CITY OF YORK COUNCIL

Notice of a public meeting of

Health and Wellbeing Board

To: Councillors Simpson-Laing (Chair), Looker and Healey,

Kersten England (Chief Executive, City of York Council),Dr Paul Edmondson-Jones (Deputy Chief Executive and Director of Health and Wellbeing, City of York Council),Jon Stonehouse (Director of Children's Services, Education and Skills),Dave Jones (Chief Constable, North Yorkshire Police),Garry Jones (Chief Executive, York Council for Voluntary Service (CVS)), Siân Balsom(Manager, Healthwatch York), Chris Long (Local Area Team Director for North Yorkshire and the Humber, NHS England),Patrick Crowley (Chief Executive, York Teaching Hospital NHS Foundation Trust), Dr Mark Hayes (Chief Clinical Officer, NHS Vale of York Clinical Commissioning Group), Rachel Potts (Chief Operating Officer, NHS Vale of York Clinical Commissioning Group),Chris Butler (Chief Executive, Leeds and York Partnership NHS Foundation Trust) and Mike Padgham (Chair, Independent Care Group)

Date: Wednesday, 2 April 2014
Time: 4.30 pm
Venue: The George Hudson Board Room - 1st Floor West Offices (F045)

A G E N D A

1. Introductions

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 29 January 2014.

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 1 April 2014.

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

Filming or Recording meetings

Please note that this film will be recorded and webcast and that includes any registered public speakers, who have given their permission. This broadcast recording can be viewed at: http://www.york.gov.uk/webcasts

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

The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are being carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at:
http://www.york.gov.uk/downloads/download/3130/protocol_for_webcasting_filming_and_recording_of_council_meetings

5. Pharmacy Services (Pages 17 - 42)

The Board will receive two presentations in relation to pharmacy on a new inspection model for pharmacies and the role of community pharmacies.

6. The Better Care Fund Plan (Pages 43 - 88)

This report introduces the latest version of York's Better Care Fund plan which will be sent to NHS England on 4 April 2014.

7. Strengthening Safeguarding Arrangements-Joint Working between Boards (Pages 89 - 102)

The purpose of this report is to propose a protocol is agreed to strengthen and clarify the alignment of accountabilities between the Health and Wellbeing Board (HWBB), its sub group, the Children's Trust YorOk Board (YorOK) and the City of York Safeguarding Children Board (CYSCB).

8. Annual Report- Adult Safeguarding Board (Pages 103 - 140)

This report provides information on the work of the Safeguarding Adults Board over the course of 2013. Kevin McAleese CBE, the Independent Chair of the Safeguarding Adults Board will be in attendance at the meeting to present the report.

9. Urgent Business

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

Democracy Officer:

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

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

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

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

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.

This page is intentionally left blank

Health & Wellbeing Board
Declarations of Interest

Cllr. Tracey Simpson-Laing, Deputy Leader of City of York Council

- Member of Unison
- Safeguarding Adult Board, CYC – Member
- Peaseholme Board – Member
- Governor of Carr Infant School

Kersten England, Chief Executive of City of York Council
My husband, Richard Wells, is currently undertaking leadership coaching and development work with consultants in the NHS, including Yorkshire and the Humber, as an associate of Phoenix Consulting. He is also the director of a Social Enterprise, 'Creating Space 4 You', which works with volunteer organisations in York and North Yorkshire.

Patrick Crowley, Chief Executive of York Hospital
None to declare

Dr. Mark Hayes, (Chair, Vale of York Clinical Commissioning Group)
GP for one day a week in Tadcaster.

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

Garry Jones, Chief Executive York Council for Voluntary Service
As the Council for Voluntary Service has the contract to run York Health Watch

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 Health Watch York

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

This page is intentionally left blank

Agenda Item 3

City of York Council | Committee Minutes

Meeting	Health and Wellbeing Board
Date	29 January 2014
Present	Councillors Simpson-Laing (Chair), Looker and Healey, Kersten England (Chief Executive, City of York Council), Dr Paul Edmondson-Jones (Deputy Chief Executive and Director of Public Health and Wellbeing, City of York Council), Siân Balsom (Manager, Healthwatch York), Chris Long (Local Area Team Director for North Yorkshire and the Humber, NHS England), Patrick Crowley (Chief Executive, York Hospital NHS Foundation Trust), Rachel Potts (Chief Operating Officer, Vale of York Clinical Commissioning Group), Chris Butler (Chief Executive, Leeds and York Partnership NHS Foundation Trust), Tim Madgwick (Deputy Chief Constable, North Yorkshire Police) (Substitute for Dave Jones), Mike Padgham (Chair, Independent Care Group)
Apologies	Dr Mark Hayes (Chief Clinical Officer, Vale of York Clinical Commissioning Group), Dave Jones (Chief Constable, North Yorkshire Police)

34. Declarations of Interest

Board Members were invited to declare any personal, prejudicial or disclosable pecuniary interests, other than their standing interests attached to the agenda, that they might have had in the business on the agenda.

None were declared.

35. Minutes and Matters Arising

Resolved: That the minutes of the Health and Wellbeing Board held on 4 December 2013 be signed and approved by the Chair.

The Chair also updated the Board in reference to Minute Item 32 (Progress Report- Section 136 Place of Safety). It was confirmed that building work had been completed and that the Place of Safety would be open on Monday 3 February 2014.

36. Public Participation

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

David Smith from the Retreat spoke in regards to the recent Mental Health Strategy launched by the Government.
He commented that he felt that it was the most positive strategy for years. He remained curious as to how implementation of the strategy would be monitored at a local level.

John Yates from York Older People's Assembly raised a number of issues in relation to Agenda Item 7 (Urgent Care and Delayed Transfers of Care Update). He congratulated the Clinical Commissioning Group (CCG) on information supplied to the public about how they intended to use the Winter Pressure money given to them by the Government. He also spoke about a media release that the CCG had recently been issued on a Winter Proofing Scheme regarding the use of Emergency Care Practitioners to treat people in their homes.

He detailed how this release did not include information on how individuals could contact this service.

He also felt that the service should operate for 24 hours and seven days a week. If the service was to be run by GPs it should be available for access over the holidays and at weekends. Finally, he spoke about older people who were living by themselves and that their special requirements should always be considered when setting up this service. This was because in his opinion, home might not always be the best option for someone without relatives or other care provision on hand.

37. "If You Could Do One Thing"(Local Actions to Reduce Health Inequalities)-Professor Kate Pickett and Professor Alan Maynard, University of York

Board Members received a report and PowerPoint presentation from Professor Kate Pickett and Professor Alan Maynard on current findings of health inequalities. Slides from the PowerPoint were attached to the agenda, which was subsequently republished following the meeting.

During Professor Maynard's presentation he told the Board;

- There must be greater evidence in policy making. In his view most policy had been an unevidenced experiment on people, and investment in certain areas would always have a knock on effect in depriving other sections of society.
- He felt it was un-ethical and against the public benefit if rigorous examination using evidence and evaluation of practice in Health and Social Care was not always used.
- There was a need for collation and pooling of data across all sectors of public life, not just in the health service but also in education and in justice services for example.
- South Somerset for example had merged all data for individuals and attached costs in regards to their needs. They had also added in details such as Long Term Conditions to the data. He felt this could be done by the Council and that York would be behind the pace if this was not done.

- Great data collation could enable greater demand management and allow for Government ministers to not "fly free" when presenting policy.

During Professor Pickett's presentation she told the Board that there was now a 25 year difference in life expectancy between the richest and poorest in the richest and poorest boroughs of London. She also reported that it was estimated that 40% of all health problems were socially determined.

She shared with the Board the 9 key local policy changes that were recommended in the British Academy report on Health Inequalities. These responses were;

- Living Wage: There was a need to implement a living wage, for example Local Authorities could use their procurement powers to stimulate this across the public sector.
- Giving Children the Best Start in Life: Resources should be focused as early as possible in a child's life.
- 20 mph Speed Limits in all Residential Areas: 20 mph speed limits imposed on 30 mph zones would be easy to enact at a local level. This might reduce the number of fatalities, in particular child fatalities.
- Tackle Worklessness: To overcome worklessness, more focus should be made on a person's individual health situation rather than getting them a job as quickly as possible.
- Use of Participatory Budgets: Using participatory budgets in mental health provision to make decisions. The process of participation in intervention does make an impact on the individual.
- Improve Further and Adult Education: Further and Adult Education could reduce health inequalities and could lower mortality rates.
- Better Focus on Ethnicity: Ethnicity had been substantially neglected in discussions about health inequalities.
- Friendly Environments for Older People: It was necessary to create Older Friendly Environments, as place matters in greater social integration.
- Rigorous Evaluation and Use of Evidence: This had been discussed already in the presentation by Professor Alan Maynard.

Discussion between took place on the two presentations. The following points were raised;

- That often when looking for examples of good international practice there was a tendency to look towards the United States, which had a poorer health and social care system in comparison.
- That there was always research available for service providers and commissioners to use, but there always seemed to be reluctance to access this.
- That there were people who had a job but were in poverty.
- Income inequity was a driver in health inequality, and although York had high levels of growth there was a worsening picture of income inequality in the city.
- There was a necessity to look at the whole family when examining mental and emotional health. In some cases, it might be better for one parent to not work.
- Unless a community was 'healthy, learning and safe' it would fall behind more prosperous communities.

Board Members asked what work would be done to push the momentum raised by Professor Pickett's report. They added that data sharing required more work and that all partners needed to have the courage to evaluate their practices.The Board were told that a Health Inequalities Board had been established which would look at having a wider discussion with partners in the city. It was noted that an update would be given on this at the next Board meeting.

Resolved: (i) That the report and presentations be noted.

(ii) That an update on the work of the Health Inequalities Board be given at the next meeting.

Reason: In order to inform future work of the Health and Wellbeing Board.

38. Building the Relationship between the Health and Wellbeing Board and the Health Overview and Scrutiny Committee

Board Members received a report which asked them to consider their working relationship with the Health Overview and Scrutiny Committee (HOSC). The report put forward some suggestions as to how this could be progressed.
It was underlined that the HOSC now had the role to hold to account commissioners and providers of care in the city, not just the Local Authority and NHS Bodies.

The Chair suggested that along with the report's recommendation that the Chairs of the Health and Wellbeing Board, Health Overview and Scrutiny Committee and Healthwatch York meet to look at each other's Terms of Reference and Functions to avoid duplicating work.

Resolved: (i) That Option (i) be developed and a further report be submitted to future meetings of this Board and HOSC, setting out a proposed framework.

(ii) That the Chairs of Health and Wellbeing Board, Health Overview and Scrutiny Committee and Healthwatch York meet to discuss each other's Terms of Reference and Functions.

Reason: In order to establish a strong working relationship between HOSC, HWBB and the patient voice in York.

39. Urgent Care and Delayed Transfers of Care Update

Board Members received a report which provided them with a summary of how the national Winter Pressures Money allocation had been used to support the local health and social care economy. The report outlined the schemes which had been agreed by the local Urgent Care Working Group (UCWG) and how the Vale of York Clinical Commissioning Group (CCG) is monitoring outcomes.

In response to points raised by John Yates under Public Participation. The Chief Operating Officer of the CCG reported

that they were looking at a single point of access to Emergency Care Practitioners (ECP). Some Board Members felt that the public needed to know more about ECP's and make it clear what the service was.

Members were informed that due to the Winter Pressures Money, York Hospital's targets at the last quarter had improved significantly in the light of the last three, where there had been reported failure. Given that they had not reached targets in the previous three months, this showed that it was not solely a winter phenomenon.

In regards to Delayed Transfers, it was reported that at the end of December 20 people had been delayed in York; ten of these were the responsibility of the NHS and ten the responsibility of Social Care. This was a small decrease on the October figure. The bulk of delays in acute care were the responsibility of the NHS while the bulk of delays in mental health and non acute care were the responsibility of social care.

Resolved: That the report be noted.

Reason: So that the Health and Wellbeing Board are kept informed.

40. Clinical Commissioning Group Strategic Planning Update

Board Members received an update report on the NHS Vale of York Clinical Commissioning Group's (CCG) strategic planning process.

The Chief Operating Officer of the CCG confirmed that they had held a stakeholder event and would be consulting further with the community in March in relation to Resident Centred Health and Care Models.

Board Members from Healthwatch York and Centre for Voluntary Service informed the rest of the Board that they had received excellent feedback from attendees at the public consultation events hosted by the CCG. They wished to receive the dates for the next consultation events as soon as possible, as they were keen to get involved.

Some Members raised concerns about similar language being used by different partners, often to mean different things. They suggested that this should be tightened up to stop any confusion that might occur as a result of this.

Resolved: That the update report be noted.

Reason: So that the Board are kept informed.

41. Integrating Health and Social Care- Draft Integrated Plan

Board Members received a report which accompanied York's draft submission of the initial plan for the Better Care Fund (BCF).

The Chief Operating Officer from the CCG and the Chief Executive of York Hospital NHS Foundation Trust shared some additional comments with the Board. These were;

- That the plan needed to be presented in Plain English, without unnecessary jargon.
- It needed to be recognised that as the money provided by the BCF was from existing funds that there would be challenges in redistribution.

Officers who put together the initial plan accepted that the language used was not particularly accessible, but would continue to work with partners to refine this. The aim of the plan was to prevent local residents from always having to use Accident and Emergency departments as the first response.

One of the elements of the plan was to pilot Intensive Support Teams. This concept had been developed because it was felt that there was a need for health and social care providers in the city to develop high intensive support teams on a geographical basis that had good diagnostic tools in order to support those people who needed to remain or return home into the community. Once high intensive support teams had been piloted with intensive users of health and social care services, this would be rolled out across other areas in the city, dependent on the findings of the evaluation.

Board Members raised several issues about the plan and the proposed model for health and social care in the city. These included;

- That no Mental Health Liaison currently existed in A & E departments.
- The Police as another Out of Hours Service, needed training about the plan and model so that they could respond to those who contacted their control rooms.
- That engagement with the voluntary and independent care sector was crucial.
- That there was a need for examination and evaluation of the impact of the plan at the end of the first quarter of implementation.

The Chair commented that other areas in the country were getting their plans together quickly but urged caution about rushing implementation as this was not helpful.

Resolved: That the Board;

(i) Review the draft submission for the Better Care Fund.

(ii) Agree with the approach set out in the Better Care Fund draft submission.

(iii) Agree that final approval for the Better Care Fund initial plan will be delegated to the Chair on behalf of the Board.

Reason: So the Health and Wellbeing Board can take full and formal ownership of our integration plan and our approach to the use of the Better Care Fund. It is a requirement that Health and Wellbeing Boards sign off the Better Care Fund plans before they are submitted to NHS England.

42. Local Safeguarding Children Arrangements- Changes and Developments

Board Members received a report which covered recent activity undertaken in respect of child safeguarding. It also asked the

Board to consider the format in which they would like to receive future reports.

The Chair of the Independent Children's Safeguarding Children Board, the Assistant Director for Children's Specialist Services and the Interim Director of Children and Education presented the report.

They explained that the Children's Safeguarding Board's guidance stated that that Board should have a productive relationship with the Health and Wellbeing Board. Therefore they wished to develop a framework which would allow for reports to be brought to the Board particularly as the Children's Safeguarding Board was also statutory.

The Chair suggested that a Joint meeting of both the Adult Safeguarding Board and Children Safeguarding Board be set up to recognise that there are overlaps in their agendas. One Board Member felt that was particularly crucial for those in transition from childhood to young adulthood. He added that there should not be any children incarcerated in the city with mental health issues. It was noted that the Children's Safeguarding Board championed the provision of a Section 136 Place of Safety to avoid this situation.

Another Board Member asked that the 'data run' from January 2014, which was mentioned in the report, be circulated to the Board following the meeting.

Resolved:

(i) That the attached scrutiny report be noted.

(ii) That the Board receive further updates and the method of how this is done is discussed between partners at the next Health and Wellbeing Board meeting.

(iii) That a joint meeting of the Adult Safeguarding Board and Children's Safeguarding Board be arranged.

(iv) That the January 2014 'data run' be circulated to Board Members.

Reason: (i) To note current progress of child safeguarding.

(ii) To maintain awareness of current issues in child safeguarding.

(iii) To acknowledge the overlap between the Adult Safeguarding and Child Safeguarding agendas.

Councillor T Simpson-Laing, Chair
[The meeting started at 4.35 pm and finished at 6.50 pm].

This page is intentionally left blank

Health and Wellbeing Board **2 April 2014**

Report of the Deputy Chief Executive and Director of Health and Wellbeing

Pharmacy Services

Summary

1. The Board will receive two presentations in relation to pharmacy at today's meeting as follows:

   i. Modernising Pharmacy Regulation: A new regulatory model in pharmacy which will be delivered by Mark Voce, Head of Inspection and Andy Jaegar, Policy Adviser from the General Pharmaceutical Council (GPhC) – Annex A refers

   ii. The wider role of pharmacies in improving health and wellbeing which will be delivered by Professor Richard Parish.

