: questions marked with * are mandatory				
Healthwatch prior	ities			
★ 1. Initial feedback ha for Healthwatch York to important?	• •	e following potential issues agree that these are		
	Yes - you should look at this	Yes - but others are working on it	No - it's not important	
living an active life				
loneliness				
living with long term conditions				
healthy eating				
living with mental health issues				
stress				
access to green spaces				



2. Do you think Healthwatch York can do useful work addressing the issues in any of the above areas? If yes, please give details. If no, please explain why not.			
☐ Yes	□ No		

**Comments:** 



# Help us identify priorities

3. Other areas have also been suggested by individuals. Please let us know if you think these suggestions reflect a wider problem.

	Yes, I have experience of this, it needs looking at	Yes, I have heard about this from others	No, I don't think there are issues	l don't know
discrimination against disabled people				
wheelchair services				
increasing the use of children's centres				
use of alternative health therapies, such as hypnotherapy, chiropractors, reiki, acupuncture				
wellbeing for new mums and families				
Comments				



4. Do you think Healthwatch York can do useful work addressing the issues in any of the above areas? If yes, please give details. If no, please explain why not.				
☐ Yes	□ No			
Comments:				

- 5. Are there other things (not included above) that you think Healthwatch York should look at? Please list up to 3 areas:
  - \* 6. What do you think Healthwatch York should do to improve health and social care in York? What issues should we aim to address?
  - 7. If you could wave a magic wand to fix one thing in health and social care what would it be?
- 8. Where you have identified or agreed with areas of work for Healthwatch York to focus on, how can Healthwatch York work in a way which adds value / enhances the work of others?

- 9. Which partner organisations do you think Healthwatch York should be working with in the city in respect of the work areas identified above?
- 10. Are there other potential partner agencies you think we should be aware of generally?



# Who's Who in health and social care

These questions aim to find out how aware people in York are of the changes to health and social care recently, and how much these matter.

### 11. Are you aware of the following health and social care bodies;

	No, I'm not aware of it	I've heard of it but I don't know what it does	I know about it	I'm a member	I work for them
Adult Social Care at City of York Council					
Children's Services at City of York Council					
Public Health team at City of York Council					
Sports and Active Leisure team at City of York Council					
York Teaching Hospital NHS Foundation Trust					
Vale of York Clinical Commissioning Group					
Leeds & York Partnership NHS Foundation Trust					

Yorkshire Ambulance Service					
York Health and Wellbeing Board					
Healthwatch York					
Healthwatch England					
Care Quality Commission					
12. Do you think it is im listed in Question 11, and			each of th	ne bodies	
Yes		☐ No			
Yes  Comments:		□ No			
	<del>-</del>	o health and	d social ca	are	



14. Should Healthwatch York do anything to help explain who's who in health and social care, and who does what since the Health and Social Care Act came into force?			
Yes	□ No		

# **Your Experiences**

We'd now like to ask some questions about your recent experiences of health and social care in York.

15. Which health and care service		•			
months? Please select all the service below.	vices	you have used from the list			
GP (doctor) Social care support from City of York Council Opticians Hospital (outpatient) Hospital (inpatient) Hospital emergency department Out of hours doctor  Other: (please specify)		Dentist Social care support from another provider Mental health support Community health teams Private health care Befriending services  Voluntary and community sector support, eg Age UK York, York MIND			
16. Have you been able to get the services you need, eg , GP appointment, outpatients appointment, carers assessment at times to suit you?					
17. Is there anything you would li your experiences of using health a Please note that this should be fro	and s	social care services in York?			
You can give us information anon contact details these will be kept contact Healthwatch directly to sh	confi	dentially. You can also			

621133 or <a href="mailto:healthwatch@yorkcvs.org.uk">healthwatch@yorkcvs.org.uk</a>.



# Concerns, complaints, comments and compliments

18. Do you know your rights about making a complaint, raising a concern, making comments and compliments about the following services? Please tick if you know how to do this.

	I know how to make a complaint	I know how to raise a concern	I know how to make a comment	I know how to provide a compliment	I don't know how to do any of these
Adult Social Care at City of York Council					
Children's Services at City of York Council					
Public Health at City of York Council					
Sports & Active Leisure at City of York Council					
York Teaching Hospital NHS Foundation Trust					
Vale of York Clinical					

Con Gro	nmissioning up					
Part	ds & York nership S Foundation st					
_	kshire oulance vice					
Hea York	Ithwatch					
Comments:						
19.	How likely are	e you to c	omplain if	you recei	ve poor serv	vices?
	Very likely					
	Fairly likely					
	Neither likely nor unlikely					
	l Fairly unlikely					
	Very unlikely					
20.	Please provid	le any rea	sons for y	our answe	er.	



- 21. Are you aware of advocacy services in the city? Please list any you know about.
- 22. Are you aware of other groups that can support you to raise issues, concerns or complaints? Please provide details.

