Notice of a public meeting of Health and Wellbeing Board

To:	Councillors Runciman (Chair), Craghill, Cannon and Rawlings	
	Keith Ramsay (Vice Chair)	Lay Chair, NHS Vale of York Clinical Commissioning Group (CCG)
	Sharon Stoltz	Director of Public Health, City of York Council
	Martin Farran	Corporate Director, Health, Housing & Adult Social Care, City of York Council
	Jon Stonehouse	Corporate Director, Children, Education & Communities
	Lisa Winward	Deputy Chief Constable, North Yorkshire Police
	Sarah Armstrong	Chief Executive, York CVS
	Siân Balsom	Manager, Healthwatch York
	Gillian Laurence	Head of Clinical Strategy (Yorkshire & the Humber) NHS England
	Colin Martin	Chief Executive, Tees, Esk & Wear Valleys NHS Foundation Trust
	Patrick Crowley	Chief Executive, York Hospital NHS Foundation Trust
	Dr Shaun O'Connell	Medical Director, NHS Vale of York Clinical Commissioning Group
	Phil Mettam	Accountable Officer, NHS Vale of York Clinical Commissioning Group
	Mike Padgham	Chair, Independent Care

Group

Date: Wednesday, 24 January 2018

Time: 4.30 pm

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

A G E N D A

1. Declarations of Interest (Pages 3 - 4)
At this point in the meeting, Board 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.

2. Minutes (Pages 5 - 14)
To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 8 November 2017.

3. 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 at **5.00pm on Tuesday 23 January 2018.**

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

Filming, Recording or Webcasting Meetings
Please note that, subject to available resources, this meeting will be filmed and webcast, or recorded, including any registered public speakers who have given their permission. This broadcast 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 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/download/downloads/id/11406/protocol_for_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

GOVERNANCE

4. Appointments to the Health and Wellbeing Board
(Pages 15 - 18)
This report asks the Board to confirm new appointments to its membership.

THEMED MEETING: LIVING AND WORKING WELL
THEME LEAD: SHARON STOLTZ

5. Progress Against the Living and Working Well Theme of the Joint Health and Wellbeing Strategy (including performance)
(Pages 19 - 28)
This report asks the Health and Wellbeing Board (HWBB) to note the update on progress made against delivery of the Living and Working well theme of the Joint Health and Wellbeing Strategy 2017-2022.

THEMED MEETING: MENTAL HEALTH
THEME LEADS: MARTIN FARRAN AND PHIL METTAM

6. Mental Health Strategy for York (Pages 29 - 52)
This report presents the near final draft of an all age mental health strategy for York and provides the Health and Wellbeing Board with an update on establishing a new mental health delivery partnership for the city.

7. **Mental Health Housing & Support** (Pages 53 - 90)
This report outlines a direction of travel for the development of a housing and support pathway for people with mental ill health.

OTHER BUSINESS

8. **Older People's Survey** (Pages 91 - 134)
This report asks the Health and Wellbeing Board to note the results of the York Older People's Survey and respond to the recommendations in the report.

9. **Better Care Fund** (Pages 135 - 214)
This report provides an update on the Better Care Fund (BCF) assurance process.

10. **CQC Whole System Review** (Pages 215 - 228)
This report updates Health and Wellbeing Board on the CQC Local System Review of York, the development of an action and future governance arrangements for the delivery of the action plan. (Annex 1 to follow)

11. **Update from the HWBB Steering Group** (Pages 229 - 234)
This report provides the board with an update on the work that has been undertaken by the Health and Wellbeing Board (HWBB) Steering Group.

12. **Work Programme** (Pages 235 - 238)
To note the Board's Forward Plan.

13. **Urgent Business**
Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Angela Bielby
Telephone No – 01904 552599
Email – a.bielby@york.gov.uk

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

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

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

☎ **(01904) 551550**

This page is intentionally left blank

Agenda Annex

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

Agenda Item 1

Health & Wellbeing Board
Declarations of Interest

Patrick Crowley, Chief Executive of York Hospital
None to declare

Dr Shaun O'Connell, Medical Director NHS Vale of York Clinical Commissioning Group

- Employee of South Milford Surgery, working 1 day per week
- Wife an employee of York Hospitals Foundation Trust

Mike Padgham, Chair Council of Independent Care Group

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

Siân Balsom, Manager Healthwatch York

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

Keren Wilson, Chief Executive Independent Care Group (Substitute Member)

- Independent Care Group receives funding from City of York Council

Councillor Douglas (Substitute Member)