Background

2. The General Pharmaceutical Council's vision *'is for pharmacy regulation to play its part in improving quality in pharmacy practice and ultimately health and well-being in England, Scotland and Wales'*. Today's presentation sets out how the GPhC intend to achieve this.

3. The wider role of pharmacies in improving health and wellbeing presentation will look at the future of community pharmacy including making full use of pharmacists in pursuing public health goals.

Main/Key Issues to be Considered

4. The presentations will identify the key issues to be considered.

Consultation

5. Consultation is not applicable to this item on the agenda.

Options

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

Analysis

7. This section is not applicable to this item on the agenda

Strategic/Operational Plans

8. This topic relates to the theme of the CYC Council Plan “Protect Vulnerable People”. It also links to the priorities and actions identified in the Joint Health and Wellbeing Strategy under the priority “Reducing Health Inequalities”.

Implications

9. There are no known implications associated with the recommendations in this report.

Risk Management

10. There are no risks attached to the recommendation below.

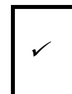
Recommendations

11. The Health and Wellbeing Board are asked to consider the contents of the presentation.

    Reason: In order to inform future work of the Health and Wellbeing Board.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator Public Health Team Tel: 01904 551714	Dr Paul Edmondson-Jones Deputy Chief Executive and Director of Health and Wellbeing Tel: 01904 551993

Report Approved  **Date** *24 March 2014*

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex A - Modernising Pharmacy Regulation: An inspector calls: A new regulatory model in pharmacy

This page is intentionally left blank

General Pharmaceutical Council

Modernising Pharmacy Regulation

An inspector calls: A new regulatory model in pharmacy

Mark Voce
Head of Inspection, GPhC
2 April 2014

General Pharmaceutical Council

Our statutory role

"To protect, promote and maintain the health, safety and wellbeing of members of the public...by ensuring that registrants, and those persons carrying on a retail pharmacy business... Adhere to such standards as the Council considers necessary..."

About us

Professional regulation

- Regulating pharmacy professionals through standards for conduct, ethics and performance
- Taking action where the fitness to practise of a registered pharmacy professional may be impaired

- **If the standards are not met, registration of that pharmacy professional at stake**
- **Individual professional accountability**
- **Analogous to GMC/NMC**

'System' regulation

- Regulating pharmacies through standards for registered pharmacies
- Requiring owners and superintendents to secure compliance with those standards

- **If the standards are not met, registration of the pharmacy is at stake**
- **Organisational accountability (through owner/superintendent)**
- **Analogous to Care Quality Commission**

Summing up our approach

General Pharmaceutical Council

Council's vision is for pharmacy regulation to play its part in improving quality in pharmacy practice and ultimately health and well-being in England, Scotland and Wales

General
Pharmaceutical
Council

Professionalism – a key strategic aim

- **Using regulation to promote a culture of patient-centred professionalism in pharmacy**

- We are committed to regulating in a way which supports pharmacists and pharmacy technicians to embrace and demonstrate professionalism in their work
- Professionalism, not rules and regulations, provides most effective protection for patients
- Prescriptive rules let us all off the hook

STANDARDS FOR REGISTERED PHARMACIES

General Pharmaceutical Council

Our approach to standard setting

- A focus on outcomes, not prescriptive rules: set out what safe and effective pharmacy practice looks like for patients
- Leaves it to pharmacy professionals - they are the experts - to decide how to deliver that safe and effective practice
- New accountability structure: being accountable for what they are responsible for which is why pharmacy owners and superintendents are accountable for meeting the new standards

So what do we mean by outcome ...

- An outcome is the ultimate result of something being in place or for an action being undertaken

- Example: Putting in a pedestrian crossing is an **output**
  - People are safer crossing the road is the **outcome**
  - Easier for those with mobility difficulties to get about is also the **outcome**

General Pharmaceutical Council

What does this mean in pharmacy?

- In practice, this means pharmacies should have as their top priority, patients and keeping them safe, and should be able to show how they do that, every day
- It will be up to pharmacies to provide the evidence and examples in whatever way they choose

General Pharmaceutical Council

Standards for registered pharmacies: Five principles

- Principle 1 – looks at how risk is managed
- Principle 2 – looks at how people / staff are managed
- Principle 3 – looks at how the building / premises is managed
- Principle 4 – is about how pharmacy services are delivered
- Principle 5 – is about the equipment and facilities they have and use to deliver services

General Pharmaceutical Council

Meeting the standards

- Pharmacies should meet the standards every day – not just when an inspector calls
- Our inspections are just one way that we assure that pharmacies are keeping patients and the public safe
- For instance, owners and superintendents renewing the registration of their pharmacies need to declare that they have read the standards and undertake to meet them

How will we know the standards are being met?

General Pharmaceutical Council

- Prototype of our approach to inspecting against the standards running from 4 November
- Testing four indicative judgements of performance – poor, satisfactory, good and excellent
  - Inspection outcome decision framework to aid inspectors in making consistent judgements
- Improvement action plans operational
- Pharmacy owner and superintendent will get a report, but no public reports during prototype phase
- Strategic relationship management has started

Inspection labels and descriptions

Poor pharmacy

- has failed to achieve the pharmacy standards overall. There are major concerns that require immediate improvement.

Satisfactory pharmacy

- achieves all or the majority of standards and may require some improvement action to address minor issues.

Good pharmacy

- achieves all standards consistently well and has systematic review arrangements that ensure continual improvement in the quality and safety of pharmacy services delivered to patients.

Excellent pharmacy

- demonstrates all the hallmarks of a good pharmacy. In addition, it is either innovative and/or provides unique services that meet the health needs of the local community and that other pharmacies might learn from.

What feedback was received from testing?

- Pharmacists value the instant feedback
- Positive engagement with staff team
- ‘Show and tell’ approach welcomed
- Seen as a learning and development opportunity for all pharmacy team
- Inspector on site for longer

Responsible Pharmacist Feedback since 4 November

RPs strongly agreed/agreed:

- 'Feedback from inspector was helpful and well presented'
- 'Feedback from inspector was accurate'
- 'Inspector explained clearly what would happen after the inspection'
- 'Inspector identified where the pharmacy was performing well' 'Inspector helped me to think about how I can improve the quality of services provided to patients and the public'
- A clearer understanding of the standards after the inspection

Responsible Pharmacist feedback (continued)

- ‘Very professional & clear’
- ‘Relaxed approach and constructive’
- ‘Issues were raised we may have not thought of i.e. vulnerable people’
- ‘Explained what she was looking for and summarised feedback’
- ‘Very informative and conveyed ideas clearly and explained where we needed improvement and why’
- ‘Inspector was informative, helpful and friendly’
- Improvement areas: mainly around making appointments, but many understood need for unannounced visit.

Owners/Superintendents strongly agreed/agreed:

- 'The inspector has explained clearly what action I am required to take following the inspection'
- 'The judgements in the report are supported by the evidence and are in line with the Inspection decision making framework'
- 'The report broadly reflects my knowledge of the pharmacy and its likely performance against the registered pharmacy standards'
- 'The report has helped me to think about how we can improve the quality of services we provide to patients and the public'

Owner/Superintendent feedback (continued)

- ‘Very comprehensive ... very fair and accurate report’
- ‘I find the reports informative and they represent a paradigm step forward’
- ‘Well structured way of inspecting a pharmacy’
- ‘Focussed on patient safety, clear standards’
- ‘Non confrontational meant that the learning process for us was better’
- ‘Positive, helpful and friendly style of the inspector; involvement of staff in the process’
- ‘I felt that it made us think about what we are doing and look at ways to improve the service we offer’

Areas for improvement from feedback

- ‘Would appreciate more time to reflect on our inspection report and comment’
- ‘There are still areas which are 'grey' and we were told to think about how we do something. I still like to be told what is acceptable and what is not’
- ‘I have concerns about publishing the report with certain sensitive figures, such as prescription numbers’

General Pharmaceutical Council

Resources

- We have a new resource with more information at
http://pharmacyregulation.org/pharmacystandardsguide

General Pharmaceutical Council

Questions?

This page is intentionally left blank

Vale of York
Clinical Commissioning Group

Health and Wellbeing Board 2 April 2014

Report of the Deputy Chief Executive of City of York Council and the Chief Clinical Officer of NHS Vale of York Clinical Commissioning Group

The Better Care Fund Plan

1. This report accompanies the latest version of York's Better Care Fund plan (attached as Annex A and B).

2. It is requested that the Health and Wellbeing Board:

   a. Review and agree the Better Care Fund plan.
   b. Accept that work will continue to fine tune the plan up until the NHS England deadline, 4th April.
   c. Agree that the Chair can formally sign off the Better Care Fund final plan on behalf of the Health and Wellbeing Board.

Background

3. The Better Care Fund (formerly known as the Integrated Care Fund) has been set up to support councils and Clinical Commissioning Groups (CCGs) to deliver their local plans for integrating health and social care. The fund amount is £3.8 billion nationally; this represents a top slice (3%) of CCG budgets to be reinvested in local integration plans (it should be noted that this is not new money and therefore we must develop our plans wisely in order to derive the maximum benefits for our residents).

4. At the Health and Wellbeing Board on 29th January 2014, the initial plan for York's Better Care Fund was approved (link to this report attached as a background paper). Following this approval, the plan was submitted to NHS England on 14th February. This cover report introduces the latest version of the Better Care Fund plan which will be sent to NHS England on 4th April.

Summary

5. York's integration plan is a 5 year plan, which is wider than the Better Care Fund and extends beyond the course of this fund. The Better Care Fund is one of many elements of our five year plan, enabling us to test a number of specific schemes throughout 2014/15, for delivery in 2016/17. The Better Care Fund is not the totality of York's vision for integrating health and social care.

6. The Better Care Fund has to be submitted to NHS England on 4th April. Work will continue on the Better Care Fund after the publication of this paper up until the 4th April deadline to fine tune our submission, however the latest version is attached as Annex A.

7. York's vision for integration has not changed since the Better Care Fund initial plan was presented to Health and Wellbeing Board on 29th January. However, since that date, the development of the plan has been ongoing and there is now much more detail about specific schemes and the finances attached to them. Improved and ongoing dialogue with our partners has allowed us to progress our integration plan and identify this further level of detail. We have also worked to address feedback received following the assurance of our initial Better Care Fund plan from both NHS England and local government peer review.

8. The integration plan is a major change, resulting in a more responsive approach, through increased cross-organisational working and more innovative use of pooled budgets, leading to true personal wellness budgets. This will require significant practice and system change, with an increased focus on partnership working that will deliver improved outcomes for residents and organisational financial benefits.

Consultation

9. Since the past Health and Wellbeing Board meeting, two further events have taken place: a large scale stakeholder event and a development session with members of York's Health and Wellbeing Board.

10. The stakeholder event took place on 10th March and was attended by 100 people, from community volunteers, to social care managers and pharmacists.

    The purpose of the event was to inform a variety of stakeholders about how the Health and Wellbeing Board are working to achieve more integrated care and support over the next five years, including the Better Care Fund and to give stakeholders opportunities to be involved and give their views in the early stages of our integration plan. We are currently analysing comments received from this event so we can address them in our integration planning and delivery. A link to the presentations used at this event is attached as a background paper.

11. On 17th March members of the Health and Wellbeing Board along with senior lead officers met to discuss the development of our local integration plan. Discussions included feedback on the initial plan, development new models of care for elderly patients, improving mental health services, data sharing and developing a joint communications strategy across the organizations on the Health and Wellbeing Board for our integration plan. Since January a number of meetings have also taken place between the council, NHS Vale of York and individual members of the Board to ensure there is ongoing dialogue with our partners.

Options

12. It is a requirement that Health and Wellbeing Boards sign off Better Care Fund local integration plans.

Analysis

13. Not applicable

Strategic/Operational Plans

14. Supporting the integration of health and social care services is a core purpose of Health and Wellbeing Boards. This is a key theme running through York's Health and Wellbeing Strategy 2013-16 and is related to all five priorities, with particular relevance to 'Creating a financially sustainable local health and social care system'. Integration is a fundamental element in the Vale of York CCG Strategic Plan 2014-19 and their Operational Plan 2014-16.

Implications

15. As our integration plan develops and approaches are tested during 2014/15, the extent of any implications will be identified. There are likely to be a number of implications, including financial, human resources, legal and equalities resulting from this whole system change.

Financial
To be identified

Human Resources (HR)
To be identified

Equalities
To be identified

Legal
To be identified

Crime and Disorder
None

Information Technology (IT)
To be identified

Property
None

Other
None

Risk Management

16. As we develop the details of our five year integration plan and begin testing of new models of care, potential areas of risks will be identified, rated and mitigated. The integration plan is at an early stage, however, integration will only be achieved though genuine partnership working across the NHS Vale of York CCG footprint, which includes North Yorkshire and East Riding local authorities.

Recommendations

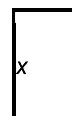
17. The Health and Wellbeing Board are asked to:

    a. Review and agree the Better Care Fund plan.
    b. Accept that work will continue to fine tune the plan up until the NHS England deadline, 4th April.
    c. Agree that the Chair can formally sign off the Better Care Fund final plan on behalf of the Health and Wellbeing Board.

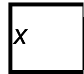
Reason: So the Health and Wellbeing Board can take full and formal ownership of York's integration plan and the use of the Better Care Fund. It is a requirement that Health and Wellbeing Boards sign off the Better Care Fund plans before they are submitted to NHS England.

Contact Details

Authors:	Chief Officers Responsible for the report:
Helen Sikora Health and Wellbeing Policy and Partnerships Officer City of York Council 01904 551134	Dr. Paul Edmondson-Jones Deputy Chief Executive City of York Council 01904 551993
John Ryan Service Delivery Lead North Yorkshire and Humber Commissioning Support Unit 07867 429625	Dr. Mark Hayes Chief Clinical Officer NHS Vale of York Clinical Commissioning Group 01904 555789

Report Approved  **Date** *24/03/2014*

Specialist Implications Officer(s)
None

Wards Affected: **All** 

For further information please contact the author of the report

Background Papers:
Health and Wellbeing Board Better Care Fund report,
(http://democracy.york.gov.uk/ieListDocuments.aspx?CId=763&MId=7501&Ver=4) 29th January
Presentations
(http://www.york.gov.uk/downloads/download/3189/presentation_-_health_and_wellbeing_board_event_-_10th_march_2014)from the 10th March stakeholder event.

Annexes

Annex A – Better Care Fund plan

Annex B – Better Care Fund finance section

Glossary

CCG – Clinical Commissioning Group

ANNEX A

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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**
Boundary Differences	**City of York Council sits entirely within the footprint of NHS Vale of York CCG. However the CCG also sits within the boundaries of both North Yorkshire County Council and East Riding of Yorkshire and the CCG is working across organisational boundaries to ensure all plans align**
Date agreed at Health and Well-Being Board:	**29/01/2014**
Date submitted:	**14/2/14**
Minimum required value of BCF pooled budget: 2014/15	**£3,354K** Which comprises: Health Gain Transfer £2,744K Better Care Funding 14/15 £610K
2015/16	**£12,127,000**
Total agreed value of potential pooled budget: 2014/15	**£4,665K** Which comprises:

	As above £3,354K Reablement Funding £915K Carers Funding £396K
2015/16	**£12,127,000**

b) Authorisation and signoff

Signed on behalf of NHS Vale of York Clinical Commissioning Group	
By	Dr Mark Hayes
Position	Chief Clinical Officer
Date	13/2/14

Signed on behalf of City of York Council	
By	Kersten England
Position	Chief Executive
Date	13/2/14

Signed on behalf of York Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Tracey Simpson-Laing
Date	13/2/14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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 fortnightly 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.

On 16th December 2013, CYC and VoY co-hosted a Health and Social Care Integration Workshop, attended by many our local stakeholders. The event was part of our communication and engagement to help draw on local experiences, prioritise and develop support options for whole-systems integration. The workshop was also an opportunity to share learning about different ways people themselves had managed to overcome barriers to integrated care already.

The common theme from this workshop was that we needed a sustainable joined up approach to care; this was the highest priority for our residents. This means health and social care staff working together in multi-agency operating teams. We have built our plan on this theme and working with our providers both in health and social care, we believe we can make significant improvements to the way care is delivered. Through these engagement processes, we are building on our system wide successes and using the BCF to both embed what is working well and develop more improvements.

Following on from this workshop, the Health and Wellbeing board held a joint engagement event on 10th March 2014 where the detail around the BCF plan was discussed with over 90 members of the public and local providers. Feedback from this event has focussed our attention on the requirement to turn our plans into actions and to continue to engage at all levels on a regular basis. We have acted on this feedback and specific responses are detailed later on in this submission.