# Attitudes to health and wellbeing

These questions aim to find out how you feel about taking care of your own health.

heal	Who do you think is most important in looking after your lth and well being? Please rank in order of importance (1 being st important)
	Me Family GP NHS Pharmacist Other practitioner (please specify)
	Where would you look for advice and information about ping healthy?
	GP surgery Vale of York Clinical Commissioning Group website NHS Choices website Other website (please specify) Library Community Centre Children's Centre Voluntary organisation (please specify) Other (please specify)

25. Do you feel you need more support to be healthy? What other things would help? Please specify:



# **About You**

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

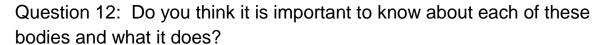
* 26. For monitoring purposes please tell us the first part of your postcode: (e.g. YO24)					
27.	Are you				
	male		female		
28.	How old are you?				
	Under 18 18-25 26-35 36-45 46-55 56-65 Over 65				
29.	How would you desc	ribe y	our ethnic origin?		
30.	How would you desc	ribe y	our religious beliefs?		
31.	How would you desc	ribe y	our sexual orientation?		
32.	Do you consider you	ırself t	to be a disabled person?		

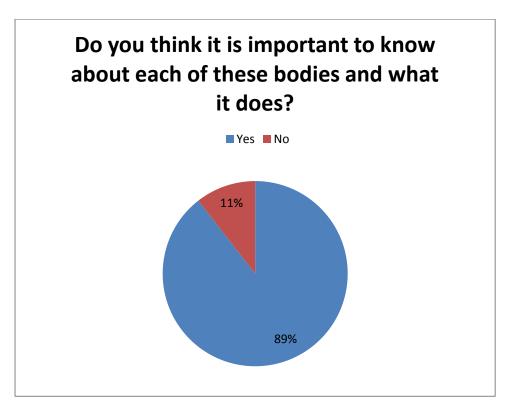


# Appendix 2 – Summary of survey responses

Question 11: Are you aware of the following health and social care bodies?

Organisation	No, I'm not aware of it	I've heard of it but I don't know what it does	I know about it
Adult Social Care at City of York Council	9	13	51
Children's Services at City of York Council	6	14	52
Public Health team at City of York Council	7	13	53
Sports and Active Leisure team at City of York Council	10	10	51
York Teaching Hospital NHS Foundation Trust	3	4	46
Vale of York Clinical Commissioning Group	14	7	47
Leeds & York Partnership NHS Foundation Trust	10	9	44
Yorkshire Ambulance Service	1	4	64
York Health and Wellbeing Board	19	7	44
Healthwatch York	5	9	47
Healthwatch England	9	10	52
Care Quality Commission	5	9	59





People made the following comments:

#### Yes:

- Definitely but my knowledge is so vast due to the last 8 months. Before that I wasn't aware of it all. I believe that you only know how to improve, listen and act when you have been on the other side, or needed assistance from these bodies.
- It would be useful to have one info point.
- In general, yes, but the long list indicates already the need for good communication!
- complexity is horrendous
- See my previous comments on need for an Information Officer to oversee information flow and needs.
- I think it's useful to have information and contact address etc. I also think that a large number of people don't feel this and expect NHS and Social Care Employees to know about these so they can advise where necessary.
- It is vast quagmire that the average citizen is not aware of the existence never mind the details. Please do not interpret my answers above as being in full possession of all the facts...I know

they exist, I have a reasonably clear idea of their principal responsibilities. I would not pretend to be au fait with all the detailed operation/personnel.

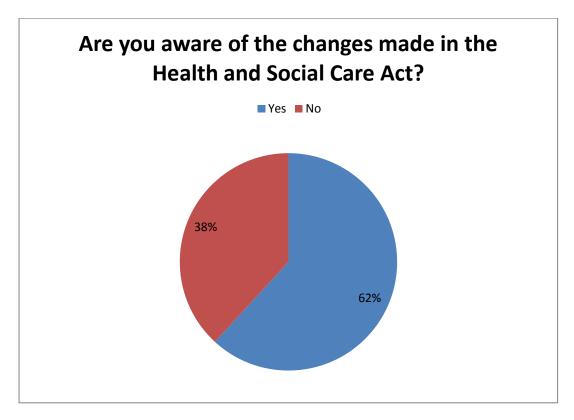
- A lot of over-lap in my opinion.
- They all need to be held to account
- the wide picture is needed to see where work in being delivered or NOT
- knowledge is power and self help is possible if you have the right knowledge
- Only will things succeed by Networking
- to know who to contact
- Especially York Health & Wellbeing Board as it is local.
- Only if they affect me
- superficially
- Most people are too worried about getting on trying to live till something hits them then they need to know.
- More transparency for the general public.
- If only to be able to tell others.
- Unclear what each do & how this impacts positively on York residents
- As people get older they find it difficult to use the phone when needing help, very often you get a call centre or hold the line please, press various buttons to get person you need. I suppose this is progress.
- Certainly it's good to know how to find out about these agencies

#### No:

- for the individual, generally knowledge only needed of specifically relevant services.
- Not important to know about all just the ones which affect yourself or your family/friends
- Everybody can't know about everything but to know where information can be found is important for all!!



Question 13: Are you aware of the changes made in the Health and Social Care Act?



#### Yes:

- I have read as much as I can in last 8 months
- In broad terms
- Check out Kings Fund new animated cartoon on the NHS
- I seem to have spent far too much time in researching this
- GPs are raising alarms about funding being moved from direct health into social care and the effect on the pool of money allocated to GP activities including recruitment of more GPs which they believe to be a risk
- I am aware of some of the recent changes but not sure if I know them all
- But the changes are changing or not being implemented very successfully
- Some but not all
- Good idea in practice but needs dedicated people to lead and that's not happening.

