

BCF Strategic Narrative – DRAFT 6.6 (27-9-19)

Section A. Person-centred outcomes max 1500 words

Your approach to integrating care around the person, this may include (but is not limited to):

- Prevention and self-care
- Promoting choice and independence

The York BCF Plan 2017-19 offered a portrait of our system at a stage on our journey towards full integration. It focused on the improvement in partnership working (compared to earlier years) and on the leadership connections being made across the system, and was indicative of the partnership relationships developing at the time. It pinpointed the commitment to joining up services around individuals, families and communities, and integrating through closer working at the frontline, rather than organisational reconfiguration. Reflecting the multiple challenges we faced, it described prevention and self-care as critical to our demand management. It recognised that only a whole system community response would succeed in shifting away from institutional and hospital dominated services towards new models of care and support, concentrating investment on the upstream services of early intervention and prevention. The Joint Health and Wellbeing Strategy provided the overarching system vision for the future of care and support, articulating the outcomes we sought for local people.

Our schemes in 2017-19 built on existing arrangements from earlier years. The combined impact of BCF and iBCF has been to strengthen our services which are geared towards avoiding admission and supporting people's independence and resilience. Following the approval of our plan in December 2017 we refreshed our BCF Performance and Delivery Group, including updated terms of reference to reflect integration and enhance our approach to co-production and collaborative leadership. We have developed our partnership arrangements significantly, covered in more detail in section D.

We re-launched our BCF programme in early May 2018, with a special event for partners, where we looked at the history and progress as well as the future of BCF, and invited external guests to help us learn from good practice elsewhere in the region. This afforded an opportunity to

look in detail at the SCIE Integration Logic Model, and to further develop our vision in partnership. We adopted the headline: *Integration: Collaboration; Innovation; Prevention* to describe our overarching approach. Later in May 2018 we held our annual evaluation, taking this as an opportunity to bring schemes together to report back to each other on their achievements, challenges and learning. This enriched our shared understanding of the whole system, and fostered collaboration among partners, instead of competition for funding among providers. In addition to members of the multi-agency BCF Performance and Delivery Group, these sessions involved representatives of the various schemes, and key stakeholders such as Healthwatch York and The Independent Care Group (ICG). Schemes were required to bring customer / patient experience and individual testimony into their presentations and to ensure we heard their voice as part of our appreciation of what was working well and what could be better. The sequence of co-production events has been built into our annual planning cycle, with partnership events in November 2018 and February 2019 to look forward to our 2019-20 plan, in the light of our agreed vision and our shared assessment of the outcomes being delivered by our schemes.

Embedding co-production across the partnership has contributed to our journey of integration, with a powerful emphasis on shifting towards prevention and approaching all our challenges from an asset based / strengths based perspective. Further events are scheduled for November 2019 and spring 2020 to plan for 2020-21.

We are rightfully proud of our strength and depth in schemes which are working upstream in communities to deliver early intervention and prevention, as part of our overall commitment to promoting York as an inclusive city, improving population health and reducing health inequalities. Our annual evaluation events in May 2019 generated a wealth of evidence about the value of our schemes individually and working together. We have provided a snapshot of this evidence to the Health and Wellbeing Board (HWBB) through an annual report [R1], and by including at least one individual story (*cf* case study) within each of our quarterly updates to the HWBB.

We have deployed BCF to develop Ways to Wellbeing social prescribing, led by the Centre for Voluntary Service (CVS) and embedded in GP practices. We will describe how this service is developing in the context of Primary Care Networks in section B. Social Prescribing operates alongside other schemes rooted in our communities, such as Local Area Co-ordination, now expanded to the

eight areas of greatest need within the city thanks to BCF. The council's redesigned operating model for Community Led Support, and the development of Talking Points in community settings enable rapid access to social work expertise, avoiding unnecessary waits for costly Care Act Assessments where a person's circumstances can be better dealt with by accessing universal services and local resources to build the support networks around them and their family. Ways to Wellbeing and our Local Area Co-ordination programme have both been independently evaluated, providing impartial evidence of the impact they are making. [R2 & R3].