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.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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 VoY 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. The most recent event in March 2014 focussed on integrating health and social care, transforming adult social care and the Joint Strategic Needs Assessment (JSNA). 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.

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.

e) 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
Terms of Reference for York Health and Wellbeing Board	This sets the strategy by which our plans are being delivered
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health & Wellbeing Strategy.	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
Health Gain Plan	Joint agreement to invest health gains money in areas that deliver both Adult Social Care capacity and improved health benefits
Winter Pressures Plan	Additional funding from NHS England to assist patients through the health and social care system during what was anticipated to be an extremely busy period. Plans jointly agreed.
Financial Plan	Appendix to main BCF submission which outlines financial plans and performance metrics
Outcomes Framework	We have an agreed outcomes framework to support the delivery of our programme of work.

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- **What changes will have been delivered in the pattern and configuration of services over the next five years?**
- **What difference will this make to patient and service user outcomes?**

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.

We know that all the different parts of the system (GPs, Hospitals, Mental Health, Social Care, Community Based Services and others) need to change the way they work to ensure we can continue to deliver the right care at the right time in the right place. Specifically we need to ensure:

- That 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 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.

- 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.

Our vision is to bring together a comprehensive range of health and wellbeing services to provide Care Hubs for local people that are:

- Dedicated to their needs
- Coordinated for their convenience and effectiveness
- Consistently delivering high quality, successful outcomes.

ENID'S STORY NOW

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 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.

ENID'S STORY – THE FUTURE

The Care Hub Team identify Enid as a risk for admission and proactively assesses and manage 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 care worker that she and her family and contact for support. When she contacts the NHS111 and the OOH GP her medical details are available. Alternatively during the week she is seen by her GP or an ECP 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. 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, updated DNACPR 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 adjust her management plan and involve her family to anticipate risks in her disease trajectory.

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 to achieve the best health and wellbeing for everyone in our community.

To do this 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". If we succeed we will see reduced hospital based activity and a much greater use of community and home based support.

In order to achieve our vision we know that significant system and process changes will need to happen.

We will do this by focusing on partnership working and innovations that are more financially effective.

We are also mindful that to achieve true transformation for all of our residents we will need to address the difficult issues of more collaborative Local Authority work and the challenges this will bring. Specifically we will need to address how the various Local Authorities which work with VoY CCG can work more closely to develop shared services where appropriate.

The key themes we will see in our integrated health and social care system will be the development of:

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.

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 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.

These key themes will be supported by additional enabling schemes which are explained in more detail later in this submission.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- **What are the aims and objectives of your integrated system?**
- **How will you measure these aims and objectives?**
- **What measures of health gain will you apply to your population?**

With our new approach we aim to improve quality of support, better outcomes and overall improved experiences for residents and be able to measure these. The specific measurable aims of our new model are:

- A reduction in the proportion of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge.
- Less demand for emergency placements.
- A reduction in the length of stay for residents who do require an emergency placement where no other alternative is available.
- A reduction in the proportion of residents being admitted to care homes, from both acute and community settings.

To support this we will also expect to see significant improvements through joined up support. Initial aims we expect to deliver are:

- Residents only having to tell their story once.
- Faster response times and more joined support to individuals and their carers/families
- Positive feedback and customer satisfaction reports

Measuring success

We aim to put in place a multi-agency programme team who will be responsible for the planning and implementation of the models across the health economy. This team will also be tasked with developing a suite of monitoring and reporting mechanisms (monthly and quarterly) that will allow us to analyse the impact of the new approach. Specifically, these reports will need to identify:

- The impact on our local acute provider on a case by case basis. This level of detail will be crucial in order to release resources sustainably and increase the scale of our potential funding model of pooled budgets we hope to be able to achieve, significantly beyond the minimum requirement for BCF.

- The impact on the local authority, specifically in the Adult Social Care Sector, focussing on the financial implications of any intervention.

- The impact on GPs, wider primary care and the voluntary sector.

- The more appropriate allocation of care packages to identify how our model has enabled a greater level of appropriate independence.

- How activity has moved through the system in order to help future proof the model and identify new opportunities.

- The level of satisfaction from people who have used the new system. We intend to further develop relationships with York University and other industry providers to investigate new and more effective ways of capturing, understanding and building on the feedback received.

An early piece of work that is currently being undertaken is to establish a base-line of current activity and expenditure, in both health and social care settings, so that we can clearly measure and report on the impact our new service models are having. A robust evidence base to support change and measure delivery is crucial to our overall vision and we intend to build the necessary partnerships to develop this evidence base.

A key measure of our success will be delivering our vision and the aims and outcomes detailed earlier in this document. We recognise that we will have to work more closely across organisational boundaries to help drive out the inefficiencies and duplication of work that currently happens on a regular basis.

By integrating systems, processes and where required workforces, we will be able to achieve truly transformational changes for our residents.

The truest measure of success will be a financially balanced system where the shift of spending from the acute sector to community settings has supported transformation and allowed acute providers to re-configure under their terms to ensure their on-going financial viability. To ensure the risks in reaching financial balance are fully mitigated, we will develop a shred risk agreement between health and social care organisations.

We will work closely with colleagues in health and social care, through the Collaborative Transformation Board, to ensure this measure is achieved.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- **The key success factors including an outline of processes, end points and time frames for delivery**
- **How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care**

CARE HUBS

The main scheme which sits at the core of our joint work programme is the introduction, through a series of pilots, of a refreshed model of integrated health and social care provision based on Care Hubs.

In the first two years, the most significant change we are proposing to the way health and social care is currently delivered is the development of the principle of Proactive Care.

Our vision for this approach is about working with individuals to identify their current and prospective health and care needs, whilst working actively with them to promote independence and reduce risk of escalation and/or relapse in health and well-being. Early and proactive care will be delivered through a multi-disciplinary and multi-agency team, based in a community setting and with all the necessary infrastructure in place to deliver rapid, safe and sustainable services. This approach will help us deliver the outcomes for residents we identified earlier and will be a key contributor to making our joint vision work.

In order to ensure we gain maximum learning and innovation from this approach, we do not intend to be too proscriptive on how Care Hubs and Proactive Care should be delivered. We will however, expect potential providers of these models to work within a clear framework that identifies the outcomes we want to achieve and the impact we expect their respective models to have. Specifically we expect to see rapid and measurable evidence that the following have been delivered:

- A reduction in the proportion of residents being admitted to care homes from both acute and community settings
- A decrease in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge
- A reduction in the number of emergency department attendances
- A reduction in the proportion of admissions following an emergency department attendance
- A reduction in the requirement for emergency placements
- A reduction in length of stay for individuals where emergency placements are necessary
- A reduction in the proportion of attendances at emergency departments for individuals presenting with mental health problems
- A reduction in the number of patients known to the Community Mental Health Team attending emergency departments
- A reduction in the number of falls related injuries for residents over the age of 65
- A shared care record for each individual accessing the Care Hub
- A named single contact point for each individual accessing the Care Hub

We will also expect our service providers to evidence how they will engage with and involve key partners in the development and delivery of their proposed service model. Specifically we will expect to see plans which include (but are not limited too):

- Local Authorities
- Acute Providers
- Mental Health Providers
- The Voluntary Sector
- Health Watch

We intend to pilot the approach in 2 or 3 areas, with a range of different providers.

Providers will be expected to use formal joint Action Learning Sets so that we can identify shortcomings and share best practice to make sure our long term model is as efficient as possible.

The Care Hubs will be supported by a range of services and interventions in both community and hospital settings. Many of these already exist, in both health and social care and some will be the subject of community services procurement and refresh.

A key work stream during the implementation of the proposed model will be working with partners to ensure existing and future interventions are fit for purpose and capable of reacting to the pace and accessibility we require the new service to deliver.

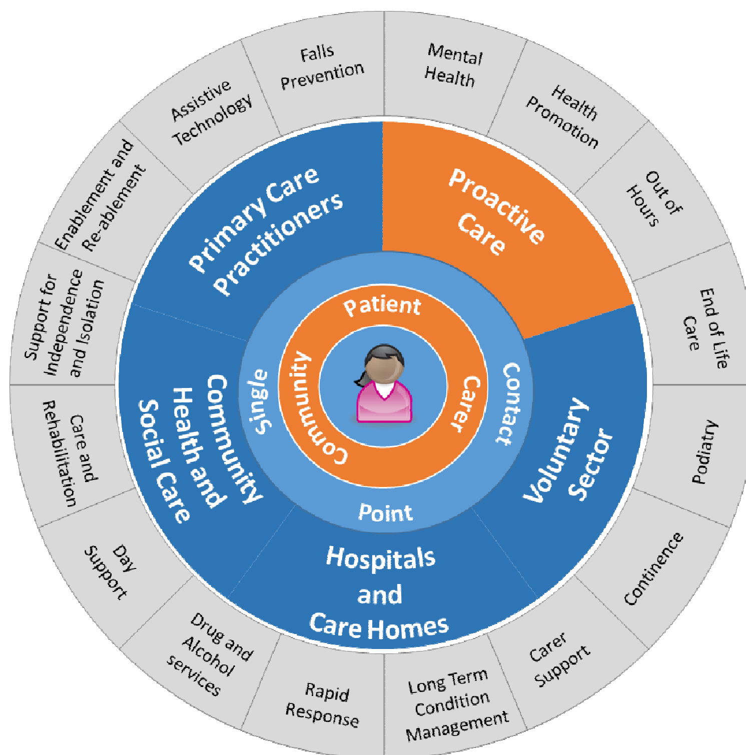
We will also require our providers to develop 7 day working. Not all health and social care services will be required to be available 7 days a week and we will focus on those services which have the biggest impact for our residents.

Where residents are registered with GP practices that are not taking part in the initial phase of Care Hubs we will use our best endeavours to achieve the same level of quality and outcomes, taking the experiences from the Care Hubs to shape their required service provision.

We intend to launch our pilots as soon as possible after 1 April 2014 and will put in place fortnightly progress meetings and formal quarterly reviews where we will evaluate the successes and failures of each pilot. At the end of September 2014 we will formally re-align the pilots based on the issues identified to that point and our intention is that we will be in a position to go live across the health economy by 1 April 2015.

We expect that this element of our overall joint work programme is where the majority of resource will be allocated, both during the pilot stage and, once the service is embedded and delivering the outcomes we expect, over the coming years. We anticipate that as the new model takes effect, we will be able to make a greater shift of resource from existing hospital and care home spend to this new integrated model.

The diagram and notes below show how we envisage the Care Hub model working and explain how the various elements of the model will work together.



- In this model, the individual sits at the heart of all we do and the various services and interventions work around their needs and what they want to achieve.

- We recognise the vital importance that individuals' own support networks play in their overall support and we intend to continue to focus on supporting carers, with a special focus on child carers, to minimise the requirement for emergency interventions.

- The role and impact of the single contact point will be crucial in making the whole system work.

Specific Scheme Details

The specific schemes we intend to implement in 14/15 are:

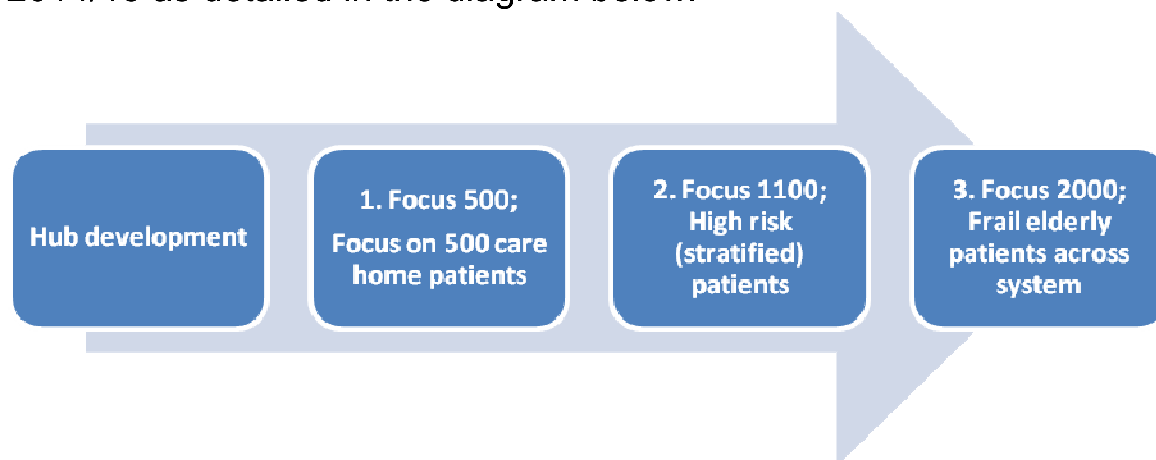
Care Hub – Priory Medical Group

The care hub will be a scalable, proactive and responsive care model that seeks to continually improve health and care outcomes, whilst reducing the cost burden on the local health and care economy.

The aims of this model are:

- To put service users at the *centre* of hub delivery
- To *improve* defined population-based health and care outcomes
- To *reduce* population-based healthcare costs, social care costs and associated costs
- 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

This model will take a phased approach to delivering its strategic aims over 2014/15 as detailed in the diagram below.



This is a primary care led scheme, but is being delivered in partnership with CYC Adults Social Care and YTHFT Community Services. Additional input from York CVS and other voluntary organisations will be sought as the project develops.

Mental Health Street Triage

This scheme is intended to enable timely and appropriate interventions to individuals at their point of contact with the police. It is based on a similar scheme which is being successfully run in Leeds, Leicester and Cleveland. Other pilots are also being rolled out across the country.

The scheme involves creating a small team of skilled mental health professionals who are available to be deployed by the police to provide initial assessment and advice for individuals with mental health related issues.

It will complement the recent investment in the Health Based Place of Safety for Mental Health Act detainees in York and help avoid unnecessary detentions under the Act.

The scheme will be open and accessible to people of all ages, where it is believed they may have a mental health illness, learning disability, personality disorder or are abusing substances, who come into contact with the police outside of custody. The objective is to divert people from the Criminal Justice System (where 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.

This scheme is led by North Yorkshire Police in a partnership with LYPT. It is proposed it will be joint funded with North Yorkshire County Council as part of the CCGs BCF submission to the North Yorkshire H&WB Board.

Emergency Care Practitioners

As part of the winter pressures projects an additional three members of staff from the Yorkshire Ambulance Service have been employed to work alongside regular ambulance crews to attend falls, faints and minor injuries. They are working on a roving basis around the City 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.

Similar pilots in Sheffield have shown a 50% reduction in conveyance to the ED for minor call outs. This scheme has been ongoing since 2nd December 2014; a total of 268 calls attended were recorded up to the end of December and 173 in January. 35% of patients were not conveyed to ED during December 2013 and 44% in January 2014. This activity positively impacts on reducing ED attendance, admission and discharge planning requirements.

Modelling has been done to show the potential impact on the specific areas where ECP's are shown to have a significant intervention rate; these are the green 2 and green 4 types of call which include falls, fits, abdominal pain, breathing problems and convulsions. It is anticipated that the three ECP's in City of York will continue to cover this area, and additional ECP's and supporting administrative staff would be required to work in the wider NYCC and ER areas.

These staff working outside City of York may follow a different model where they have a specific GP base and work to support community teams.

It is intended to continue to fund this project through the BCF.

Hospice at Home

St Leonard's Hospice will be working with numerous stakeholders across the Vale of York (incorporating the City of York Council, and those parts of East Riding of Yorkshire Council and North Yorkshire County Council areas within the Vale of York) to develop its Hospice at Home service and is dependent upon their full support, engagement and motivation.

The project aims to focus on those clients who are approaching the end of their life and who wish to die at home/usual place of care. The team provides a response to crisis service, a terminal care service, a rapid discharge support service and a service at home whilst clients await a hospice bed. The service provision is co-ordinated through a hub so that clients are assessed and resources are deployed to generate the most effective and co-ordinated response. The approach to service users will be to examine their likely holistic needs and requirements as well as their carers' and in addition will look to survey their experience of the developing services as well as the experiences of other stakeholders.

Progress will be measured by the project team and monitored by health and social care commissioners. Risks and issues will be identified, managed and where required escalated to commissioners/project delivery group.

Psychiatric Liaison

This model will provide a dedicated Acute Liaison Psychiatry Service (ALPS) to the Emergency Department of YTHFT 24 hours a day 7 days per week. The model would provide one Band 6 Registered Mental Nurse on duty 24 hours a day to conduct lone mental health and self-harm assessments.

The ALPS team will assess patients aged 18-65 who present to the ED with mental health difficulties and following presentations of self-harm. They will also provide a self-harm assessment service to the acute medical areas of YTHFT, when the medical consequences of self-harm cannot be managed within the ED.

This is a joint project between YTHFT and LYPT, with additional co-funding from BCF allocations from CYC and NYCC.