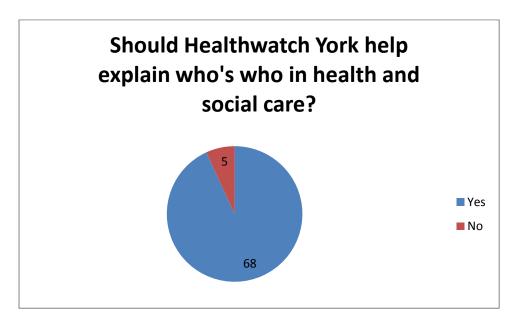
- Nothing should be set in stone if it does not change it
- Some
- Superficially
- Not sure I could describe them correctly
- Probably only a tiny part

#### No:

- But I should be
- Some but would really welcome knowing more!
- I am a pensioner with Rheumatoid Arthritis, I expect my Health and Social Services advisors to know about recent changes in policy and that they can advise me as required.
- To some extent
- I would really like to learn more about this.
- I have said no because I am not familiar with all the details of this act....as I suspect are too many of us. We only have so many hours in a day to study stuff!!
- Can't keep up with the constant changes in every field!
- Except for patient records going on computer & unlikely to be insecure on the Internet. I objected at the time & returned the paperwork to say I do not want my records stored & shared over the Internet. I never received any acknowledgement & do not trust my GP practice (clerical team). I bet if/when I check, my info will be on there.



Question 14: Should Healthwatch York do anything to help explain who's who in health and social care, and who does what since the Health and Social Care Act came into force?



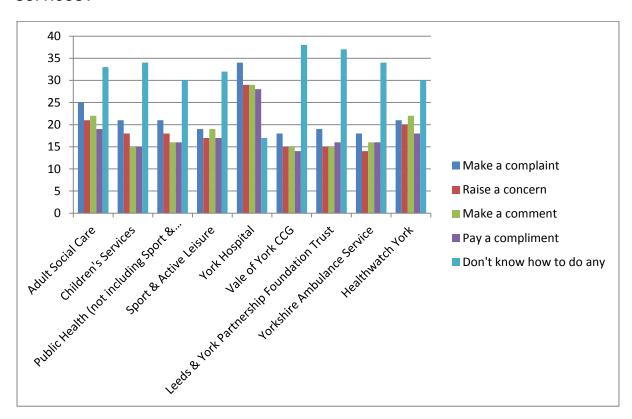
#### Comments:

- Produce user friendly easy leaflets or posters to put up in GP surgeries or any other public health agency, and also advertising. The power of marketing is essential in this modern day and age. Maybe a Facebook message or campaign would be a more suitable form of media marketing.
- · Organisation & flow charts needed
- Have relevant information available for those users who wish to know Who's Who. I believe that very much older people without on-line facilities etc. look to their younger carers for advice.
- Essential -map it; picture it; display it; promote it. People need to know. There is a case for a simple digest/reference source.
- So many people do not know who's who & who to go to with issues
- Easy to read explanations on website
- Information in a language and style that is easy to understand
- I think this information should be available to everyone and not everyone is in contact with Healthwatch
- So many changes = a great deal of confusion & a lot of people just 'switch off'
- Radio, newspapers
- Information is power and people need to know the structures and where they can be effective

- General public are VERY confused
- Point people in the correct direction to be able to access information about this
- More articles in York Press, TV. Posters in GP surgeries and the hospitals
- Any easy to access information would be very welcome.
- But I am afraid goal posts keep moving
- information is always beneficial to us all.
- Make sure Drs are made aware of who's who in health & social care, most surgeries now have screens in the waiting rooms & most certainly notice boards. Also the monthly York magazine which is delivered free to most areas would be a good place to give out information.

Concerns, complaints, comments and compliments

Question 18: Do you know your rights about making a complaint, raising a concern, making comments and compliments about the following services?





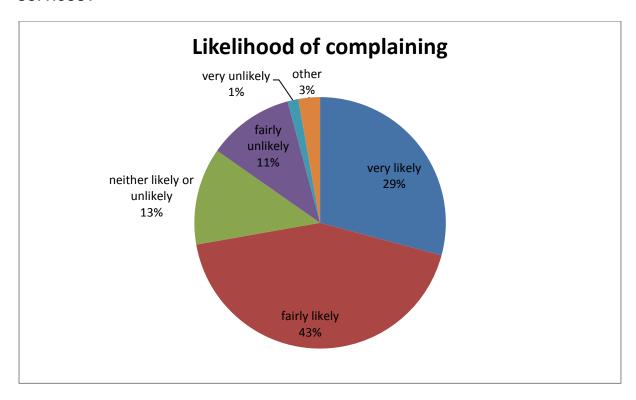
#### Comments:

- There is very poor publicity for how to complain or compliment these bodies. There should be prominent notices at GP surgeries and the hospitals.
- I didn't tick complaint boxes as didn't think I would need to make complaints to anyone... the ones I don't know how to contact got ticks in the "I don't know how to do any of these". The rest, I know how to contact people who matter in those organisations...
- I know how to and hopefully when to.
- I have on-line facility to look for contact advice. I have a nursing background which gives me a basic knowledge of how and where to look for advice in health and social care matters.
- Courteous letters whatever the subject never come amiss
- I presume info would be available on line for those I do not know
- I would have to look up how to do it.
- The ones I do not know I have never had any previous contact with
- If people needed to make a complaint etc to any of the above bodies statutory requirements mean they would be able to find the appropriate information. People may not know simply because they have never needed to. A better question would be do you know you Healthwatch can provide information on how to complain to all of the above.
- I would have to look up details, so don't 'know' how to do any of these, but know how to find out.
- I would look online if I needed to fill my gaps!
- My responses above are negative for most, but I do know how to find out how to raise a comment should I need to.
- Look on internet for service details
- If one has a problem then it is a matter of probing til the right department is found.
- In general if I did need to praise, complain, express a concern, I should find out quickly to whom & where to do it.
- I would simply drop the relevant people a line
- Do I have rights? The only time I complained (a few years ago re hospital care) I felt it achieved nothing but paperwork creation & shuffling. Better to "suffer in silence" & avoid all contact with "health care" as far as possible! (Although my consultant was the exception - amazing, fantastic brilliant! But I would be moved to



someone else for NHS clerical reasons if I ever needed another op).

Question 19: How likely are you to complain if you receive poor services?



Question 20: Please provide reasons for your answers:

# Very likely:

- Because I believe in justice and fairness, but only if I am right.
- If I did have poor service, I would say so.
- never had to, but given plenty of compliments
- I think that positive feedback both good and bad is valuable for change to be made
- I believe it is only by bringing problems to the attention of managers etc that positive changes can be made.
- Feedback helps services improve
- I would want an issue resolved and for people to learn from experiences good and bad
- Provided one complains in a reasonable manner then that is the best way to draw attention to shortcomings which need to be rectified for the benefit of others.



- Have no reason to complain but would do so if necessary.
- Complaints should encourage change
- If poor services are accepted they'll continue! If service deliverers are made aware they can change & improve & eliminate poor service.
- I am used to enabling others to make complaints if needed.
- To make the service aware that standards can be improved
- Experience, confidence
- We learn from Complaints if they are Genuine and help those providing services to raise standards where everybody benefits
- If one does not complain things get worse
- I can only speak from experience 2 years ago with the York & North Yorkshire PCT and the complaint was a complete waste of my time and energy. As I could not get any results from the complaint or staff.

#### Fairly likely:

- Depends on how serious it is
- Unless you complain, no action will be taken and others may be poorly treated in future.
- Depends on severity of issue and whether learning would benefit others
- Sometimes intend to complain, then get too busy to do so
- priority for that moment then other things take over
- More likely to feed back on behalf of others than myself as I would raise issues at point of contact for myself. More likely to complete feedback forms etc than do off my own back unless feel very strongly either positive or negative
- because I would want to help make things better for other people
- I think it is important to flag up problems as this may lead to them being corrected and not affecting others
- It would have to be very bad- verging on dangerous, just because I'm English!.
- Depends if I know how to.
- If no complaint is received, there is no likelihood in the service being improved.
- never very sure if anyone listens
- In a positive and constructive way.
- Unless someone point out an issue NOTHING will be done about it
- I often think I will write but then once the moment is past I don't.

- We are all human and can make mistakes
- To help improve services for other people as well as myself.
- It is important to give feedback good & bad to make changes in a positive way.

#### Neither likely nor unlikely:

- It would depend on the circumstances.
- it depends on the circumstances & how much I feel any complaint subsequent response/changes would help future users.
- It would depend on the gravity of the situation.
- On the whole I don't have any complaints.
- I would be concerned about being victimised later.

## Fairly unlikely:

- Too much hassle
- Staff are often under intense pressure to deliver services.
   Complaints niggles or dissatisfaction with services / people doesn't often help.
- Time, lack of belief that things will change
- Don't like to make a fuss, and we can all have a bad day, just try to find an alternative
- It's often the system not the people in it.
- Concern about consequences of any complaint made
- Feel I have not been listened to (or understood) by GPs & other practitioners so why should I be listened to (or understood) when I complain.
- I fear there is no alternative. I fear it will go on my record (as a "problem" person).

# Very unlikely:

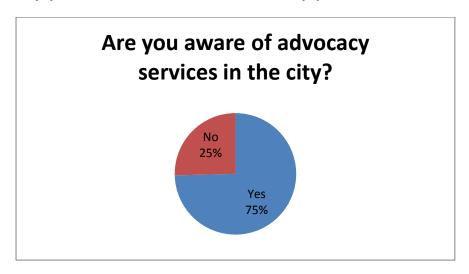
Lack of access to communication

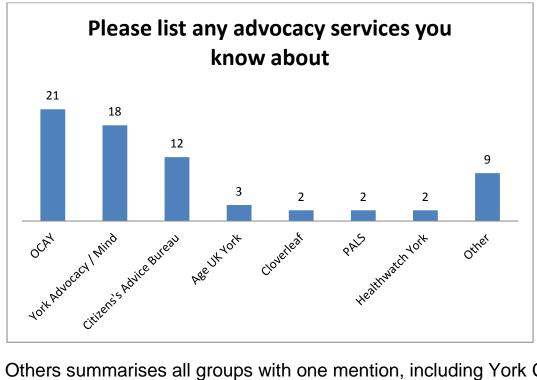
#### Other:

- I feel it is important to voice concern at the time of the event so that action can be taken quickly
- It would depend VERY MUCH on the circumstances.