Allied to these, the York Integrated Care Team (YICT) and the Rapid Assessment and Treatment Service (RATS) together with the Home from Hospital Service provided by Age UK York, are enabling people to manage their wellbeing and their challenges in the least institutional setting possible, supporting individuals to remain at home or return there, with creative solutions when required. Personalisation, in its full sense, is central to these developments, supporting people to exercise choice and control over how their care and support needs are met, maximising their own resources as part of their personal plan for a good life, and promoting their rights as citizens in an inclusive community, with a positive risk appetite for enabling independence.

Reablement - delivered by Human Support Group (HSG) – and YICT form part of the One Team in York, alongside the Community Response Team (CRT) and dedicated social work posts, funded from BCF. The One Team represents a significant aspect of our approach to joined-up care and seamless services for people requiring support to avoid a hospital admission or to return home from hospital. The evolution of the One Team into a single service is ongoing, with digital integration a major block to progress. However, there have been very significant improvements over the past year, reducing delayed discharges, liaising with other services and supporting the implementation of the High Impact Change Model by planning discharges earlier, seven days per week.

Our Mental Health provider, Tees, Esk & Wear Valleys (TEWV) have supported patients becoming active participants in developing their own care plans and their voice is heard and listened to throughout their engagement with us. They have developed a 'Peer Mentoring' programme that enables existing service users to benefit from others with lived experience of the challenges they face, providing personalised non-clinical support through treatment and recovery. They have also

developed a 'Virtual recovery College' to aid understanding and promote prevention, self-care and recovery.

The Recovery College provides:

- a public area available to anyone worldwide, providing generic, non-Trust specific information on mental health and wellbeing topics.
- an e-learning section providing teaching and learning on a range of mental health topics, available to anyone within the TEWV catchment area

We have recognised the room for improvement in our system, particularly to ensure that all people receive the right care at the right time in the right place. The CQC Local System Review in 2017 and Progress Review in 2018, which focused on the experience of older people at the interface of health and social care, highlighted the need to go further faster in relation to seamless, joined-up services. In response, we used BCF money to fund the Venn Consulting Capacity and Demand Model for York during the spring of 2019. This has provided vital insight into how our system flows, and it has re-shaped some of our plans for 2019-20. For example, instead of continuing to increase year on year the amount we invest in short term beds, we will be targeting our funds towards more care for people in their own homes, as this was shown to be insufficient to meet demand in York. We have learned from experience that our population as a whole does not favour the offer of admission to a short term bed as part of the discharge pathway in most cases. People would far prefer to go directly home with more support. This chimes with the strategic intention of the council to reduce the number of admissions to permanent residential care, and to ensure no one goes to a permanent new placement from a hospital bed. We have committed a proportion of the winter funding in 2018-19 and again in 2019-20 towards live-in care at home to support timely discharge from hospital. This has expanded the range of options for people, giving them more choice and control about how their care needs are met.

[Total 1461]

Section B. Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
maximum word count 800

Joint commissioning arrangements

- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

BCF has been the catalyst for a whole system engagement in Joint Commissioning. Much of this has been captured in section A of this plan, for example in terms of collaboration, co-production, transparency and shared decision making.

Over past two years joint commissioning arrangements have evolved, firstly with a joint CCG and council interim post for Head of the Joint Commissioning Programme, then the new post of Assistant Director - Joint Commissioning, leading the BCF programme. Wrapped around this, the establishment of the Joint Commissioning Strategic Group, with members from CCG Executive Group and Council Corporate Management Team, confirms the level of significance and commitment to joint working and shared objectives. The Place Based Improvement Partnership, established in 2018, brings together system leaders across council, NHS, Police, CVS and NHSE to focus on the health and care agenda for York as a place. Here, as at the HWBB and BCF Performance and Delivery Group, the voice of the voluntary and community sector is strong. The sector itself is pivotal to the authenticity and sustainability of our strengths based approach to our challenges, and our delivery of better outcomes in asset based areas.

The non-coterminous relationships for CYC and VoYCCG have meant it has been essential to build positive working relationships across the system, and where relevant to work across a wider footprint, particularly with NYCC, and our emerging Integrated Care Partnership across North Yorkshire and York.

The Primary Care Home model has been a focal point for delivering integrated care in communities, responding to needs of the populations around practices as well as the wider population health and prevention agenda. With the publication of the NHS Long Term Plan, the Primary Care Home steering group has worked collectively to respond to the establishment of Primary Care Networks, achieving all target goals on time. The CCG has led protected learning time and CCG governing

body workshops, bringing the clinical directors together to shape the agenda for anticipatory care with partners.