Alignment with existing plans and strategies

The York Health and Wellbeing Board provides leadership for continued partnership working between VoY, local authorities, providers, commissioners, the voluntary sector and Healthwatch to ensure our strategic plans for health and social care remain consistent in their aims and objectives. The JSNA was the basis from which our Joint Health and Wellbeing Strategy was developed and subsequently this has influenced the operational and commissioning plans of the CCG and local authority social care.

We now need to join up our systems, funds and teams to ensure that our strategic ambitions for integration can be achieved practically. The Health and Wellbeing Board have a major role here. They will approve our plans for integration and through this governance they will use their decision making powers to move towards this joint approach, i.e. agreements to share risk and reward and to pool budgets. We intend to work more closely with members of the Health and Wellbeing Board as our integration plans develop to ensure they are aware of the impact and consequences, equipped to make timely decisions and can confidently fulfil their core purpose of leading the local health and social care system towards integration. We also recognise that we need to replicate this partnership working at every level. Below the Health and Wellbeing there are a number of partnerships to facilitate and deliver our joint approach, we are working hard to ensure that this becomes the norm, rather than the exception.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The key drivers for understanding the implications on the acute sector is that the funding to support BCF is already committed and the necessary shift of demand and related funding is most likely to shift from our spend with acute providers.

We have not underestimated the impact this will have and have shaped our joint plans accordingly. These are reflected in our 5 year commissioning plan and in YTFT's 5 year strategy.

Modelling is underpinned by the assumption that spending on hospital based activity can and will be reduced; this will require a seismic change in the way we deliver care and manage wellness and we believe that partners across our local area understand and accept this challenge. YTFT acknowledge that the success of BCF and our wider Care Hub strategy will lead to significantly reduced demand for hospital beds, both in the immediate and longer terms.

We would work with the Trust to develop a multi user approach to using any vacated hospital estate (DGH and community hospitals), as appropriate to local need and to minimise financial risk to the system.

The main purpose of our joint plan is that those individuals at high risk of health and social care interventions are proactively managed and supported to avoid the requirement for hospital based interventions. We recognise that in order to make both the BCF and our joint longer term sustainability a reality, we have to reduce the overall spend in the acute sector in order to properly fund our integrated out of hospital model. From our joint workshop and series of meetings with our main acute provider we have agreed the proposed model which will help us achieve this; the key to success will be in turning this high level plan into real actions that allows all partners to reshape their model of service provision accordingly. We believe that that we have a joint approach to addressing this issue and at a recent joint meeting, colleagues from YTFT re-iterated their commitment to reduce their footprint, based on scalable change in the way services are provided outside of hospital. This joint understanding and acceptance of how we might now deliver sustainable and transformational change is a significant step towards being able to operationalize our proposed model.
Specifically we will aim to target our efficiency savings around:

- Admissions avoidance
- Reduced length of stay
- Reduction in delayed discharges

Admissions avoidance

Our proposed Care Hubs will play a pivotal role in admissions avoidance. Through risk stratification, patients could have an advance care plan – making sure those at most risk of defaulting to acute services have the necessary support packages in place – and rapid intervention when their needs are acute, to enable return to their normal place of residence as soon as possible.

Our plans for augmented Emergency Care Practitioner Teams will also significantly address the key deliverable of admissions avoidance.

Whilst the impact of subsequent levels of service provision are currently being worked up, we envisage acute providers making significant cost efficiencies through refreshed models of service delivery based around footfall changes and related activities. In our discussions with providers, it is clear that they are committed to shaping their services to reflect the impact of the expected changes.

Together we recognise the challenges this might create if we are to sustain high quality hospital care for our residents and we will continue to work in partnership to minimise this risk.

Length of Stay/Delayed Transfers of Care

For those patients who have to be admitted to hospital, we want to ensure their stay is of high impact and as short as possible. We aim to plan discharges as soon as possible following unplanned admission and return patients to home, with a care package where necessary, as soon as they are medically fit and it is safe to do so. Current blocks to this such as delays to care packages, limited support over weekends and other system inefficiencies will all be addressed through the Care Hub, where local practitioners will follow patients from home into hospital and back home again. We believe our new model will secure much greater level of cooperation between organisations and will ensure any blocks to discharge are identified and removed as soon as practicably possible.

Our new approach to a single contact point will have a key role to play in this scenario, as will the introduction of 7 day a week working across organisations. We are under no doubt about the challenges this system change will bring but our joint commitment to making the necessary changes will help us to deliver the change we need.

Risks

We recognise that what we are proposing carries an element of risk for both health and social care commissioners and providers. Collectively we need to ensure that our new model delivers the necessary shift away from hospital based activity to community based activity that enables individuals to retain independence and wellbeing in a place of their choice. We are developing a risk share strategy to help us fully understand and manage these risks and will progress this at pace through individual project boards and the CTB.

e) Governance

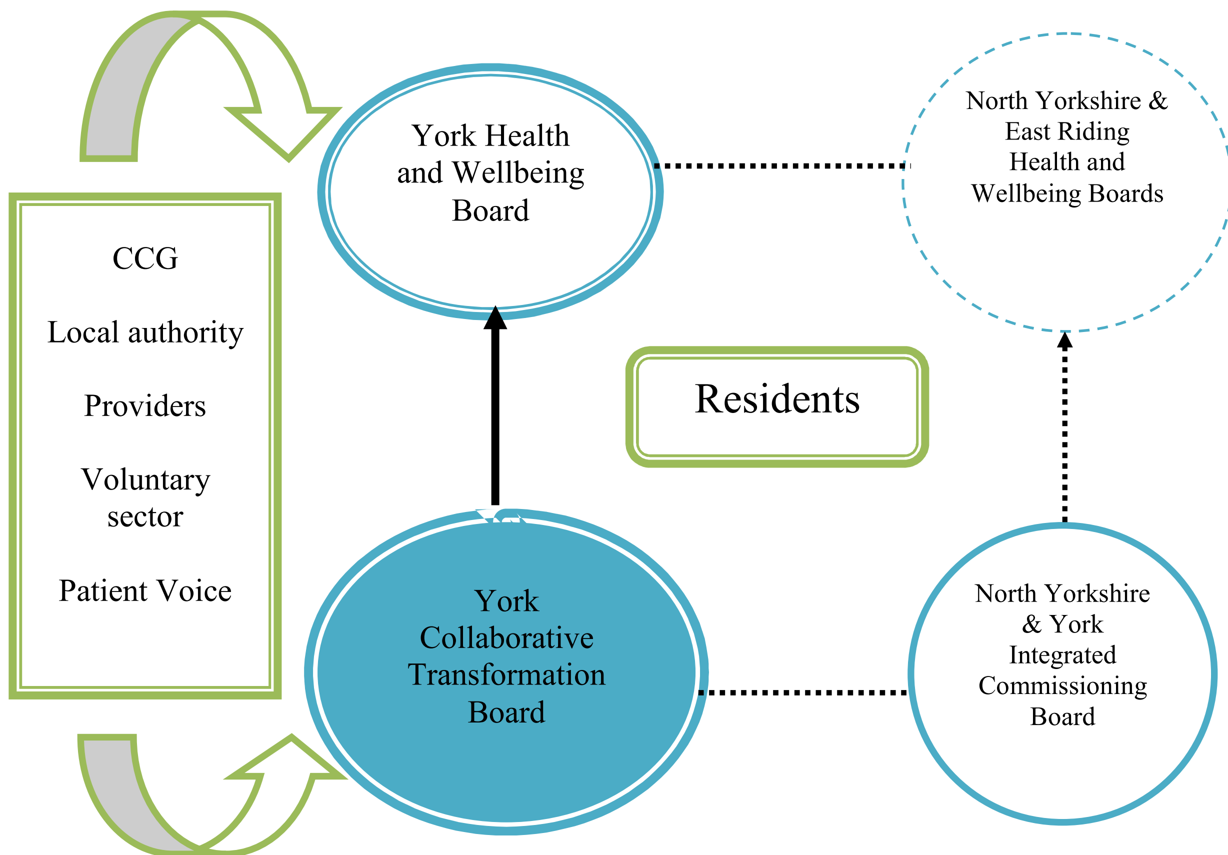
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The York Collaborative Transformation Board has been established to progress and govern our integration plan. The Collaborative Transformation Board 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 is chaired by the Director of Adult Social Services, who reports progress on BCF to the HWB.

Because the CCG works alongside 3 Local Authorities, we are actively exploring opportunities to work across geographical boundaries, particularly with North Yorkshire and East Riding local authorities, ensuring our plans are aligned across the whole CCG footprint.

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

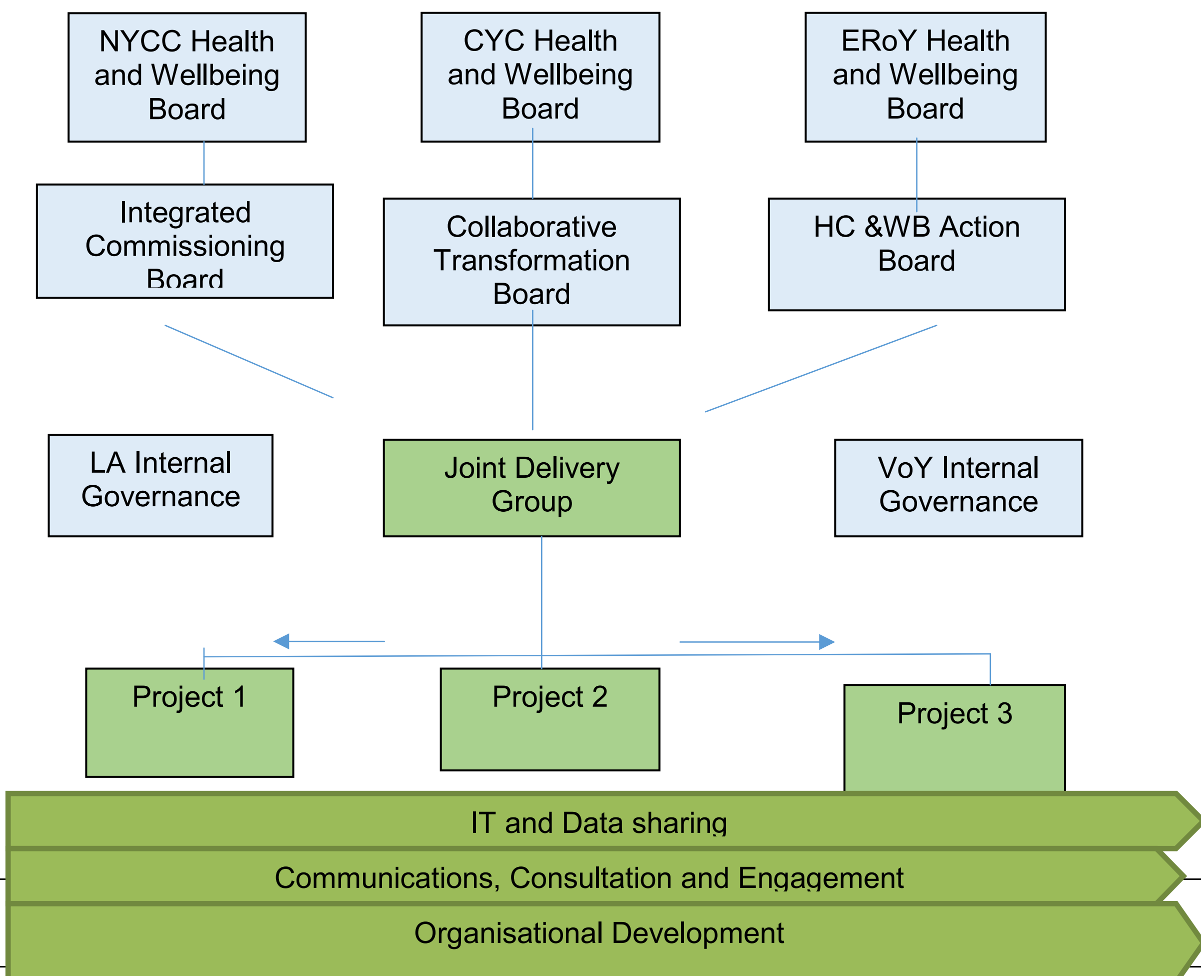

York Health and Wellbeing Board
North Yorkshire & East Riding Health and Wellbeing Boards
CCG
Local authority
Providers
Voluntary sector
Patient Voice
Residents
York Collaborative Transformation Board
North Yorkshire & York Integrated Commissioning Board

ANNEX A

BCF is a significant component in securing our joint vision for health and care, which we envisage will be delivered through Care Hubs across the system in the longer term. We have therefore produced a more detailed delivery framework, driven through a Joint Delivery Group which sits below the Collaborative Transformation Board.
This will provide robust and systematic programme management, assurance and scrutiny of proposed plans and will be the forum for joint learning and problem solving.

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. In the diagram below, these enablers and the new boards and groups that need to be put in place are identified in green.



We recognise the time pressures that many people within the CCG and Local Authority face and in order not to commit people to too many meetings, we propose the following composition for the new boards and groups identified above:

Joint Delivery Group

The Joint Delivery Group (JDG) is responsible for ensuring the delivery of the proposed BCF schemes and will hold providers to account for the delivery of their respective programme plans. The Group has an agreed set of Terms of Reference, an agreed reporting process and has already started to meet and agree processes for monitoring and support with providers.

The JDG is co-chaired by the Vale of York and City of York. Membership includes senior empowered managers from both organisations as well as clinical and social care leads who provide professional oversight and scrutiny to the developing schemes.

Project Teams

Project Teams for each scheme will be responsible for the day to day management and delivery of their respective work. We do not intend to dictate to providers how they should manage the delivery of their projects, however we are clear that the levels of engagement and involvement highlighted earlier in this paper will form a crucial part of their success. We intend to work closely with our potential providers to help them establish these Project Teams and have already agreed additional resource for them to help maintain rigour and traction in the delivery process. We have also put in place weekly and monthly reports which will focus on the delivery and benefits realisation of the projects. These reports (initially for the JDG) will form the basis of more formal reporting to the CTB and the H&WB Board and will also provide internal assurance to both the CCG and CYC.

In order to benefit from shared learning we have also established 6 weekly Action Learning Sets (ALS) where we will use external expert support to ensure we continue to support our projects to deliver at pace. The first of these ALS was held in March, supported by a team from the NHS England Analytical Services (Policy and Commissioning).

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Locally we have agreed that protection of adult social care services means that we will initially continue to fund the social care support funded to date by the 'health gain' money. These services will be reviewed as we develop the Care Hubs, with the expectation that they will be realigned to fit with the Care Hub model. We have also agreed that for 2015/16, the elements of the reablement and carers funding, which have not historically been made available from health commissioners, will now be included in the BCF fund.

The fund will be used to support adult social care services within the local authority, which also have a health benefit. It will be incumbent on social care to work closely with health colleagues to transform the way their services are currently delivered and this is being addressed through the City of York Transformation programme.

We will develop our detailed plans and agree as partners how this existing money will be used to protect current innovations within services and help to develop future commissioning models and practices within health and social care. We will put in place clear measures and outcomes to help us monitor the fund.

In order to help protect social care services in York we must ensure that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of joined up care which will help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole.

We will take a proactive early intervention approach to divert crisis situations and emergency admissions to hospitals for those residents who currently present with the highest level of demand. However, we recognise that this is not always possible in which case we will ensure the named worker for that individual is made aware of their situation at the earliest point and is then able to coordinate their early discharge and procure the support and equipment they may need to re-establish them back at home.

Our preventative agenda aims to support people at the earliest opportunity by providing relevant information and advice in a timely and accessible way, signposting people to the most appropriate resource for their particular needs. We will encourage appropriate self-help options and only become more actively involved when requested or required. Supporting people to remain well, and facilitating the self-management of their own wellbeing and wherever possible enabling them to stay within their own homes is a key priority for us and our focus will be on protecting and enhancing quality of life by tackling the causes of ill-health and poor quality of life, rather than simply focusing on service options.

Please explain how local social care services will be protected within your plans

As local organisations we recognise the need to take urgent action to make integrated care happen. We believe person centred coordinated care and support is key to improving outcomes for individuals. Too often services have not been 'joined up' and we haven't communicated well with each other. We have innovated in some areas and are working hard to develop a person focussed approach for all service areas. This approach was used to establish more capacity within our reablement services that promote independence and self-help. The funding for the care hubs will allow joint purchase of support, including through personal budgets and early intervention, which will include a social care offer. This will enable the council to protect the reablement home care service contract and will enable the support to carers to be developed in preparation for Care Bill responsibilities.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authority to sustain the current level of eligibility criteria and to provide increased assessment capacity within hospital and locality care management teams and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular to meet the increased demands arising from the new Social Care Bill requiring additional needs and financial assessments to be undertaken for carers and self-funders.