Question 21: Are you aware of advocacy services in the city? Please list any you know about. Please list any you know about.





Others summarises all groups with one mention, including York CVS, Foundation, Lifeline, York Older People's Assembly, York Racial Equality Network.

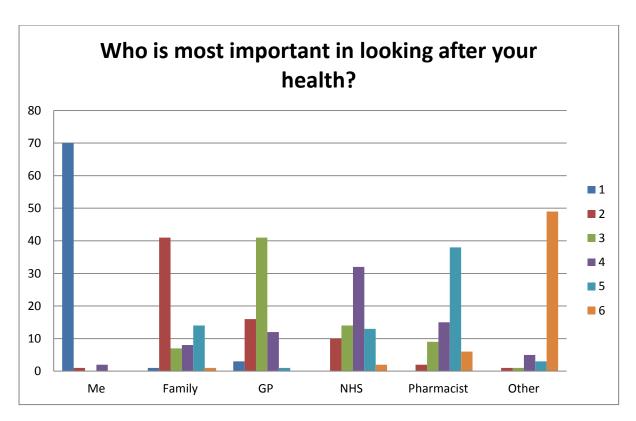
Question 22: Are you aware of other groups that can support you to raise issues, concerns or complaints?

People mentioned the following groups and organisations:

York CVS, York CAB, York Racial Equality Network, York Older People's Assembly, York Blind and Partially Sighted Society, Alzheimers Society, Age UK York, York Carers' Centre, National Rheumatoid Arthritis Society, York MIND, York Carers' Forum, LGBT Forum, PALS, Older Peoples Liaison Group, MPs, Equality Advisory Group, Association for Improvements to Maternity Services (AIMS), NHS Ombudsman, York Independent Living Network, York Carers Forum, Joseph Rowntree Housing Trust, MP's office.

#### Attitudes to health and wellbeing

Question 23: Who do you think is most important in looking after your health and well being? (Rank in order of importance)

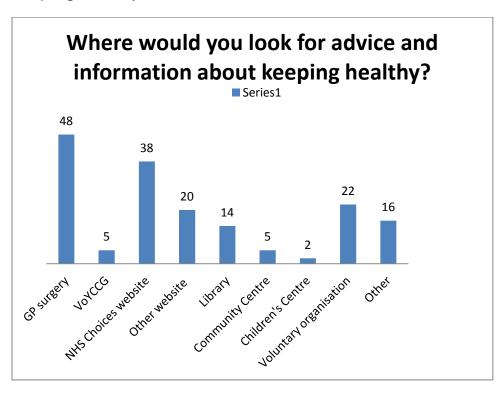


70 people said they are most important in looking after their health (1 giving joint top ranking with their GP)

10 people felt another practitioner was more important than their GP



Question 24: Where would you look for advice and information about keeping healthy?





# Appendix 3 Materials taken to focus groups:

#### Other organisations' materials

#### Online resources

King's Fund animation:

www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

Connected York website (updated by Healthwatch York in 2014):

www.connectedyork.org.uk

#### **Directories and A to Z listings**

A to Z of useful organisations and groups (originally created by York Carers Centre, adapted by Healthwatch York with their permission)

A to Z of useful organisations and groups for older people (originally created by York Carers Centre, adapted by Healthwatch York with their permission)

#### Leaflets/factsheets

Age UK factsheet 44. NHS services

Age UK factsheet 5. Dental Care: NHS and private treatment

Department of Health: NHS dental services in England

Where to go for Benefit Support in York (Citizen's Advice Bureau)

How to make a complaint booklet. York Teaching Hospital NHS Foundation Trust

City of York Council: York's Health and Wellbeing Strategy 2013-2016 Easy Read Version

Healthwatch Brent Factsheet No 1: NHS Brent Clinical Commissioning Group

Healthwatch Brent Factsheet No 5: Patient Participation Groups (PPGs)

Care Quality Commission: About us. What we do and how we do it

York Teaching Hospital NHS Foundation Trust list of support groups

Yorkshire Ambulance Service NHS Trust: Feeling unwell? How to choose the right treatment for you in North Yorkshire

Worcestershire NHS Clinical Commissioning Groups: Your Guide to Local Health Services in Worcestershire. Is A&E for me?

NHS North Yorkshire and York Community and Mental Health Services: Visiting the dentist if you have Autism

#### **Healthwatch York produced material**

#### **Directories and A to Z listings**

York Health and Social Care Directory issue 1

#### Leaflets/factsheets

Who's who and what's what – NHS dental services in York

Who's who and what's what – NHS eye care services in York

How to complain about a health or social care service

Hospitals in the York area

What is: The City of York Health and Wellbeing Board

What is: Leeds and York Partnership NHS Foundation Trust

What is: The City of York Safeguarding Adults Board

Maternity and Young Mum useful information





### Contact us:

Post: Freepost RTEG-BLES-RRYJ

Healthwatch York 15 Priory Street York YO1 6ET

Phone: 01904 621133

Mobile: 07779 597361 – use this if you would like to leave us a text

or voicemail message

E mail: <u>healthwatch@yorkcvs.org.uk</u>

Twitter: @healthwatchyork

Facebook: Like us on Facebook

Web: www.healthwatchyork.co.uk

# York CVS

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

# This report

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

Paper copies are available from the Healthwatch York office

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







# Consistency and Confidence in Patient Led Assessments of the Care Environment



February 2015

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# **Consistency and Confidence in Patient Led Assessments**of the Care Environment

#### Introduction

The purpose of this report is to highlight the role of Patient Led Assessments of the Care Environment (PLACE), and how we can improve the PLACE process to give more consistency and confidence to those involved and the wider public.