We have welcomed the NHS Long Term Plan shift towards collaborative commissioning and whole system working. The clinical directors from the York PCNs are sharing representation at the BCF Performance and Delivery Group meetings to exchange information, build relationships and begin to shape a shared agenda. Alongside social prescribing, our Local Area Co-ordination programme and www.livewellyork.co.uk website are well placed to support the PCNs' prevention agenda, particularly in our most deprived or unequal communities.

The history of social prescribing in York has been solid preparation for the expectations of the Long Term Plan, with our Ways to Wellbeing scheme funded by BCF delivered by the CVS in partnership with GP practices. This has paved the way for PCNs to continue the relationship with the service into the future, ensuring continuity and consistency as well as value for money for local people. It has also provided inspiration to look at other settings where social prescribing could be a better alternative to calling upon scarce public sector services.

Beyond BCF, we have been making important advances on Joint Commissioning, and making connections across other strategic programmes such as the ICP and ICS development, the Complex Discharge Steering Group and Health and Care Resilience Partnership (A&EDB). We have deployed BCF to fund strategic activity to support the whole system strategic objectives. For example, the Venn Capacity and Demand Model is an asset for all strategic / system leadership groups. BCF is also funding a project manager for digital integration to enable our whole system preparation for the Yorkshire and Humber Care Record. Other local strengths include our commitment to become an Age Friendly City, and to work towards the Trieste model in mental health.

We have characterised our approach to integration as 'learning by doing'. We have mapped our existing local activities against the 6 principles of integrated care, and worked with clinical directors of PCNs to describe the local approach to anticipatory care as: 'Identification, Communication, Shared Responsibility and Learning'. [R8]

[Total 658]

Section C. Your approach to integration with wider services (e.g. Housing), this should include: maximum word count 800

Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

The Housing Service of the council is a member of BCF P&D group, with the DFG schemes included in the annual evaluation. In 2017 the Council took the opportunity to review its DFG major adaptation programme, delivered through the BCF, using a system thinking approach.

The Housing Authority (City of York Council) agreed the use of DFG, as set out in the BCF Plan. CYC is a unitary council and Housing sits within a joint Directorate of Health, Housing and Adult Social Care. All changes including the revised Private Sector Housing Policy were taken through the council decision making process and then approved by the member of Housing and Safer Community Safety based on the BCF allocation. <https://www.democracy.york.gov.uk/ieListDocuments.aspx?CId=932&MIId=10309&Ver=4>

- 1) A dedicated resource working with customers accessing the DFG programme. Two additional Occupational Therapist (OTs) are now co-located within the team, providing this dedicated resource.
- 2) Reviewing the DFG eligibility policy using opportunities provided by the Regulatory Reform Order 2002. This was completed in June 2017. Changes introduced include a non-means tested grant for low value work less than £5k.
- 3) Expanding the pool of contractors, in particular for bathing work, as delays to adaptations had previously been caused by this. Contractors are vetted both Age UK and CYC's Trading Standards Service, offering reassurance to customers. The same contractors are also used by the council to deliver their adaptation programme in council homes. This year a new framework for adaptations in council homes will expand the pool of contractors, releasing time for work with private customers.

The outcome of this systems approach means that in 2016/17 160 grants were completed in 2018/19 274 grants were completed enabling 42% more customers to be helped to live warmly safely and independently at home

Customers accessing the major adaptation service are also supported by a range of other council based services namely Be Independent telecare care and warden services, the falls prevention service, minor adaptation services, handy person service and a range of initiatives delivered through the Better Homes Scheme aimed at providing energy efficiency and affordable warmth. This is complemented by a range of voluntary schemes like Good Gym and York Neighbours Community Bees which offer a range of services to help customers remain at home.

The evaluation of the Falls Service pilot showed a significant reduction in falls and in people's fear of falling. The evaluation includes impressive analysis of the social value return on investment. [R4]

TEWV remain committed partners and contributors to the multi-agency forums developing improved housing offers for people with disabilities or care needs. The Mental Health Housing and Support Programme Board is developing housing support options including recovery team support requirements and multiple-complex needs support.

Changing Lives – A Bed Ahead project, BCF funded, helps avoid hospital admissions for people who are homeless when seen and treated in A&E. We are including additional funding in 2019-20 to maximise take up of vaccinations for this vulnerable customer group.