It is proposed that additional resources will be invested in social care to deliver enhanced support to help reduce hospital admissions, delayed discharges and admissions to residential and nursing home care.

We are carrying out a contracts and project audit to identify current projects that are delivering successful outcomes and financial benefits. We would wish to retain these and build on the knowledge base they have started to provide for us. This will enable us to develop local market intelligence, provide good reference points and help us contribute to the wider region within the health and social care markets.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

By improving access, assessment processes and introducing self-help options we believe we can work towards a 7 day service model. This will be an integral part of our development during the first year.

A work stream will be established to identify current commissioning, operational and service delivery patterns, establishment and budget for health and social care. This will help evaluate the "as is" position and inform the "to be" development. This approach was approved at the Health and Wellbeing Board on the 29th January 2013.

Development of a 7 day service will be centred around the person, based on the needs of local people and their communities helping to secure best value. Building on what is 'working well' within current service models and exploring partnerships / joint ventures with the private sector, public and third sector.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Whilst we are not currently using the NHS number as the prime identifier, our systems have the capability to do this and we will rapidly develop a work stream to facilitate this national condition by April 2015. To support his work stream we have put in place a dedicated resource in CYC, who is working closely with colleagues in the CCG. This has been a recent appointment and whilst a detailed plan is currently under development, the key deliverables of this plan include:

- Ascertain current level of live clients within Framework i that do not hold NHS number against them
- Identify NHS numbers for those identified as missing
- Update records within Framework i to ensure 100% NHS number compliance
- Investigate and implement NHS number mandatory field within Framework i
- Work with colleagues (communicate/educate) the necessity/ benefit realisation of NHS number identification

This work will be subject to the same overview and scrutiny afforded to other projects within BCF through the Joint Delivery Group and the Collaborative Transformation Board.

The CCG has also been selected to be one of 6 pioneer sites to work with Monitor as a pilot for the Payment Innovation and Local Support (PILS) project and is sending a joint team from the CCG, CYC and 2 of our care hubs to the launch event in April. This is seen as a significant enabler to our plan and will help drive pace and innovation in overall delivery plan.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

As above

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We confirm our commitment to work towards this by April 15.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldecott 2.

We will comply with all current and future IG issues and will develop a specific IG work stream as part of our overall programme plan. This will also incorporate compliance with Caldecott 2 and other national conditions.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The methodology and integrated model proposed in this submission will enable us to identify a single contact point for every person with whom we engage within the programme. “Telling my story only once” is what our residents tell us they want us to achieve through integrated working. We will work towards a single assessment process and data share where it is appropriate.

Acting as the single contact point for an individual will enable the worker (whether they are health or social care) to act as the coordinator of the individuals support. They will be enabled through access to the pooled budget to purchase care and equipment when required in a far more expedient way. They will be able to signpost to other professionals and points of relevant advice and information if required. This will require us to identify and pool budgets which under current legislation will need to be managed through the local authorities mechanisms.

In order to help identify those high risk residents, we have a series of procedures in place. These include:

- Social Care Eligibility Criteria
- Risk and Exception Panels

- GP Practice Quality and Outcome Framework (QOF) registers
- Adult Safeguarding Board
- Risk assessment and identification built in to provider contract and monitored through contract management groups
- Joint Strategic Needs Assessment
- Neighbourhood Teams

Whilst we acknowledge that each of the above has a part to play in risk identification, we do require a more structured and joint approach to risk stratification and this will form a key work stream of our overall plan for 2014/15.

We have identified that new approaches to allocating and managing budgets across health and social care, both at the micro and macro levels, are crucial to the success of our joint plans and we intend to pursue putting in place the right financial models to incentivise the right level of support at the right time whilst at the same time maximising the overall efficiencies across the system.

We will work together and put in place joint agreements to achieve this. This will inform and help us to plan and develop future commissioning contracts with providers in all sectors. Our focus will be on outcomes and improved performance. We will put measures in place to monitor these funds and explore contractual options which may include PBR (payment by results), alternative market development and management models. Our risk stratification plan will be developed detailing joint and shared responsibility.

This is an exciting opportunity and has clear synergies and links with the developments of the Transformation programme now underway within the City York Council. We anticipate the learning from this initiative will also inform the future delivery models for the programme.

We believe focusing on high intensive current users of health and social care within our area addresses this question and will provide us with the maximum impact and benefit from the fund in our joint work towards sector improvement and resident satisfaction. Creating and maintaining a positive environment within which we can transform and integrate local health and social care services

4) RISKS

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

Risk	Risk rating	Mitigating Actions
The proposed plans do not deliver the activity shift required.	Probability: 3 Impact: 5 Risk Score: 15	Programme plans and delivery models scrutinised and agreed by Collaborative Transformation Board (CTB). Action learning and frequent review during implementation year (14/15). Rapid escalation from JDG to CTB.
Agreed system changes between partners are not realised	Probability: 2 Impact: 4 Risk Score: 8	Clear governance, including MOUs and contracts to ensure delivery. Risk/Reward schemes in place to incentivise all involved. Monitoring by CTB and H&WB Board
Impacts of the model do not have sufficient benefits for the Adult Social Care agenda	Probability: 3 Impact: 5 Risk Score: 15	Continuous performance monitoring through JDG. Rapid escalation to CTB. Formal quarterly benefits realisation review.
7 day a week working cannot be achieved because of HR issues	Probability: 3 Impact: 4 Risk Score: 12	Development of an Organisational Development (OD) plan agreed with partners.

The shift of activity from Acute to community settings increases the pressures on Primary Care	Probability: 3 Impact: 3 Risk Score: 9	Modelling of the role and impact of Care Hubs, linked to CCG Primary Care Strategy should mitigate any adverse impact.
Pace of implementation of models impacts on in year financial delivery	Probability: 3 Impact: 4 Risk Score: 12	Additional PM resource and capability provided to project teams

This page is intentionally left blank

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

Association

Finance - Summary

##

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
City of York Council	N	£ 3,354	£ 951	£ 951
NHS Vale of York CCG	Y	£ 1,311	£ 11,176	£ 11,176
BCF Total		**£ 4,665**	**£ 12,127**	**£ 12,127**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

A contingency plan requires, to an extent, an ability to implement an alternative strategy which is more effective at delivering what the plan sets out to achieve, since it has to deliver more quickly than the primary plan. Therefore, the contingency plan will be somewhat unwieldy, somewhat risky and certainly counter to the original intent. Early views on how this can be achieved centre on reverting to old processes, investment in additional capacity and cash bail-out to support over-stretched services

Contingency plans have not yet been defined in detail. There are risks inherent in the transformation of services which lead to the reduction of capacity of acute and secondary care settings instituted on the belief of reducing volumes. Reinstating this capacity at pace as a contingency response will not be quick and will not be easily achieved, especially where it concerns staffing.

To mitigate these risks, it is intended to plan for a phased introduction of our plan, with well-planned change management, robust evaluation and reporting, with carefully staged capacity release to ensure the risks are minimised and that corrective action is taken as early as possible.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
4 Respite(beds) for dementia	City of York Council	*82*		*130*		*82*		*130*	
Supporting carers assessments and direct payments to help carers at risk maintain their health and well being	City of York Council	*100*		*234*		*100*		*702*	
Increase telecare equipment, installation, monitoring and response capacity	Social Enterprise	*75*		*130*		*75*		*260*	
Additional care co-ordination capacity	City of York Council	*50*				*50*			
Placement Hub to free up care management time to focus on assessments and reviews	City of York Council	*70*				*70*			
Additional care management capacity to support assessment of needs	City of York Council	*137*				*137*			
Home Care provision to enable throughput from reablement service and thus offer support for hospital discharges	Private provider	*1,734*		*1,734*		*1,734*			
12 Transitional care and intermediate care beds	City of York Council	*300*		*438*		*300*		*438*	
Provision of reablement service to residents	Private provider	*915*		*1,170*		*915*		*1,170*	
Support to Carers	VoYCCG	*396*		*468*		*396*		*2,340*	
Data analyst expert developing data sharing protocols necessary to integrate health and social care services	CYC	*40*				*40*			
Community Facilitators to create community capacity and alternatives to "traditional" care provision	CYC	*40*		*120*		*40*		*120*	
Pilot Care Hub - Priory Medical Group	Priory Medical Group	*250*		*750*					
Emergency Care practitionersCPs	YAS	*216*		*648*		*216*		*648*	
Street Triage (part fund with NYCC)	NY Police	*100*		*300*		*100*		*300*	
Hospice at Home (part fund with NYCC)	St Leonards Hospice	*135*		*405*		*135*		*405*	
Pyschiatric Liaison (part fund with NYCC)	LYPT/YTHFT	*25*		*75*		*25*		*75*	
Further schemes to be developed and extension to existing schemes	VoYCCG					*6,320*		*18,960*	
Various smaller schemes <£100k						*441*			
Disabilities Facilities Grant - grants to individuals to adapt home/install equipment enabling them to remain independent	CYC					*544*		*750*	
Social Care Capital Grant - contribution to Elderly Persons' home reprovision in York	CYC					*255*		*255*	
Social Care Capital Grant - investment in IT systems to implement the Care and Support Bill	CYC					*152*		*152*	
Total		£ 4,665	£ -	£ 6,602	£ -	£ 12,127	£ -	£ 26,705	£ -

Association

Enigla

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

As part of our plan to deliver proactive care through local care hubs, we are working with 2 provider groups to implement our agreed approach. Specifically we intend our models to deliver the following performance outcomes:
* A reduction in the proportion of residents being admitted to care homes from both acute and community settings. We expect too see performance improvements in the range of 8-9% in year 1.
* A decrease in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge. We expect to see performance improvements in the range of 20% in year 1, increasing to around 35% by mid 2015.
* A reduction in the number of falls related injuries for residents over the age of 65. We expect to see performance improvements in the range of 6%.
* A shared care record for each individual accessing the Care Hub. We intend to work with providers to determine stretch targets for compliance.
* A named single contact point for each person accessing the Care Hub. We intend to work with providers to determine stretch targets for compliance.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We will initially use the national metric (under development) to measure patient experience but we intend to investigate additional measures of experience and service user well-being.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Joint Delivery Group

The Joint Delivery Group (JDG) will be responsible for ensuring the delivery of the proposed Care Hubs and other BCF related schemes and will hold providers to account for the delivery of their respective programme plans. This board will also design and implement the reporting and monitoring framework and will be accountable to the respective existing boards (ICB, CTB and HC&WB Board) for tracking and reporting progress. The JDG will also act as a forum to address shared issues across the Care Hubs and will manage the combined risk register, escalating as necessary.

The JDG is co-chaired by the Vale of York and City of York and membership includes suitably empowered representatives of City of York Council, North Yorkshire County Council and East Riding of York Council. A GP from the CCG sits onthe JDG to provide clinical oversight and scrutiny and a senior social worker is also a cor emember to provide specialist scrutiny and support to proposed schemes.

Care Hub Delivery Groups

The Delivery Groups (one in each Local Authority area in which Vale of York CCG works) will be responsible for the day to day management and delivery of their respective models. We do not intend to dictate to providers how they should manage the delivery of their projects, however we are clear that the levels of engagement and involvement highlighted earlier in this paper will form a crucial part of their success. We intend to work closely with our potential providers to help them establish these Delivery Groups and we will support these groups with specialist input (finance, modelling etc.) as required. We have already held a joint workshop with 2 of the hubs, supported by a team from NHS England, to build on the assurance processes we have put in place, and have put in a place a 6 weekly joint Action Learning Set which will complement the 2 weekly JDGs.

We will expect the Delivery Groups to work collaboratively to make sure we capture all the learning from their respective models and we are putting in place the required support network to make this happen. We will also develop the necessary reporting structure and processes we expect the Delivery Groups to follow, which will in turn give the necessary assurance to respective boards and accountability bodies

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

NHS Vale of York CCG sits across the local authorities of City of York Council, North Yorkshire County Council and East Riding of Yorkshire Council. Separate BCF plans have been submitted to cover these areas.

Please complete all pink cells:

	Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
1	**Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population**	*Metric Value*	617.7	N/A	525.3
		Numerator	215		197
		Denominator	34805		37500
			(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
2	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**	*Metric Value*	69.8	N/A	83.3
		Numerator	30		40
		Denominator	45		48
	NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
3	**Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)**	*Metric Value*	18.3	14.9	11.5
		Numerator	30	25	19
		Denominator	163950	164934	165923
	NB. The numerator should either be the average monthly count or the appropriate total count for the time period		april 2012 - march 2013 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
4	**Avoidable emergency admissions (average per month)**	*Metric Value*	2137.8	2113.1	2063.5
		Numerator	4276	4252	4177
		Denominator	200018	201218	202425
	NB. The numerator should either be the average monthly count or the appropriate total count for the time period		(State time period and select no. of months) 1	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
5	**Patient / service user experience** For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used		(State time period and select no. of months) 1	N/A	(State time period and select no. of months) 1
6	**Local measure** *Injuries due to falls in people aged 65 and over per 100,000 population*	*Metric Value*	2288.3	2106.3	1936.0
		Numerator	771	773	726
		Denominator	33693	36700	37500
			april 2012 - march 2013 12	april 2014 - march 2015 12	oct 2014 - sept 2015 12

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

Health and Wellbeing Board 2 April 2014

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

Strengthening Safeguarding Arrangements – Joint Working between Boards

Summary

1. The purpose of this report is to propose a protocol is agreed to strengthen and clarify the alignment of accountabilities between the Health and Wellbeing Board (HWBB), its sub group, the Children's Trust YorOk Board (YorOK) and The City of York Safeguarding Children Board (CYSCB).

Background

2. 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 Role of the City of York Safeguarding Children Board

3. 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**.

4. Member organisations of the Health and Wellbeing Board and the YorOk Board are represented on the Safeguarding Board.It is essential that there are transparent agreements for these Boards to have reciprocal arrangements to share needs information, plan jointly and influence priorities and report progress against relevant strategies and plans in relation to safeguarding.

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

6. Members of the CYSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to:

   - speak for their organisation with authority;
   - commit their organisation on policy and practice matters; and
   - hold their own organisation to account and hold others to account.

7. The new Independent Chair of CYSCB is currently reviewing the Board structures, membership and constitution to ensure effective engagement of all agencies and also joint working with the Adult Safeguarding Board.

8. The Independent Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. There is a joint Child Death Overview Panel (CDOP) hosted by North Yorkshire which should prepare an annual report of relevant information which will inform the CYSCB annual report.

9. 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 should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

10. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.

11. The report for 2013-14 will be scheduled into the forward plan in the new municipal year for formal consideration by this Board.

12. In order to fulfil its statutory function the CYSCB should assess the effectiveness of the help being provided to children and families, including early help; in order to do this the CYSCB will seek a

report from the YorOK Board on behalf of the Health and Wellbeing Board to inform the annual report.

13. The Director of Public Health ensures that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment (JSNA) that is developed by the Health and Wellbeing Board. The CYSCB will work with the Health and Wellbeing Board, informing and drawing on the Joint Strategic Needs Assessment.

Main/Key Issues to be Considered

14. It is critical that the Boards work closely together to drive forward improvements in prevention, early help and ensuring local safeguarding arrangements are effective. This requires each Board to be clear about its specific leadership roles in relation to the broader safeguarding children agenda. This will also provide an opportunity to reduce duplication of reporting for agencies who service all Boards.

15. It is also important that there are mechanisms for reciprocal challenge and support which can ensure the best possible arrangements to protect children through prevention, early help, prevention and child protection are in place.

Consultation

16. The Independent Chair of the Safeguarding Children Board has discussed joint working and the development of a joint protocol with the following people; the Chair of Health and Wellbeing Board, the Chair of YorOk Board, the Director of Children's Services, The Director of Adult Services and Public Health and the Chair of the Adult Safeguarding of Vulnerable Adults Board.

Options

17. Option 1. The Health and Wellbeing Board agree a written protocol as soon as possible with the Safeguarding Children Board that sets out the key responsibilities of each board, reporting arrangements and accountabilities and how each board will provide assurances to the other of the effectiveness of the help being provided to children and families, including early help.

Analysis

18. The advantage of this will be to provide greater transparency and a robust structured framework for understanding of roles and accountabilities between the Health and Wellbeing Board, YorOK Board and the Safeguarding Children Board. Work on a protocol with Adult Safeguarding is in development and therefore this protocol should also set out joint reporting arrangements and joint working with the Adult Safeguarding Board on overlapping areas of work.

Strategic/Operational Plans

19. The Health and Wellbeing strategy and The YorOk Board plan “Dream Again” 2013-16 includes 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.

20. YorOK Board has detailed how it will deliver the principles and actions for this priority in ‘Dream Again’, York’s Strategic Plan for Children, Young People and their Families, 2013-2016.

    - Helping children and young people to always feel safe;
    - Supporting those who need extra help at the earliest

21. Without Walls Strategy 2011-2015 states “An essential factor affecting people’s quality of life is that they feel safe and secure in their home and local area.” Although this was written in the context of crime reduction it should also apply to safeguarding children.