In April 2013 NHS England introduced PLACE, a new system for assessing the quality of the patient environment. These are yearly assessments, which apply to hospitals, hospices and day treatment centres that provide NHS funded care. They give local people the chance to enter hospitals as part of a team. They look at how the environment supports patient care. They look at privacy, dignity, food, cleanliness and general building maintenance. The reports do not look at clinical standards (medical care), or at how competent members of staff are.

The results of these reports are openly published, showing how hospitals are performing nationally and locally.

In NHS England's guidance and information for PLACE Assessors they state that:

"Good environments matter. A clean environment is the foundation for lower infection rates. Good food promotes recovery and improves the patient experience. High standards of privacy promote patient dignity. Good maintenance and décor support a safe and comfortable stay. ... Patient-led assessments of the care environment (PLACE) help organisations understand how well they are meeting the needs of their patients. They identify where improvements can be made. They take place across all hospitals, hospices and independent treatment centres providing NHS-funded care. They use information from patient assessors to report how well a site / organisation is performing – in terms of national standards and against other similar sites / organisations."

#### PLACE looks at:

- How clean the environments are
- The condition, inside and outside, of the building(s), fixtures and fittings

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- How well the building meets the needs of those who use it, for example through signs and car parking facilities
- The quality and availability of food and drinks
- How well the environment supports people's privacy and dignity<sup>ii</sup>

We believe that PLACE assessments are a valuable opportunity for interested members of the public. It gives a chance for the patient voice to be heard. Visits bring members of staff together with members of the public. They allow staff to see their place of work afresh. But from the feedback we've received, we think more could be done to guarantee public confidence in the process, and provide consistency across organisations.



## Why is Healthwatch York looking at PLACE?

Healthwatch York is already involved in PLACE Assessments. As identified in NHS England guidance to hospitals, "The first route to identify patient representation should always be through local Healthwatch, who have the right to join any PLACE assessments." Healthwatch York is proud to be able to support members of the public to get involved in these assessments.

We put forward volunteers for the PLACE assessments in 2013 and 2014. The organisations who requested volunteers were York Teaching Hospital NHS Foundation Trust, Nuffield Health York Hospital, and Leeds & York Partnership NHS Foundation Trust. Last year, our volunteers requested a debriefing session with us, and have asked us to make recommendations to improve the process.

This report is not intended to raise concerns about any one provider in York. The aim is to highlight ways in which we can improve transparency, confidence and consistency in the process overall. We believe this can be done best by working effectively together.



# How has the PLACE experience been for volunteers locally?

Healthwatch York, as requested, asked for volunteers to take part in the PLACE Assessments for local providers. Three of our regular volunteers took up the opportunity. These volunteers collectively conducted visits arranged by three different providers. They subsequently requested a meeting with us, to discuss the PLACE process.

At the meeting, they shared a number of concerns about the process. Most importantly, they felt that the experience overall had been very different depending on the provider's approach and the staff involved. These varied from feeling they'd had a really great day where their involvement was fully supported and appreciated, to feeling that the process was a tick box exercise that would fail to bring any changes to services.

#### Before the visit

There were differences in pre-visit training. This included differences in how organisations arranged and notified volunteers of training. Our volunteers felt that local Healthwatch could support the training of volunteers. This would reduce the administrative burden on local hospitals and provide greater consistency. It could also encourage volunteers found through other routes to get more involved in local Healthwatch activity.

# **Pre Visit Briefings**

The standard of pre visit briefing varied. Volunteers emphasised that where there is a gap between initial training and the visit, the pre briefing is particularly important. It provides an opportunity to remind volunteers of the ways in which they can record their concerns. It also helps remind volunteers how their feedback is used. At one location, the whole team went into the pre visit briefing - volunteers remarked that this was useful for building a sense of teamwork. Staff were not involved in pre visit briefings at all sites.

# Leading the visit

Although the guidance from NHS England suggests teams should collectively choose a team leader, our volunteers reported that they had only been on staff-led visits. In one organisation, they reported that although they "did not choose the team leader, they had confidence that they would be okay" because the staff member listened, wrote down



their comments, and explained clearly how they could use the patient assessment summary sheet to add any further details or note any concerns they had to make sure nothing was missed.

Another provider appeared to use the same staff member for every visit. There was some concern over this approach. Volunteers felt that this meant they were involved in a 'led' assessment rather than a 'patient-led' one. The person leading the visits appeared to be involved in ordering food, and was proud of some changes they'd made. They were therefore unwilling to listen to concerns raised about the food provided. Volunteers reported making lots of comments which they insisted be written down, but they lacked confidence that these would be reflected in the report / action plan.