- Governor of Tees, Esk and Wear Valleys NHS Foundation Trust

This page is intentionally left blank

City of York Council	Committee Minutes
Meeting	Health and Wellbeing Board
Date	8 November 2017
Present	Councillors Runciman (Chair), Craghill, Cannon and Rawlings Martin Farran(Director of Adult Social Care, CYC) Jon Stonehouse (Corporate Director, Health, Housing & Adult Social Care, CYC) Lisa Winward (Deputy Chief Constable, North Yorkshire Police) Sarah Armstrong (Chief Executive, York CVS) Sian Balsom (Manager of Healthwatch York) Phil Mettam (Accountable Officer, NHS Vale of York CCG) Keith Ramsay (Chair, NHS Vale of York CCG) Keren Wilson (Chief Executive, Independent Care Group) Substitute for Mike Padgham Dr Andrew Phillips (Medical Director, NHS Vale of York CCG) Substitute for Dr Shaun O'Connell Gillian Laurence Head of Clinical Strategy, NHS England (North Yorkshire & the Humber) Substitute for Julie Warren Ruth Hill (Director of Operations (York and Selby) Tees, Esk and Wear Valleys NHS) - Substitute for Colin Martin Mike Proctor (Deputy Chief Executive, York

	Teaching Hospital NHS Foundation Trust) - Substitute for Patrick Crowley
Apologies	Sharon Stoltz, Julie Warren, Patrick Crowley, Colin Martin, Dr Shaun O'Connell, Mike Padgham

---

103. Declarations of Interest

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

No further interests were declared.

104. Minutes

Resolved: That the minutes of the meeting of the Health and Wellbeing Board held on 6 September 2017 be approved and signed by the Chair as a correct record.

With reference to the Update on the Humber, Coast and Vale Sustainability and Transformation Partnership (STP) given at the meeting held on 6 September 2017, members were advised that the modelling for acute hospital service provision in the Humber, Coast and Vale area had begun.

105. Public Participation

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

106. Annual Report of the Children's Safeguarding Board

The Board was presented with the Annual Report of the Independent Chair of City of York Safeguarding Children Board (CYSCB) 2016/17. The Independent Chair of CYSCB highlighted the key issues and priorities for CYSCB and noted that the current arrangements would cease with the introduction

of new arrangements from April 2019. He also reported that there would be a young person's version of the annual report and that young people would be involved in producing this.

The Director of Children's Services, Education and Communities noted the contribution of staff and non statutory agencies to the work of the CYSCB. He added that the arrangement in York for capturing the voice of young people was exemplary.

Board members noted the outstanding work of the board and thanked both the CYSCB and the Independent Chair for the report.

Resolved: That Health and Wellbeing Board members received the Annual Report of the Independent Chair of the CYSCB and reflected on the key messages and priorities when considering plans.

Reason: So that communication between Boards and an understanding of each Board's key messages and priorities enhances collaborative work and optimum outcomes.

107. Developing an All Age Mental Health Strategy for York 2017-2022

Board members received a report which presented progress against producing an all age mental health strategy for York.

The Head of Joint Programmes NHS Vale of York Clinical Commissioning Group gave an overview of the feedback received during the consultation period. It was noted that consultation had closed on 8 October 2017 and had been predominantly collated via an online survey hosted by Healthwatch York.

It was noted that following the Board had already agreed to split the Mental Health and Learning Disabilities Partnership Board into two discrete groups one focusing on mental health and one on learning disabilities; (each to be the delivery mechanism for their related strategies).

Since then two workshops had been held to look at how this could be achieved. Discussions were ongoing as to how to create the new mental health partnership and Health and Wellbeing Board were updated on the key factors identified for the partnership.

Members welcomed the report and feedback and noted the following points:

- The action plan for the mental health strategy could be presented to the Board, and should include information on how the impact of the strategy was being measured.
- The waiting times for talking therapies stood out as an issue
- The important role that carers played needed to be included within the new mental health strategy
- The importance of the Pathways initiative was noted
- The governance of the progress and outcomes against the strategy needed to be built in
- The long term strategy needed to be examined
- Consultation needed to be wider with users of the service
- The links with schools was commended. The Corporate Director of Children, Education and Communities gave an overview of the School Wellbeing Service noting Headteachers' support in setting the service up.

Resolved: The Health and Wellbeing Board noted the feedback from the consultation and progress made on producing an all age mental health strategy for the city and establishing a new mental health partnership.

Reason: Health and Wellbeing Board oversight of the development of an all age mental health strategy.

108. Progress Against the Mental Health Theme of the Joint Health and Wellbeing Strategy (including performance)

Members considered a report from the Health and Wellbeing Board theme leads for mental health which updated them on progress made against delivery of the mental health and wellbeing theme of the joint health and wellbeing strategy 2017-2022.