Implications

22. **Financial** - Statutory Guidance; Working Together 2013 states, “All Local Safeguarding Children Boards (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.

23. **Human Resources (HR)** - There are no HR implications

24. **Equalities** - There are no specific implication in this report

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

26. **Crime and Disorder** - There are no specific implications

27. **Information Technology (IT)** - There are no IT implications

28. **Property** - There are no property implications

29. **Other** - None

Risk Management

30. The key risk in not accepting the recommendation is that governance arrangements and leadership accountabilities may be unclear and this could negatively affect implementation of key strategies. Also this could have an impact on any external scrutiny or inspection.

Recommendations

The Health and Wellbeing Board are asked to consider:

i. Nominating a lead board member to negotiate and agree a written protocol based on the draft attached at Annex A, as soon as possible, with the Safeguarding Children Board.

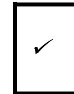
Reason: This will provide greater transparency and a robust structured framework for understanding of roles and accountability between the Health and Wellbeing Board, YorOK Board and the Safeguarding Children Board.

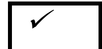
ii. The protocol is formally considered for approval at the next meeting of the Board. The Health and Wellbeing Board agree to commission a report from the YorOK Board on the effectiveness of the help being provided to children and families, including early help to inform the CYSCB annual report 2013/14.

Reason: This will enable planned scheduling of reporting for the forthcoming municipal year.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Simon Westwood Independent Chair City of York Safeguarding Board	Dr Paul Edmondson-Jones Deputy Chief Executive and Director of Health and Wellbeing Tel: 01904 551993

Report Approved  **Date** *24 March 2014*

Wards Affected: **All** 

For further information please contact the author of the report

Background Papers:

Working Together 2013
http://www.workingtogetheronline.co.uk/documents/Working%20TogetherFINAL.pdf
"Dream Again" – York Children's Plan
York Health and Wellbeing Strategy

Annexes

Annex A - Draft Protocol between the City of York Health & Wellbeing Board, YorOK Board and City of York Safeguarding Children Board.

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

Annex A

DRAFT March 2014

City of York Health & Wellbeing Board/YORoK Children's Trust Board and Local Safeguarding Children Board Protocol

Annex A

1. Introduction

1.1 This document sets out the expectations of the relationship and working arrangements between City of York Health & Wellbeing Board (HWBB) YorOK Children Trust Board and the City of York Safeguarding Children Board (CYSCB). It covers their respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny and performance management.

1.2 The Chairs of the Boards have formally agreed to the arrangements set out in this document, which will be subject to review annually.

2. The City of York Safeguarding Children Board

2.1 The CYSCB is a statutory partnership with responsibility for agreeing how relevant local organisations will co-operate to safeguard and promote the welfare of children. The CYSCB's role is to monitor and evaluate the effectiveness of local arrangements to safeguard all children.

2.2 The CYSCB's key responsibilities are to:

- Develop policies and procedures for safeguarding and promoting welfare of children in the area of the authority, including policies and procedures in relation to the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention, ensuring safe recruitment and working practice, investigating allegations and concerns and training provision.

- Monitor and evaluate the effectiveness of what is done by the Local authority and board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve.

- Communicate and raise awareness of the need to safeguard children and promote the welfare of children to those who work with children including volunteers and members of the public

- Through the Child Death Overview Panel (CDOP) collect and analyse information about child deaths with a view to learning from experience and safeguarding and promoting the welfare of children

- Participate in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account

- Undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or a child has been seriously harmed, and there is cause for concern about the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

- Lead on or contribute to specific safeguarding initiatives e.g. sexual exploitation, e safety, substance misuse, licensing.

3. The Health & Wellbeing Board

3.1 The Health & Wellbeing Board (HWBB) is a partnership of providers and commissioners of community, health and social care services in the City of York.

3.2 The Board commissions programmes of work to improve health outcomes and reduce health inequalities including for children living in City of York.

3.3 The basis for decisions about strategy and design for service delivery is the **Joint Strategic Needs Assessment (JSNA)** in City of York.

Within this context the overarching strategy for Health and Well Being Strategy and "Dream On" the Children's Plan for children should focus on prevention, early intervention and local delivery of care, provided within effective and integrated models of service delivery.

Annex A

3.4 The members of the Board, through working together and developing integrated services, will:

1) Provide a forum to enable provider and commissioner dialogue

2) Play an expert and advisory function to the overarching Health and Wellbeing Board in respect of the setting of strategic priorities for children's health and wellbeing.

3) Implement the agreed programme of service transformation to meet the needs of children, provide services as close to home as possible, safeguard children and avoid duplication.

3.5 The HWBB's and YorOK key areas of responsibility are**:**

- The provision of expert advice on children's health across the city and input to commissioning as required
- Development and implementation of delivery plans for seamless pathways and integrated service delivery.
- Agreeing operational processes to deliver joined up care.
- Driving forward the further integration of multi-agency services.
- Developing children's workforce planning in partnership
- 'Unblocking' pathways where organisational boundaries are causing challenges.
- Driving change and bring challenge to encourage new ways of working.
- Agreeing joint working principles e.g. information sharing, consensus on consent etc.
- Developing a joint delivery plan for improvement within children's community health services with milestones for achievement.

4. The Relationship between the CYSCB and the HWBB and YorOK

4.1 The roles and responsibilities of the respective bodies are different but complementary. They have a common purpose – to promote joint working and co-operation between partners to improve the wellbeing of children in City of York, support and develop areas of mutual interest: examples include Reducing Infant Mortality, Child Death Overview Processes (CDOP), Safe Sleeping, referrals to A&E, challenges presented and experienced by children from ethnic minority groups and the changing ethnic profile in the city, teenage conceptions and integrated multiagency practice in prevention and early intervention.

4.2 Whilst the CYSCB contributes to that wider goal of improving the well-being of all children, of necessity, it has a narrower focus on safeguarding and promoting welfare.

4.3 The CYSCB is a statutory body in its own right. In order to ensure that its separate identity and independent voice is not compromised, the CYSCB must not be subordinate to or subsumed within Children's Trust Board structures.

4.4 Through its case review, evaluation and audit programmes of work, the CYSCB must be able to form a view of the quality of local activity, to challenge organisations as necessary, and to speak with an independent voice. For that reason, the CYSCB and HWBB and YorOK must be chaired by different people.

4.5 In City of York, the CYSCB is chaired by an independent person; the HWBB is chaired by the Deputy Leader of The Council, The YorOk Board is chaired by the Lead Member for Children's Services (City of York City Council)

4.6 The independent Chair of CYSCB will be invited to attend HWBB and YorOk meetings, as/when necessary, in order to present reports and assist/advise on the development of effective plans and service delivery arrangements for safeguarding City of York children. Similarly, representatives of HWBB and YorOK will be invited to attend CYSCB when there are issues of common interest and purpose.

4.7 CYSCB will work with the HWBB and YorOK, informing and drawing on the JSNA.

The HWBB may request the CYSCB to consider issues for development, action or scrutiny or vice versa

4.8 Given the CYSCB's remit (see 2.2 above) the CYSCB's role in relation to HWBB is:

- to focus on ensuring that key people and organisations that have a duty under s11 of the Children Act 2004 are fulfilling their statutory obligations to safeguard and promote the welfare of children and that the arrangements made by the HWBB are effective in supporting this
- to offer support, guidance, advice, challenge and scrutiny to HWBB to enable the partner organisations to discharge their safeguarding responsibilities effectively
- to produce and publish an Annual Report which comments on the effectiveness of safeguarding in City of York and provides information and challenge to the work of the HWBB in order to drive improvements. The Annual Report will be submitted to the Chair of the HWBB as well as the Chief Executive of the Council, the Leader of the Council and the Police and Crime Commissioner)

4.9 The HWBB and YorOk will work with the CYSCB:

- to develop and interpret the Joint Strategic Needs Assessment with respect to safeguarding and promoting the welfare of City of York's children
- to develop a clear understanding of the effectiveness of current services, including where services might need to be improved, reshaped or developed
- to ensure priorities for change are delivered

4.10 The HWBB will consider within its remit any Community, Health and Social Care services the provision of which is the responsibility of its members; this will include safeguarding children services

4.11 In general, the CYSCB will not be an operational body or one which directly commissions or delivers services to children, young people and their families. YorOK and the HWBB provide expert advice around all issues of children's health.

It supports the shaping of children's health strategy and priorities for the city to reduce health inequalities and improve outcomes for children and families. Commissioning decisions remain the remit of the commissioning groups.

5. Planning and Reporting

5.1 There will be reciprocal bi-annual reporting on progress between the Boards

5.2 An annual planning meeting of the three chairs plus the Lead Managers will be held to set out broad strategic work plan for the year identifying the Lead Board and reporting arrangements for each work stream.

5.3 The Chairs of the CYSCB and Adult Safeguarding Board will produce a joint report to the HWBB bi annually on areas of joint working.

Signed: …………………………. Date: 25th March 2014
Simon Westwood, Independent Chair of City of York Safeguarding Children Board

……………………………………………….. Date: 25th March 2014
Signed:
Cllr. Tracy Simpson-Lang, Chair of City of York Heath and Well Being Board

………………………. Date: 25th March 2014
Signed
Cllr. Janet Looker, Chair of YorOK Children's Trust Board

This page is intentionally left blank

Health and Wellbeing Board **2 April 2014**

Report of the Deputy Chief Executive and Director of Health and Wellbeing

Annual Report – Safeguarding Adults Board

Summary

1. This report provides information on the work of the Safeguarding Adults Board over the course of 2013. The full annual report of the Board is attached at **Annex A** to this report. Kevin McAleese CBE, the Independent Chair of the Safeguarding Adults Board will be in attendance at the meeting to present the report.

Background

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

Main/Key Issues to be Considered

3. The Annual Report is for information only but clearly sets out the work the Board carried out over the course of 2013.

Consultation

4. This report is for information only.

Options

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

Analysis

6. This section is not applicable to this report.

Strategic/Operational Plans

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

Implications

8. There are no implications associated with the recommendations set out in this report; the Annual Report at **Annex A** is for information only.

Risk Management

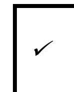
9. There are no risks associated with the recommendations in this report.

Recommendations

10. The Board are asked to note the Safeguarding Adults Board's Annual Report at **Annex A** to this report

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

Contact Details

Author:	**Chief Officer Responsible for the report:**			
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator Public Health Team Tel: 01904 551714	Dr Paul Edmondson-Jones Deputy Chief Executive and Director of Health and Wellbeing Tel: 01904 551993			
	Report Approved		**Date**	*24 March 2014*

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A – Safeguarding Adults Board's Annual Report

Annex A

Annual Report 2013

Foreword by Chair of Safeguarding Board

I am very pleased to introduce this Annual Report, having taken up my appointment on 1 April 2013 from my predecessor Gill Collinson, who served so well in the post until 31 March.

I have spent the first few months meeting key stakeholders locally and I am really encouraged by the engagement and commitment of the Board's partners, with good attendance by most representatives. Obviously my ambition is to show 100% coverage from all partner organisations in Appendix 1 of the 2014 Report!

One of the main challenges this year has been to ensure that the Board is fully plugged in to the changed landscape within the NHS, with the abolition of Primary Care Trusts and Strategic Health Authorities. The Board already had established representation from both York Teaching Hospital NHS Foundation Trust and Leeds and York Partnership NHS Foundation Trust. It is right that we now have members from the Vale of York Clinical Commissioning Group (CCG), NHS England's Area Team for North Yorkshire and The Humber and also the Partnership Commissioning Unit operating across both the City of York and North Yorkshire County Council. Development of close working relationships with the NHS on both the commissioning and providing side is essential if we are to deliver our mission of keeping vulnerable adults safe and free from any form of abuse or exploitation.

Outside the statutory partners I have been heartened by the willingness of the private, independent and voluntary sectors to engage with the Board. Representation is secure from Stockton Hall, The Retreat and the Independent Care Group, who provide services in a wide variety of settings. It is also right that both CVS York and Health Watch should now be full members of the Board.

Nationally, the issue of failings in care for vulnerable people has been a major cause of concern over past months, with publication of the report on serious shortcomings at Winterbourne View hospital in Gloucestershire followed by the deeply disturbing Francis Report on

failings and unnecessary deaths at Mid Staffordshire NHS Foundation Trust. We are as a Board clear that all lessons and recommendations must be learned and implemented locally, and it is our role to continually seek assurance about that. The publicity generated by such reports will I'm sure be one reason for the growth in alerts received by the City of York Safeguarding team, which are running at their highest level ever. I regard that as a welcome development, as we seek to spread awareness not just to service providers but also to vulnerable people themselves, who need to be supported to be resilient and to protect themselves.

I hope you find the contents of this Report both illuminating and reassuring in relation to the 2013 calendar year. The Board's next Strategic Plan will focus on what needs to be done to ensure that the Board and the City of York is well placed to implement the requirements of the Care Bill 2013, which was announced in the Queen's Speech and which will move adult safeguarding onto a statutory footing in due course.

Kevin McAleese CBE

Independent Chair, City of York Safeguarding Adults Board

CONTENTS

		Page
1.	Introduction	4
2.	The Board's work and philosophy	5
3.	Topic considered by the Board in 2013	5
4.	Local context	6
5.	Performance information	9
6.	Training	12
7.	Policies and Procedures	16
8.	Safeguarding Experience	17
9.	Assurance arrangements	19
10.	Progress on 2013 Actions	20
11.	Strategic Plan for 2014-17	21
12.	Annex 1 Membership and attendance	22
13.	Annex 2 2013 Action Plan	24

1. Introduction

2013 has seen greater clarity emerge over the future of Safeguarding Adults, with the proposals in the Care Bill outlining the statutory duties proposed for local authorities, and for Safeguarding Boards. Final guidance is still awaited, but it is intended that the Act will be implemented in April 2015.

This year has therefore seen the start of planning and preparations for the requirements of the Care Bill. Guidance from the Department of Health and Association of Directors of Adult Social Services (ADASS) was issued in June 2013, to support health and social care commissioners, providers, managers and professionals in fulfilling their responsibilities and achieving good outcomes in regard to the safeguarding adults' agenda.

April 2013 saw the change to health commissioning arrangements, the introduction of the Health and Wellbeing Boards and to the new governance arrangements with the new Police and Crime Commissioner.

This year has also seen a continuing national focus on standards, quality and safeguarding in both the health and social care sectors, with the Francis Report into Mid Staffordshire Hospital failings, the final report on Winterbourne, and several high profilestories about failures in care homes and hospitals across the country.

It is against this context that the Adult Safeguarding Board in York has continued its work to ensure that the agencies that support adults who are at risk or in vulnerable situations, and the wider community, together can:

- Develop a culture that does not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does happen, support and safeguard the rights of people who are harmed to:
    - stop abuse continuing
    - access services they need, including advocacy and post-abuse support
    - have improved access to justice

2. The Board's Work and its Philosophy

Safeguarding Adults refers to:

"All work that enables an adult who is, or may be, eligible for community care services to retain independence, wellbeing and choice and access support and services that enable them to live lives free from abuse and neglect or fear of this."

The Safeguarding Adults Board exists to serve the population of City of York's vulnerable adults. It is a multi-agency board whose role is to plan strategically and ensure the safety of vulnerable adults within the City of York Council's geographical area. It has been in existence since November 2008 and has a strong focus on partnership working, and through this partnership approach hopes to ensure that vulnerable adults are able to live their life free from violence, whilst maintaining their independence and wellbeing. The Safeguarding Adults Board believes that safeguarding should be everybody's business.

A list of board members in attached in Annex 1.

3. Topics considered by the Safeguarding Adults Board during 2013.

During 2013 the City of York Safeguarding Adults Board has considered a diverse range of topics which have enabled all the partner agencies to contribute to wide-ranging discussions. Issues considered and progressed have included:

- Monitoring progress on the development of a Place of Safety (Section 136 Suite) in York
- Development of new protocol on domestic homicides, between the Community Safety Board, Adult and Children's Safeguarding Boards
- The review of our multi agency policy and procedures
- Implementation of the ADASS National Safeguarding Adults Competency Framework
- Implementation of the recommendations following the Winterbourne View review and concordat

- Engagement with the University of York Social Policy Research Unit (SPRU) project looking at Safeguarding Adults and Personal Budgets
- Establishment of a new sexual assault referral centre in York
- Regular reviews of the progress made on the strategic action plan, on the delivery of multi agency training, and of performance information from the Abuse of Vulnerable Adults (AVA) return

4. The Local Context of Safeguarding Vulnerable Adults – A Picture of York

During 2011 and 2012 the SAB's partner agencies provided a rich picture of information that describes the local context in which we seek to safeguard vulnerable adults within the City of York to support the board in:

- determining the strategic work plan of the board
- developing a locally sensitive assurance framework

This 'picture of York' is a resource that:

- provides a better understanding of those who are vulnerable and where they are likely to reside and
- acts as an initial resource and evidence base for safeguarding adults in York
- provides evidence for deciding the SABs strategic priorities and work plan

A vulnerable adult is:

A person "who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation" *("No Secrets" 2000).*

4.1 Facts and figures

An adult safeguarding alert can originate from a huge variety of sources. In order to better prevent and safeguard adults in the city, we need to understand which adults are more vulnerable to abuse and which settings they are most likely to be in.