For another site, volunteers reported that it was not clear how teams were selected, or who should lead the visit.

A challenge was raised about the role of hospital governors in PLACE. Lay assessors agreed they were happy for them to be involved as part of the team, but not as a 'lay' representative. This is because as a governor they may be aware of other matters or agendas that could impact on the neutrality of their 'lay' voice. Whilst aware that all volunteers may have a conflict of interest in undertaking the role, there was a feeling this was more likely to be a problem for governors.

# **Listening to PLACE Volunteers**

Our volunteers reported differences in how their comments were received and recorded. For example, they went on one visit where the staff member accompanying them discouraged them from recording concerns with statements like;

"it's a busy time"

"you are lucky there's only a shoe on the floor"

This led one volunteer to reflect that their comments were felt to be trivial and unwanted by the staff leading the team, and so would make no difference to the quality of care provided. They stated that if they felt they could not make a difference, they wouldn't choose to be involved in the future.



On another visit, volunteers noted a similar reluctance to record their comments. Volunteers reported making lots of comments which they insisted be written down, but they lacked confidence that these would be reflected in the report / action plan. For example, at one location there was a chair in front of the fire exit. The volunteer was concerned about this, and raised the matter 3 times. The team leader dismissed their concerns. On a visit to a different location within the same organisation our volunteer found a fire exit had been blocked by a delivery.

At another location, the volunteers picked up issues around the choice of foods available. They noted a lack of protein options as the breakfast offer was cereal or toast. One assessor suggested providing eggs for those following a less carbohydrate based diet but their comment was ignored.

Volunteers felt that there was a clear role for the leader in helping to facilitate discussions. They felt this was important to allow groups to air comments and concerns, before agreeing to a consensus based score.

#### After the visit

Volunteers felt that to provide reassurance at the end of a PLACE assessment, the visit leader should overwrite the report in pen. Volunteers were happy overall with the scoring system but felt that providers should listen to and record comments that help give the context. Volunteers felt clearly that the scoring was not consistent across the different sites. At one site, patient assessors reported that they were not left alone for completing their feedback sheet, despite the guidance stating that they should be. The staff member insisted on sitting with them.

### Raising concerns elsewhere

Volunteers were not clear about the ability to raise concerns elsewhere, either by escalating concerns direct with providers or outside the organisation. They felt it would be helpful to include this information within the pre-visit briefing, at the beginning of each assessment visit. They wanted clear information about when and how to flag issues to both the Health and Social Care Information Centre (HSCIC) and the Care Quality Commission.



# Official PLACE results for Hospitals in York

Organisation Name	Site Name	Site Type	Cleanliness	Food Overall	Ward Food	Organisation Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
Nuffield	Nuffield	Acute	98.63%	96.46	100.00	94.97%	92.31%	95.51%
Health	Health York			%	%			
	Hospital							

Organisation Name	Site Name	Site Type	Cleanliness	Food Overall	Ward Food	Organisation Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
York Teaching Hospital NHS Foundation Trust	York Hospital	Acute	99.89%	79.62%	79.35%	80.93%	89.49%	96.15%
York Teaching Hospital NHS Foundation Trust	Archways Intermediate Care Unit	Acute	100.00%	91.03%	94.77%	86.80%	79.41%	92.39%
York Teaching Hospital NHS Foundation Trust	Whitecross Court	Acute	99.72%	92.04%	93.94%	89.73%	77.27%	92.86%
York Teaching Hospital NHS Foundation Trust	St Helen's	Acute	100.00%	90.25%	95.15%	84.28%	82.26%	98.05%



Organisation Name	Site Name	Site Type	Cleanliness	Food Overall	Ward Food	Organisation Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
Leeds & York Partnership NHS Foundation Trust	Lime Trees	General Acute & Mental Health/ Learning Disabilities	99.07%	93.67%	<b>≥</b> 98.65%	89.82%	āā≯ 77.87%	Con 85.48%
Leeds & York Partnership NHS Foundation Trust	Acomb Garth	Mental Health only	98.42%	94.07%	100.00%	88.68%	73.56%	84.17%
Leeds & York Partnership NHS Foundation Trust	Bootham Park Hospital	Mental Health only	99.63%	93.23%	100.00%	87.07%	94.07%	92.54%
Leeds & York Partnership NHS Foundation Trust	Clifton House	Mental Health only	99.47%	91.33%	96.43%	88.17%	94.25%	87.06%
Leeds & York Partnership NHS Foundation Trust	Meadowfields Community Unit	Mental Health only	98.64%	94.71%	100.00%	88.02%	80.17%	89.68%
Leeds & York Partnership NHS Foundation Trust	Peppermill Court	Mental Health only	99.62%	90.81%	94.87%	87.29%	87.35%	94.17%