As a city, York has joined the Collaborative Mental Health Learning Partnership, implementing the Trieste 'home first' model for people affected by long term mental health complex needs.

The Multiple Complex Needs Network includes a number of partner agencies funded through BCF, as well as North Yorkshire Police, Job Centre Plus and people with lived experience. The network has been successful in attracting significant external support through Lankelly Chase. The 2019-20 BCF plan includes money to facilitate small scale experiments to improve people's outcomes linked to social exclusion and homelessness.

Led by the council, the older people's accommodation programme is delivering significant increases in purpose built homes across a mix of tenures and service models. Recent research in partnership with Age

UK and a number of registered social landlords has highlighted the high demand for small, safe, single storey properties amongst our older residents. The programme includes the development of independent living, independent living with care and where required residential and nursing accommodation.

The council developed a Private Sector Housing Strategy 2016-21. In 2015 the council commissioned Building Research Establishment to provide a revised evidence base which included a Private Sector housing stock survey detailing the condition of the existing private sector housing (not council homes) and health impact assessment of those conditions on their occupants. The council used this evidence base to develop a number of services to support residents to remain at home. The evidence base clearly demonstrated there was a need to tackle falls at homes and fuel poverty. In the context of this request the strategy has a number of aims, but strategic aim 3: “To enable people whose independence may be at risk safely remain in or return to their homes” is the most relevant (see item 11 – Thursday 30th June 2016 Executive. <https://www.democracy.york.gov.uk/ieListDocuments.aspx?CId=733&MIId=9191&Ver=4>)

[total 788]

Section D. System level alignment, for example this may include (but is not limited to): maximum word count 1500

- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans
- A brief description of joint governance arrangements for the BCF plan

York BCF is a crucial building block for transformation in our system, both locally and in the context of the Integrated Care Partnership (North Yorkshire and York) and the Integrated Care System (Humber Coast and Vale)(HCV). Aligned to the Joint Health and Wellbeing Strategy 2017-22, and informed by the Joint Strategic Needs Assessment, our plan has been a consistent and coherent resource for the promotion of better population health through integrated services in communities, working in partnership across organisations and the sub-region.

A number of our schemes are part of a wider pattern, recognisable in neighbouring HWBB areas, working at scale, such as the Urgent Care

Practitioners (Yorkshire Ambulance Service). TEWV remain active partners in development of a 'system wide' approach within York, and a core member of the BCF Performance and Delivery Group. TEWV contributed to the development of the system wide capacity and demand model and remains a key member of the JSNA steering group, actively participating in sharing and alignment of business, strategic, regional and national plans through these forums.

The local system (incorporating all health and care partners) works together through a number of groups including the York Place Based Improvement Partnership and Systems Leadership Executive. The VOYCCG also works with the acute provider through the System Delivery Board (SDB) to focus on financial recovery. We have described in section B the development of the Joint Strategic Commissioning Group, which looks wider than BCF to promote integration, and support innovation and transformation through a shared leadership agenda.

The CCG and SDB both provide assurance and planning through the HCV Care Partnership (aspirant ICS) for the NHS LTP for the local place. The 5 year planning process in line with national requirements is underway. VOYCCG Commissioning Intentions [R5] support the shift from a hospital focused system towards care closer to home, prevention and self-care, with BCF an important plank in this platform for improvement.

Some of our challenges can only be addressed at the level of the ICS, such as workforce, digital and estates / capital (this is reflected in the priorities of the Place Based Improvement Partnership, which actively mirrors the STP priorities). An obstacle to developing truly sustainable improvement has been the short term nature of BCF funding for many schemes, and the limitations of a one year framework. This will be true nationally, but in York where near full employment makes recruitment and retention in all sectors extremely competitive, this is an added pressure, particularly for care providers.

Following the election of a new administration in York and the re-set of VOYCCG Governing Body, the HWBB has welcomed its new members to their first meetings, and is refreshing its ways of working. This includes renewing our focus on outcomes of the Joint HWB Strategy. The HWBB has ratified a number of specific all age strategies for York, relating to Autism, Mental Health, Learning Disabilities and Carers (Sept 2019). Under the overall vision: *for every single resident of York to enjoy the best possible health and wellbeing throughout the course of*

their life. This provides the overarching framework for the BCF approach to population health, prevention and integration.