In the City of York there are a total of 128 care services registered with and regulated by the Care Quality Commission. These cover the breadth of public, private and third sector provision. Some of the key care providers include:

- 44 residential care homes, providing over 1800 bed spaces; of these, 15 (890 beds) provide nursing services
- 31 registered to provide care in customers' homes and/or in specialist dwellings with support
- 19 hospitals or related services, including NHS Trusts, rehabilitation and urgent care locations
- three community health services
- one hospice
- one prison health service

4.2 Groups of particularly vulnerable adults

In May 2011, The Social Care Institute for Excellence, publication *"Prevention in adult safeguarding: A review of the literature"* (*Faulkner and Sweeney, May, 2011*) identified groups of people who were particularly vulnerable to abuse.

People with a Learning Disability

City of York Council currently has in excess of 500 customers who are receiving a service related to their learning disability. In total, there are 37 registered institutions in York catering for those with learning disabilities, including 13 residential care homes. There is provision for 172 supported living schemes for people with learning disabilities across 47 locations. There are a further 11 clients in two residential homes. The majority of supported living in York is for older customers with learning disabilities, who also have extensive physical support needs. Many are wheelchair users and/or past residents of old long-stay hospitals. Many are now too infirm to have challenging behaviour but there are some who as their needs change once again develop challenging behaviours, for example when a new agency or staff is used and people's routines are not respected.

People with Mental Health Problems

There are particular groups of people with a psychiatric diagnosis that have been identified as being at greater risk of abuse. These tend to overlap with some of the other groups identified in this paper, particularly, older people and carers. There are:

- 35 registered mental health services in York
- seven care homes with mental health registrations
- three with nursing
- 13 mental health home care service providers

Older People

Mid-year population estimates for 2010 show that there are over 33,000 older people (over 65) in York - 16.4 per cent of the total population:

- nearly 5,000 people are 85 years old or over, with two thirds of this total being female
- changing demographic patterns will see 11,000 more older people within the city by 2025, with 2,900 of those over 85 more likely to need support

The City of York has high a proportion of residents in care homes that self-fund and who require information to support their decisions in choosing a care home or provider of services.

There are particular complexities around specific groups of older people who may be more susceptible to abuse. Community Mental Health Teams for older people are likely to be in contact with around 1,600 older people, some of whom may have communication barriers, challenging behaviour or who are depressed or disorientated.

York has 35 registered services delivering care for dementia. Included in this total are 13 care homes, 8 of which also provide nursing care.

Older adults are also more likely to be abused if they are frail or highly dependent on care. York currently has around 700 customers receiving high-dependency homecare packages.

Carers

Research has demonstrated that isolation ie less family support or social contacts, can lead to family carers becoming perpetrators of abuse. The York Strategy for Carers (2011-2015) is a multi-agency approach to providing services and support for the estimated 18,676 adult carers in the city.

Substance abuse amongst family carers has also been found to be a risk factor in contributing to abuse rates. The Substance Misuse Service (Community Addictions Team) works closely with voluntary sector agencies to provide services for people with complex drug and alcohol problems and for service users with co-existing mental health and substance misuse problems. Their typical caseload comprises in excess of 200 patients at any one time.

5. Performance and activity information

The following information is taken from the Abuse of Vulnerable Adults (AVA) comparator report for 2012-13 and includes benchmarking information provided by the National Adult Social Care Information Centre

Responding to abuse or neglect

The number of alerts and referrals continue to increase, which is to be welcomed as public and professional awareness increases and we need to ensure that our training and awareness programmes continue to increase understanding of safeguarding and the process to be taken where there are concerns.

An alert is recorded when concerns are raised about someone. A referral is counted when it is decided that the concern needs investigation.

There has been a 32% increase in the number of alerts from 2011-12. Benchmarking data from the national information centre shows that our rate of alerts per 100,000 of population is now higher than the England average. Of the 912 alerts received 264 (28%) concerned people over the age of 85 years. 208 alerts concerned people aged between 75 and 84 (22%). We continue to have low numbers of repeat referrals compared to the England

average, but our numbers of completed referrals has gone down this year. This is a reflection of both the increasing numbers of investigations and the complexity of some of the issues being dealt with.

Figure 1: Number of alerts and referrals April 2012-March 2013

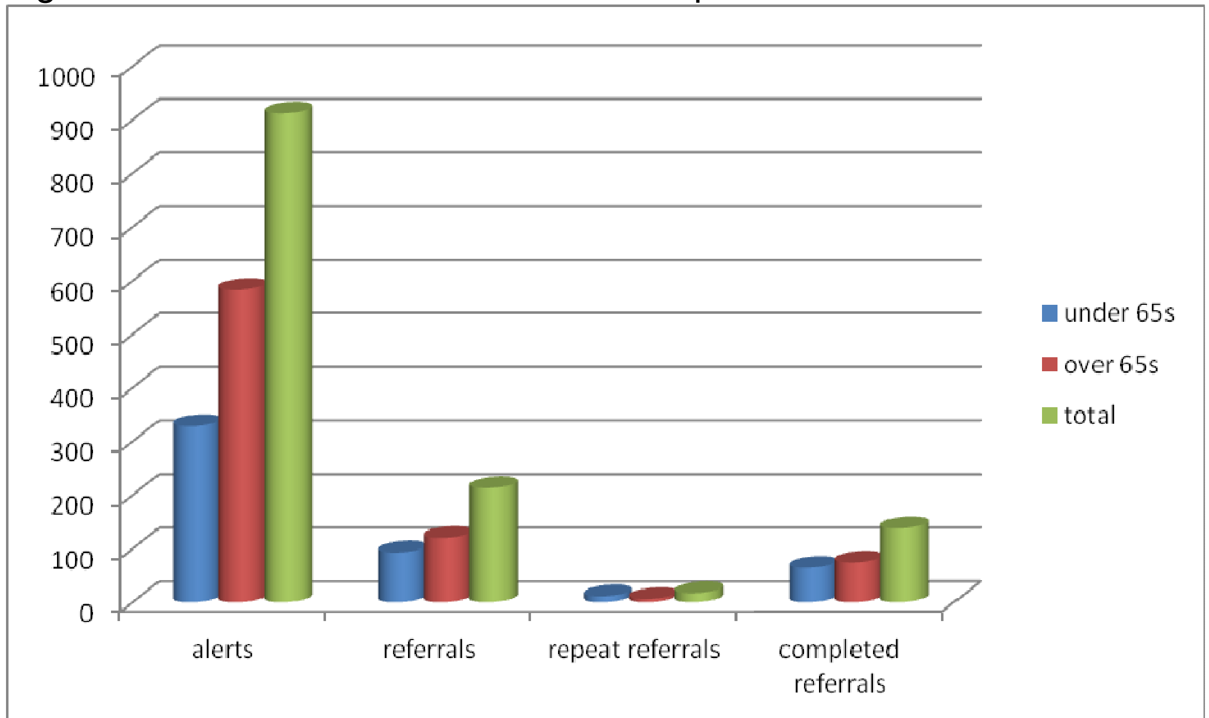


Figure 2: Nature of abuse for referrals

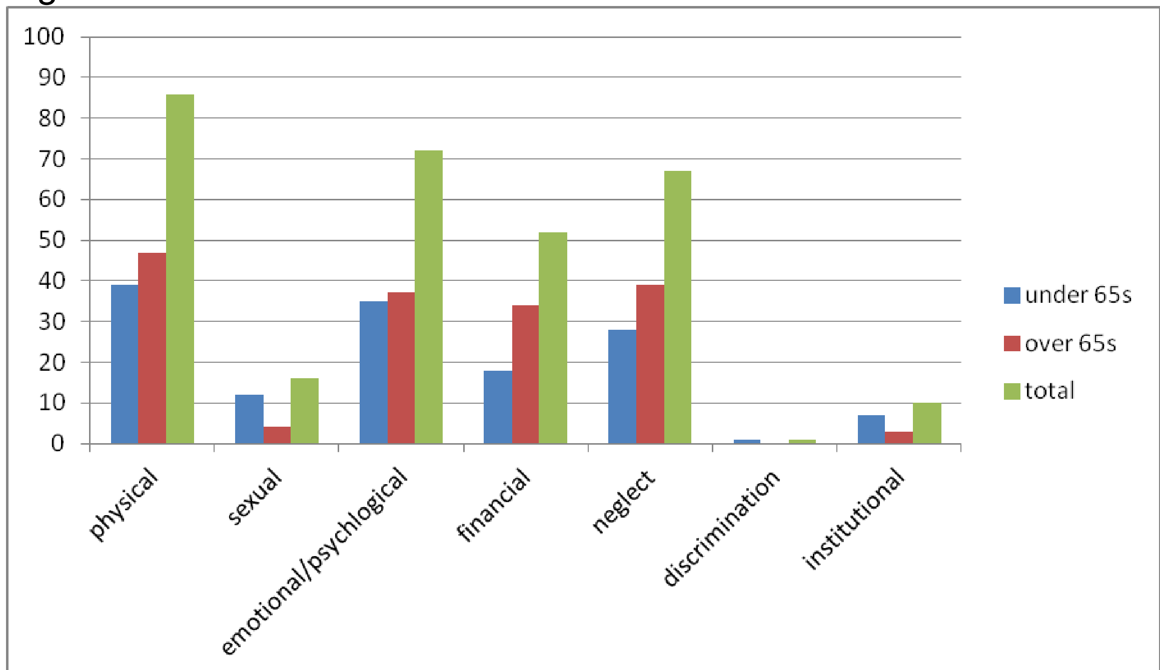


Table 1: Location of Abuse for referrals

Location alleged abuse took place:	18 - 64	65 - 74	75 - 84	85 and over	Total 18 and over
Rows/Columns	A	B	C	D	E
Own Home	42	11	25	22	100
Care Home - Permanent	5	1	5	8	19
Care Home with Nursing - Permanent	1	5	7	15	28
Care Home - Temporary	0	0	2	1	3
Care Home with Nursing - Temporary	1	1	3	1	6
Alleged Perpetrators Home	1	0	0	0	1
Mental Health Inpatient Setting	7	0	1	0	8
Acute Hospital	0	0	0	0	0
Community Hospital	1	0	0	0	1
Other Health Setting	0	0	1	1	2
Supported Accommodation	20	2	0	2	24
Day Centre/Service	2	0	0	0	2
Public Place	2	0	0	1	3
Education/Training/Workplace Establishment	1	0	0	0	1
Other	8	1	2	0	11
Not Known	2	1	0	1	4
Total	93	22	46	52	213

* Abuse may have taken place in more than one setting for some individuals.

Relationship of alleged perpetrators to the victim

Social care staff accounted for 38% of the total alleged perpetrators, a small increase on 2011/12. This is higher than the England average of 31% . We have lower levels of reports against health care workers than the England average at 2% compared to 5% nationally.

Alleged abuse by partners is higher this year, and is almost double the England average at 13%, but the number of other family members is slightly lower at 14% compared to the England average of 16%. The percentage of other vulnerable people alleged to be the perpetrator has remained stable at 13%.

Outcomes following safeguarding investigation

70 cases were substantiated, 21 partially substantiated, 215 were not substantiated and 22 were not determined inconclusive. The rate of substantiated investigation were higher than the England average, but our rates of not determined or inconclusive investigations were lower.

Outcomes for the abused person

A total of 78 referrals (40%) resulted in no further action being taken in 2012-13. This is an increase from the previous year and is higher than the number of unsubstantiated or undetermined outcomes.

Acceptance of a Protection Plan

We still have relatively low numbers of protection plans at around 20% (of what? Cases?), compared to nearly 60% nationally but over 90 % of these are now being agreed by the victim, which is a marked improvement on last year.

6. Training

A key role of the Safeguarding Adults Board is to support the development of a training strategy and encourage all partner agencies to participate in the delivery of the training plan, thereby ensuring that staff across all sectors are aware of how to raise

safeguarding concerns and are trained to the appropriate level required by their role.

The Board approved a Training Strategy for 2012-2015 last year. A training sub group of the Board has been established to oversee the implementation of the strategy and support partner agencies in developing specific safeguarding competency profiles and an organisational training plan (Standard 5).

The strategy identifies 5 levels of training to be developed and implemented:

- Level 1 – recognising and reporting
- Level 2 - responding
- Level 3 - investigating
- Level 4 - joint working and criminal investigations
- Level 5 - decision making and accountability

In addition training is provided on:

- Mental Capacity Act Awareness (Level 1)
- Mental Capacity Assessment and Best Interest Decision Making for Practitioners (Level 2)
- Deprivation of Liberty (DoLS) Responsibilities for Managing Authorities (Care homes/hospitals) Level 3
- Mental Capacity Act Complex Decision Making for Practitioners and Managers (Level 4)

An E Learning Package is also available for refreshing knowledge of Safeguarding Level 1 and MCA/DoLS Level 1.

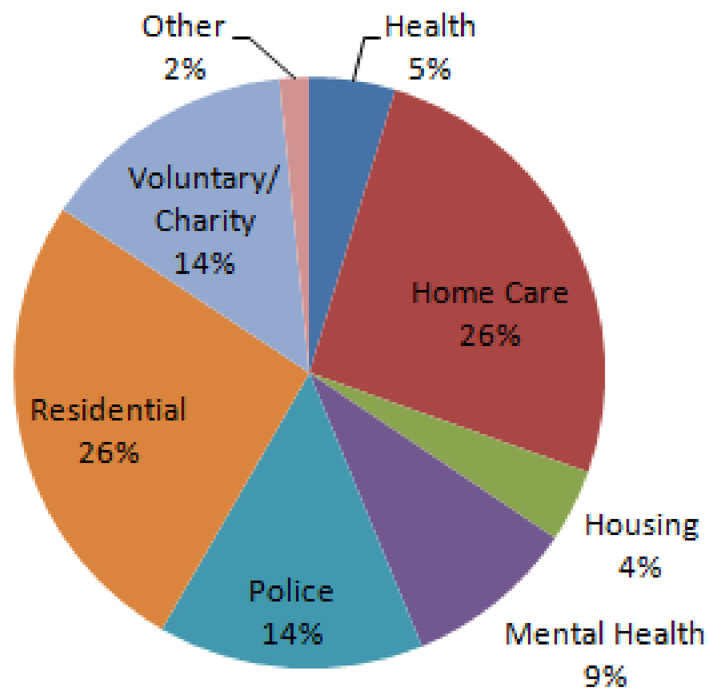
The full strategy can be accessed on the website - www.safeguardingadultsyork.org.uk

Breakdown of attendees for each course January 2013 – January 2014

Course	Number of sessions	Total attendees	CYC attendees	PVI attendees	No shows
Safeguarding Train the Trainer	1	7	1	6	0
Safeguarding Level 1	27	336	104	232	33
Safeguarding Level 2	8	96	31	65	2
Safeguarding Level 3	4	34	19	15	1
Safeguarding Level 4	1	6	4	2	0
MCA Level 1	9	103	61	42	7
MCA Level 2	7	83	57	26	5
MCA Level 3	5	47	18	29	0
MCA Level 4	4	25	17	8	3
MCA Level 5	1	5	5	0	0
MCA Level 6	1	6	4	2	0

(PVI = Private, Voluntary and Independent)

Breakdown of External Attendees:



Feedback

Feedback is collated from each course provided and is reported to the Safeguarding Board on a quarterly basis. The following is a selection of the feedback.

Safeguarding Train the Trainer Feedback

- Thoroughly enjoyable and informative training
- Extremely useful, full of information and very good training
- All very helpful, relevant to what we need at work. Useful information guidance and tips.

As a result of this feedback and the additional survey monkey which was sent to delegates six weeks after attending this training, this course will feature as part of our Safeguarding Training offer into next year.

Safeguarding Level 1 Feedback

- Excellent – really thought provoking
- Very fun and informative, good audience participation and interesting activities
- Very professional and thorough
- Enjoyable and interesting

Safeguarding Level 2 Feedback

- Not sure what to expect, but excellent day's training which was well presented
- The training was very informative and covered all I need to know
- Interesting activities
- Detailed information of referrals
- Good varied content, group work, quizzes etc.