# Recommendations

Recommendation	Recommended to
Consider ways of improving confidence in the	NHS England, Department
process, both with volunteers undertaking	of Health, Healthwatch
PLACE visits and with the wider public. This	England, LHW
could include considering the role of commissioners within PLACE teams, giving	
clear guidance on potential conflicts of	
interest for Governors when acting as PLACE	
volunteers, and expanding the role of Local	
Healthwatch organisations to support	
volunteers undertaking PLACE visits, working	
with HWE to provide a standard training	
package for volunteers. This could be	
provided within a joint training session across	
all local providers to improve consistency  Provide all PLACE assessors with copies of	All providers
the action plans for places they have visited.	All providers
Provide copies to LHW. This helps reassure	
PLACE assessors that their comments and	
feedback are taken on board	
Use a team of staff to support PLACE	All providers
assessments so that no one staff member has	
too great an influence over the process	
Develop an annual timetable for PLACE to	NHS England / All providers
show what happens when. Use LHW to book	
lay assessors into PLACE visit slots. Direct all	
local volunteers interested in taking part to	
their LHW organisation.	NU 0 5 1 1 1 1 NA
Consider ways to widen the pool of volunteers	NHS England, LHW.
used within PLACE assessments, to increase	
awareness of the programme, and to make sure recruitment is open, transparent and	
involves people from across the whole local	
community. This may require targeted	
recruitment and consideration of how to meet	
any access requirements.	



#### References

http://www.england.nhs.uk/wp-content/uploads/2014/01/place-patients-1.pdf, slightly edited for shorter sentence length.

<sup>&</sup>quot;http://www.england.nhs.uk/wp-content/uploads/2013/02/place-recruitpa.pdf, pg 4

http://www.england.nhs.uk/wp-content/uploads/2013/02/place-recruit-

pa.pdf, pg 6

v http://www.england.nhs.uk/wp-content/uploads/2015/01/place-guidinfo-assessors-jan15.pdf, pg 7

# **Health and Wellbeing Board Forward Plan 2015-2016**

Date	Item
15 <sup>th</sup> July 2015	
For discussion	Patient/personal story (including response to the March 2015 patient story)
	Children and Young People's Emotional Health and Wellbeing
	Healthy Child Service
	Report of Child Safeguarding Board
	Update on Health Inequalities Work
	Standing Item: Better Care Fund (BCF) Update
	Performance Monitoring for the Health and Wellbeing Board/System Performance
	Process for full Joint Health and Wellbeing Strategy Refresh
For Information	Governance Arrangements for the Health and Wellbeing Board
	Healthwatch York Reports
	Patient Led Assessments of the Care Environment (PLACE)
	Who's Who in Health and Social Care
August 2015	Development Session – Outcomes Frameworks (Public Health, Adult Social Care and
August 2010	NHS) and Joint Health and Wellbeing Board Strategy Refresh
	, , , , , , , , , , , , , , , , , , , ,
21 <sup>st</sup> October 2015	Patient/personal story
	Report of Adults Safeguarding Board
	Draft Children's and Young People's Plan
	Winterbourne Review Update
	Annual Report of the Health and Wellbeing Board
	Response to Recommendations in Healthwatch Reports (PLACE and Who's Who in
	Health and Social Care)
	New Healthwatch York Report – A & E and its Alternatives

# **Health and Wellbeing Board Forward Plan 2015-2016**

Item
New Healthwatch Report – Enter and View – York Hospital Discharge Lounge
Getting Past the Barriers in Mental Health Housing/Support – Report from the Mental
Health and Learning Disabilities Partnership Board
Presentation – Impact of Poor Housing on Health
Alcohol Needs Assessment
Joint Risk Register
Standing Item: Joint Strategic Needs Assessment (JSNA)
Standing Item: Better Care Fund (BCF)
Climate Just and issues of social vulnerability to climate change in York.
Update on progress made against refreshing the Joint Health and Wellbeing Strategy
Development Session – topic to be confirmed
Patient/personal story
Annual Report of Director of Public Health
Annual Assurance Statement of Health Protection Assurance Board
Performance Monitoring Report
Annual Report from YorOK Board
Update on Work Towards Implementing the Recommendations Arising from
Healthwatch Reports - ("Loneliness – A Modern Epidemic and the Search for a Cure",
"Access to Health and Social Care Services for Deaf People", and "Discrimination
against Disabled People in York").
Joint Risk Register
Update on the Joint Engagement and Communication Plan for the Health and
Wellbeing Board

# Health and Wellbeing Board Forward Plan 2015-2016

Date	Item					
	Response to Recommendations in Healthwatch York Report – A & E and its					
	Alternatives					
	Interim Update: York Together Board Progress and Initial Findings					
	Standing Item: Joint Strategic Needs Assessment (JSNA)					
	Standing Item: Better Care Fund (BCF)					
	Update on Progress made against refreshing the Joint Health and Wellbeing Strategy					
December 2015	Development Session – topic to be confirmed					
20 <sup>th</sup> January 2016	Patient/personal story					
	Draft Joint Health and Wellbeing Strategy 2016-19					
	Collaborative Transformation Board Annual Report					
	Standing Item: Joint Strategic Needs Assessment (JSNA)					
	Standing Item: Better Care Fund (BCF)					
February 2016	Development Session – topic to be confirmed					
9 <sup>th</sup> March 2016	Patient/personal story					
	Joint Health and Wellbeing Strategy 2016-19 Sign Off					
	Mental Health and Learning Disabilities Partnership Board Annual Report					
	Standing Item: Joint Strategic Needs Assessment (JSNA)					
	Standing Item: Better Care Fund (BCF)					
April 2016	Development Session – topic to be confirmed					