The Joint HWB strategy recognises the importance of the wider determinants of health, in particular the impact of the environment, the economy, and housing on the health and wellbeing of York's residents. While York compares well to national averages, key groups in our population are affected by or at greater risk of health inequalities. For example, carers, frail older people living alone, people living in the more deprived parts of the city, people with long term conditions, people with few qualifications, people from ethnic minority groups, or LGBT people.

During the planning process, these groups and areas are prioritised. Schemes such as Local Area Co-ordination and our cultural commissioning for community capacity building are targeted towards the most deprived wards of the city. The JSNA group has undertaken a deep dive into the needs of self-funders to enable us to provide better, earlier preventative information to people who could otherwise be isolated from support. The JSNA group has also conducted in depth exploration into the health needs for homeless adults, and people with a learning disability. These projects have supported and informed the Homeless Strategy and the Learning Disability Strategy.

www.livewellyork.co.uk is our community information resource that is searchable by neighbourhood, community of interest, activity or service area. It is capable of producing personalised booklets for people who are not online, either through the library service or other support routes, like families or care workers. A comprehensive report on early intervention and prevention (the asset based area) was presented to the scrutiny committee in December 2018, describing in depth the impact of these programmes.

As part of its commitment to reducing health inequalities VOYCCG uses Equality Impact Assessments to measure the impact of its decisions and how they affect the local population, particularly protected groups. This helps it to identify any action needed to reduce or remove any negative impacts. As part of this process the CCG considers and analyses a range of information and data including any engagement activity and this informs its decision making both as a commissioner and as an employer. To support the equality objectives and refreshed Equality, Diversity & Human Rights Strategy we developed an action plan, forming part of our Public Sector Equality duty reporting. (R7)

BCF schemes that support our vision for equality in healthcare are: Bed Ahead, providing link worker/discharge liaison for homeless in ED, ensuring that none is discharged to the streets after hospital treatment; the Vaccinations Outreach service to provide flu and Hep B vaccinations to the homeless community in outreach settings; the START dementia carers support service; and Street Triage supporting individuals detained in mental health crisis.

To ensure that the city's housing can meet the needs of our social care clients and York's high number of self-funders the programme is also working with commercial developers to support them to include specialist accommodation for older people, enabling the creation of vibrant multi-generational communities. Strategic assessments needs of other customer groups are being undertaken, such as people with learning disabilities, physical impairments and mental health. Work is underway to ensure that their needs are addressed in the council's housing delivery programme.

We have used the pooled budget to develop our BCF Performance Framework, recruiting a BCF project officer to build expertise in this aspect of the governance and assurance process for the fund. Over the past year our ability to monitor key performance indicators and individual outcomes, aligned to activity and expenditure, has been greatly enhanced. Information collection has become more efficient and routine, making interpretation and analysis a stronger element of our discussions at the multi-agency meeting. We are better equipped as a result to work together on understanding challenges and creating local solutions.

The BCF Performance & Delivery Group reports quarterly to HWBB. We are not satisfied with our overall performance against our targets. The BCF dashboard of four indicators demonstrates continued pressure on non-elective admissions, delayed transfers of care, residential admissions and reablement outcomes. We are aware of some anomalies in the counting which adversely affect our local picture, as well as fundamental aspects of our health and care economy, however these factors are not the story. We have benefited from regional and national support to address key areas such as seven day working and trusted assessment, and we are also using the intelligence from Venn to support our strategic intentions around reducing admissions to care, improving the flow through reablement, and reducing our reliance on

beds for people who could be better supported at home. The council is leading a programme of work to change our culture in relation to the high rate of admissions to care from hospital. We recently held a multi-agency workshop to kick start this, focusing on the determination that York will be a place where no one goes directly to a new permanent placement from a hospital bed. Our trend on delayed transfers of care is improving although still above the BCF target. By getting it 'right first time, every time' we will deliver integrated, seamless care for people who need it, and in doing so we will improve our performance.

The chair of the group is a member of the Complex Discharge Steering Group and regularly updates partners here, and through this, the Health and Care Resilience Partnership (A&EDB). Updates are also provided to the CCG Governing Body and when required through other partners' governance arrangements. The Health and Adult Social Care Policy and Scrutiny Committee requested an overview of Integration in York in March 2019, with BCF a focal point in developing members' awareness of progress and local challenges. [R6]

[total 1494]