Safeguarding Level 3 Alerter Feedback

- Really useful case study and good discussions
- Very informative

Safeguarding Level 4 Chairing Feedback

- The structure and flow of the session was clear
- Useful discussions with trainer and participants

MCA Level 1 Feedback

- Trainer fantastic, made the information easy to absorb and made it fun
- Very informative
- A really good overview of the act, with good case examples which helped illustrate the points made

MCA Level 2 Feedback

- Fantastic trainer felt very confident in the information given
- Very informative, tutor keeps it interesting and has a sound knowledge base
- Learning about the actual facts in regards to capacity
- Free discussion about problems/situations that arise in practice

MCA Level 3 Feedback

- Useful hints and tips, the trainer's approach was excellent
- Good refresh on MCA and DoLS
- Easy to understand and relate to examples

MCA Level 4 Feedback

- Useful discussion of difficult cases/wishes
- Good and clear advice

7. Policies and Procedures

The City of York Safeguarding Adults Board has a comprehensive suite of multi-agency policies and procedures regarding the safeguarding of vulnerable adults. During 2013 a review of the multi agency procedures has been undertaken and the new procedures were agreed at the December Board meeting

A new protocol was agreed on domestic homicides, between the Community Safety Board, Adult and Children's Safeguarding Boards. The protocol will ensure that any serious case review can be co-ordinated with a related domestic homicide review and Children's Serious Case Review.

All of the multi-agency policies and procedures can be accessed on the Safeguarding Adults York website.

During the period covered by this report there have been no cases or incidents which have required the instigation of a serious case review.

Deprivation of Liberty Safeguards

This year saw City of York Council work successfully with the Vale of York CCG to embed the transfer of the Deprivation of Liberty Safeguards (DoLS) scheme for hospitals into City of York Council. Policies and procedures have been updated to reflect these changes.

The CCG and CYC have worked with York Teaching Hospital Foundation Trust to publicise and embed the changes.

CYC has trained another 4 DoLS Best Interest Assessors including social workers with experience of working in acute settings.

The council continues to work with residential and nursing homes within the city to ensure they are able to fulfil their role as managing authorities under DoLS. CYC has worked with Community Links to deliver training specifically targeted at this group.

There continues be a well attended local DoLS Best Interest Assessor Forum, linked to the regional forum. This ensures that practice standards remain high and assessors are able to implement the comprehensive guidance from the social care institute for excellence ***'**Deprivation of Liberty Safeguards: putting them into practice'* SCIE (2013**).**

DoLS Activity
In the calendar year 2012-2013, 22 referrals requesting authorisation to deprive a person of their liberty were made to the DoLS scheme. Of these 5 were authorised. Reasons for not authorising included assessments that the person had the mental capacity to make decisions about residing in the care home and were supported to do so, the restrictions on the person did not amount to a deprivation of liberty, the issues raised were outside the remit of the local authority scheme and required a decision by a court.

8. Safeguarding experience

The Council's safeguarding adults team seeks feedback from those participating in safeguarding processes. This year the team has signed up for the Making Safeguarding Personal Programme, which aims to focus on the outcomes people want when they are at risk of abuse. City of York Council is working at Bronze level, and is developing ways to capture and measure what people at risk of abuse say they want to happen.

This year the Safeguarding Board has begun to look at anonymized case stories of safeguarding interventions at each of its meetings.

York Healthwatch has joined the Board and we intend that the 'Voice' of people who need the support of safeguarding interventions will continue to grow at Board level.

The following anonymized (names have been changed) case studies provide some insights into the experience of service users.

Case Study 1

Adrian 83 lost his wife suddenly, and was living with his daughter Catherine. Adrian's GP contacted CYC concerned that Catherine may have an alcohol problem and could be being emotionally and physically abusive towards Adrian.
Adrian and his daughter met with someone from the safeguarding team and the police. Together a plan was agreed to help Catherine move into her own accommodation and get help with her alcohol problem. Adrian was offered help and support for himself and a support plan was agreed with him.
A second daughter subsequently moved in to live with Adrian. A further assessment of risk was undertaken as there were concerns that this daughter also had had a history of violence, alcohol use and fraud convictions. Adrian was clear that he wanted his daughter to live with him and valued the relationship but recognised there were risks to him.
Following a statement to the police by Adrian about a violent incident, an acceptable behaviour contract was made with Deborah as Adrian chose not to pursue any allegation. Concerned neighbours developed a cocoon watch approach whereby they agreed to record and report any concerns to the police. This was developed into a protection plan which involved warden call and the carers who were going to support Adrian.
Adrian continues to live in his own home with support, a protection plan and his daughter.

Case Study 2
Robert is a 53 year old disabled man. He was living on his own, isolated and finding it difficult to manage day to day tasks. Robert was drinking excessively and started to drink with a woman called Sharon. Sharon invited other people to stay in his flat who had a conviction for violence as did Sharon. Sharon started to take control of Robert's money and control access to the flat.

Neighbours and police community support officers were concerned when Robert was seen with bruises to his face.
Safeguarding procedures were used to help Robert. Initially he told the safeguarding team, he wanted the situation to stop but he didn't know what to do. Robert was initially afraid to make a statement, but after he had built a relationship with the team he acknowledged that he had been assaulted by Sharon.
Robert was supported to access treatment for his drinking. He accessed his GP who arranged an admission to hospital because of his poor physical health. While in hospital he was supported to make contact with his niece who lived in a different area of York. His niece agreed to support him with his finances.
The police, CYC safeguarding, voluntary agencies and neighbourhood safety workers, worked through the multi agency problem solving scheme (MAPS) to help Robert stop the abuse. Through working with the housing team, Robert moved to a new property close to his niece. Support was put in place to help Robert reconnect with the community and he was supported to make an injunction preventing Sharon from getting back into his life. Sharon moved away from York before this was enacted. Robert continues to live independently with support from his niece.

9. Assurance

Following the publication of guidance by both the Department of Health and ADASS, health and social care commissioners and providers are increasingly required to demonstrate how they are fulfilling the key requirements via their own internal governance arrangements and to external regulators. It is not unusual for agencies to participate in a number of partnership boards and there has to be a balance between providing appropriate levels of assurance and creating numerous reporting mechanisms.

Therefore it has been agreed that the SAB will receive assurances from partner agencies based on an annual report that will have been previously presented to each agency's internal governance body.

In addition partner agencies will be monitored regarding their commitment to partnership working as members of the board and this will be undertaken by monitoring attendance at the quarterly SAB meetings. It has been agreed that members attend a

minimum of two meetings a year and that deputies should not attend more than the substantive member of the board.

The record of attendance is included in Appendix 1

The City of York has further ongoing assurances of the partnership working between groups of organisations represented on the SAB. For example the Health Partnership Group meets regularly to share best practice across health commissioning and provider organisations. This group reports to the SAB on a quarterly basis and demonstrates a commitment to learning and sharing across a broad range of organisations.

In addition the independent sector mental health organisations within the City of York meet on a regular basis and provide peer support in undertaking investigations and responding to issues particularly relevant to this specialist group of provider organisations.

With the recent reforms to policing, health and social care, the need to review and refine assurance processes will be kept under constant review.

10. Progress on agreed actions for 2013

The priorities and actions were agreed in June 2012, with regard to the following drivers which have been described in this report, namely:

- safeguarding context in York
- performance and activity
- new partnership relationships

The strategic objectives were therefore focussed on:

- prevention
- personalisation
- strategic links
- continuous improvements

In summary we have achieved:

- Early progress on sharing of commissioning information on quality of providers
- Development of shared approach with Community Safety Board and Children's Safeguarding Board on domestic homicide reviews
- Improving access to information on safeguarding and for people who live in York
- Improved links with the voluntary sector
- Increased focus on user stories and engagement through York Health Watch
- Review of multiagency policy and procedures
- Adoption of safeguarding competencies framework
- Assurance on action to respond to issues raised through the Winterbourne View reviews

An update on the action plan can be found at Annex 2.

11. Strategic Plan for the future

The Board considered a Draft Strategic Plan for 2014-17 at the December Board meeting. This will be completed ready for agreement the March meeting in 2014, and will be available on the Website. The themes for action have been agreed as:

A. Make sure safeguarding is embedded in corporate and service strategies across all partners
B. Ensure good partnership working
C. Focus on prevention of abuse
D. Respond to people based on the Personalisation approach, and with a clear focus on outcomes

Annex 1

York Safeguarding Adults Board Members 2012-13

Member agency	**Representatives**	**Attendance *to update Dec***
Independent Chair	Gill Collinson (January 2013- March 2013) Kevin McAleese, CBE (April 2013 onwards)	1/1 meetings 4/4 meetings
City of York Council	Pete Dwyer Director of Adults, Children and Education (ACE) (Jan-March 2013) Kevin Hall, Interim Director of Adults, Children and Education (ACE)(March-June 2013) Dr Paul Edmondson Jones , Director of Health and Wellbeing (from June 2013) Cllr Tracey Simpson-Laing, Cabinet Member for Health, Housing & Adult Social Care Kathy Clark, Assistant Director (Adult Assessment & Safeguarding) ACE Michael Melvin – Group Manager Mike Hodgkiss – Safeguarding operations lead (invited guest) Trading Standards – Matthew Boxall to attend as required	1/1 meeting 0/1meetings 1/2meetings 3/4 meetings 4/4 meetings 2/4 meetings 3/4 meetings (1 Sub) 0
North Yorkshire Police	ACC Iain Spittal (January 2013- June 2013)	1/2 meetings (1 sub)

	Det Inspector Maria Taylor(September 2013 onwards)	1/2 meetings
NHS Partnership Commissioning Unit	John Keith	4/4 meetings
Vale of York CCG	Wendy Barker (from September 2013)	2/2 meetings
NHS England	Jo Coombs (from September 2013)	2/2 meetings
Leeds and York Partnership NHS Foundation Trust	Steve Wilcox, Lead Clinician for Safeguarding Adults	3/3 meetings
York Health NHS Foundation Trust	Lucy Connolly, Assistant Chief Nurse (January – March 2013) Beverley Geary (from June 2013)	1/1 meetings 2/3 meetings (1 sub)
Ambulance Trust	Through link with NHS NY&York	0
Care Quality Commission	Dianne Chaplin – as required	0
Independent Care Group (ICG)	Keren Wilson, Chief Executive Representing independent care providers	3/4 meetings
Department of Work and Pensions	Link to be made at operational/practice level	0
Crown Prosecution Service	Jonathan Heath	0
York & North Yorkshire Probation Service	Joanne Atkin	4/4 meetings (1 sub)
Fire Service	Ian Hill	0

Children's Services/Safeguarding Children	via Assistant Director Adults Children and Education	
Care Home and Domiciliary Care providers	To action through existing provider forums.	
Service users/patients organisations/individuals who have experienced the system/carers organisations	Sian Balsom Health Watch York (from December 2013)	0
Voluntary Sector	Catherine Surtees CVS (June onwards)	3/3meetings
The Retreat	Maggie Scott	4/4 meetings (1 sub)
Stockton Hall	David Heywood	4/4 meetings

Annex 2

City of York Safeguarding Adult Board

Strategic Objectives and Action Plan 2013-14

Background

Priorities and actions for the coming year were agreed in June 2012, with regard to the following drivers:

Safeguarding context in York The Safeguarding Board received reports in March 2012 which outlined specific risk areas for York with regards protection of adults at risk of abuse. This included the number of self funders receiving care and support in York, the presence of the two independent mental health hospitals in York, and the growing numbers of older people particularly those over 85, and the numbers of people with learning disabilities and complex needs. The changing demographic profile in York also includes growing numbers of people from minority ethnic groups.

Performance and activity Reports over the last three years show that the highest proportion of alerts and referrals concern people in their own homes. But there are also significant numbers of referrals from care homes and supported living schemes, where improved quality of care could reduce the risks of abuse happening. There are growing numbers of incidents where the alleged abuser is also a vulnerable person.

SCIE guidance on safeguarding and care home commissioning recommends improving responses to falls pressure sores and challenging behaviour. In York work is already underway to improve responses to pressure sore and skin tissue management.

Key messages from analysis of our performance in 2011-12 showed we had a low number of protection plans signed and agreed by those at risk of abuse.

We received a proportionately high number of referrals for People with a Learning Disability

Policy and Practice changes; Personalisation in both health and social care brings new challenges to keeping people safe, with a growing use of informal and community support as people exercise choice and control over the use of personal budgets. Residents in the City using Direct Payments need information , support ad guidance on how t safeguard themselves particularly when the are engaging unregulated and informal support providers.

New partnership arrangements: Health and wellbeing Boards and new Police Commissioner arrangements will be developed over the coming year. Both will impact on the responsibilities and working relationships for the Adult Safeguarding Board.

Strategic Objectives set by the Board for 2012-13 were therefore focussed on:

- Prevention
- Personalisation
- Strategic Links
- Continuous improvement

Action Plan

Outcome	Action/Initiative	Key milestones	Lead responsibility	Others involved	Measures/ completio n	Notes and comments
Improve quality of care in care homes **<u>Prevention</u>**	Shared information on quality monitoring Advice and training to improve the quality of care around falls prevention and managing challenging behaviour between residents.	Joint QA visits to care homes Meetings to review quality assurance information and feedback Dementia Champions Training programme rolled out to care homes Bid to Skills for Care for training programme on challenging behaviour	CYC commissioners and PCT commissioners	ICG CYC WDU and Workforce Strategy Group	4 Visits by March 13 4 meetings by March 13 Report to Board by June 13	**4 homes visited Themes emerging from the visits: cleaning schedules, re-using single use medical products will be shared with all homes** **Progressing.**

	Continue to improve responses to pressure sores	Protocol on root cause analysis and referral for safeguarding	PCT/CCG/ CSU	Health providers and CYC Safeguarding Team		**Protocol developed: confirmed at Board December 2013**
Empower vulnerable people particularly self funders to keep themselves safe **<u>Prevention</u>** **<u>Personalisation</u>**	Improve information for self funders to help them make choices that keep themselves safe.	Information currently available on Safeguarding website to be linked to new my Life My Choice information website. Work with user led groups to improve the information and make it user friendly	CYC	York Independent Living Network	Website live Sep 12 January 13	**Website live October 2012** **Easy Read version of information developed following feedback from self advocates**

		New information to be available through e-market place information site Connect to Support		Regional Shop4 Support programme	March 13	**Live July 2013 Launch October 2103**
Update intelligence on York's safeguarding risks and activity **<u>Prevention</u>**	Review performance and data on an annual basis	Analysis from partner agencies for March meeting	M Melvin	Lead Officers	March 13	**AVA report Year end information presented at June board meeting**
Reduce risk to vulnerable people who use personal budgets **<u>Personalisation</u>**	Improve understanding of safeguarding issues for people using personal budgets	Research approval Research undertaken	CYC	University of York	Sep – March 13	**Research has commenced – Completion expected 2014**

Strong links to other strategic partnerships **<u>Strategic Links</u>**	Improve the links between Safeguarding Adult Board and the new Health and Wellbeing Board.	Induction for new CCG lead on Safeguarding Identify links in Health and Wellbeing Strategy and Safeguarding priorities Develop links with voluntary sector including induction for VCS representative to Safeguarding Board	Safeguarding Board Chair	Lead Officers from each agency	March 13 December 12 December 12	**Safeguarding Leads agreed** **Completed March 13 and reported to Board** **CVS and Health Watch now represented on Board**

	Identify and agree any common areas of activity with Safer York Board, and any successor board emerging from new community safety arrangements.	Meet with Chair of Safer York Board Review Police Safeguarding Assurance arrangements under new Commissioner and governance structures	Safeguarding Board Chair	Lead officer Police	December 13	**Reviewing the CSP Citadel Group and links to Safeguarding** **Agreement reached in June on shared approach to Domestic Homicide Reviews and Serious Case Reviews**

Continuous quality improvement **<u>Continuous improvement</u>**	Increase number of protection plans agreed by those at risk of abuse	60% agreed and signed	M Hodgkiss		AVA: completion of protection Plan	**90 % of Protection Plans offered were signed and agreed 2012-13**
	Workforce development	Adopt, implement and embed competency framework	M Melvin	Lead officers	December 12	**Adopted. 1st meeting set up Dec 13 to support partners review Safeguarding Competencies against each agencies competency frameworks**
			M Melvin	Lead officers	March 13	**Agreed December Board**

	Review of Multi Agency Procedures	Review impact of policy change, current protocols and prepare for proposed legislation	K Clark	Lead Officers, health provider reps. Reps form Valuing People Board (people with a learning Disability and Carers)	Set up by December Report by March 13	**Workshop held January 2013. Questionnaire report back June 2013**
	Winterbourne review implications	Establish Task and Finish Group, in partnership with Valuing People Board: Review of safeguards in place for people placed out of area and in independent health care settings	NY Police		March 13	**Update awaited**

	Use of intermediaries by Police	Consider proposals by Police for advocate support through Criminal Justice process for people with severe mental health needs, or a learning disability				