Members noted the report and raised a number of points in relation to the update:

- The progress of actions under the top priority of 'get better at spotting the early signs of mental ill health and intervening early' (as detailed in Annex A) was highlighted, in particular the suicide prevention strategy and positive development of ambulance rather than police conveyance
- The growing demand for mental health services and need to use the right part of the system for the right support was noted
- The pressures on students, including overseas students was noted
- The importance of the priorities to ensure that York becomes a Suicide Safer City and ensuring York is both a mental health and dementia friendly environment were noted.
- It was suggested that a medium term financial strategy and analysis could be developed.
- The Police commitment to the mental health strategy and improvements to Section 136 was noted
- Members were invited to visit Huntington House, and it was noted that this could be arranged via the Health and Wellbeing Partnerships Coordinator.
- Housing waiting times were identified as being problematic
- The Director of Operations (York and Selby), Tees, Esk and Wear Valleys NHS Foundation Trust noted the support of the CCG in reducing waiting times.

Members received the report and it was:

Resolved: The Health and Wellbeing Board noted the report and commented on the report and considered how best to support and deliver all elements of the joint health and wellbeing strategy.

Reason: To keep the Health and Wellbeing Board informed as to progress on delivery against the mental health and wellbeing theme of the joint health and wellbeing strategy 2017-2022.

109. Healthwatch York Report - Children and Adolescent Mental Health Services

The Manager of Healthwatch York outlined the report, which made a number of recommendations based on patients' experiences of Children and Adolescent Mental Health Services (CAMHS) in York.

Health and Wellbeing Board members welcomed the report and noted the recommendations; they made specific reference to support for children not attending school.

Resolved: That the:

i. Health and Wellbeing Board received and commented on the report and requested that Healthwatch York add a further recommendation to their report to progress joint commissioning in this area.

ii. Health and Wellbeing Board organisations with recommendations against their organisation's name should formally respond to Healthwatch York by no later than the end of April 2018 either individually or through the Strategic Partnership: Emotional and Mental Health (Children and Young People).

Reason: To keep members of the Board up to date regarding the work of Healthwatch York.

110. Joint commissioning

Members received a report which provided them with information on:

- Progress on the development of the Joint Commissioning Plan, in line with the joint Commissioning Strategy;
- An update on the Better Care Fund (BCF) assurance process;
- A briefing on the Care Quality Commission (CQC) Local System Review of York, currently in progress.

The Head of Joint Commissioning Programme, NHS Vale of York CCG and City of York Council updated members on Joint Commissioning, the Better Care Fund and the CQC Review.

Members discussed the timescales for the outcomes of the Better Care Fund assurance process and noted that completion of the assurance process was by 30th November 2017.

in relation to the CQC Review, the consensus from board members was to await the final report of the CQC Review, which was to be presented at the Local Summit in December. Following discussion it was:

Resolved: That the Health and Wellbeing Board note the report.

Reason: To keep the Health and Wellbeing Board informed about these areas of work.

111. Update from the HWBB Steering Group

The Board received a report which provided them with an update on the work that had been undertaken by the Health and Wellbeing Board Steering Group and its sub-group the Joint Strategic Needs Assessment (JSNA) Working Group. It was noted that the membership of the JSNA Working Group would be examined to ensure that all groups were represented on it.

It was also confirmed that the recently redesigned JSNA website was now live.

Resolved: That the Health and Wellbeing Board note the update.

Reason: To update the Board in relation to the work of the HWBB Steering Group and the JSNA Working Group

112. Healthwatch York Report: Home Care Services

Members received a report from Healthwatch York about home care services in York. Members were asked to respond to the recommendations within the report. Members welcomed the recommendations in the report and it was:

Resolved: That the

i. Health and Wellbeing Board received and commented on the report.
ii. The Health and Wellbeing Board organisations with recommendations against their

organisation's name would formally respond to Healthwatch York by no later than the end of April 2018.

iii. Health and Wellbeing Board acknowledge the engagement and consultation undertaken presently by the adult social care team and agree that the next survey includes input from Healthwatch York;

iv. Health and Wellbeing Board agree that all Healthwatch York and adult social care reports in relation to home care services are made publicly available;

v. Health and Wellbeing Board continue to work collaboratively to ensure the retention of a high quality home care service across the city.

Reason: To keep members of the Board up to date regarding the work of Healthwatch York.

113. Work Programme

Board members were asked to consider the Board's proposed work programme up to May 2018.

Resolved: That the current 2017/18 work programme be noted.

Reason: To ensure that the Board has a planned programme of work in place.

114. Urgent Business

The chair suggested that she would like to follow up on some of the recommendations arising from Health and Wellbeing Board (HWBB) development sessions that had been supported by the Local Government Association (LGA), with an emphasis on alternative working styles for the HWBB and invited board members to be involved in this.

Cllr C Runciman, Chair
[The meeting started at 4.30 pm and finished at 6.25pm].

This page is intentionally left blank

Health and Wellbeing Board **24 January 2018**

Report of the Assistant Director, Legal and Governance

Appointment to York's Health and Wellbeing Board

Summary

1. This report asks the Board to confirm new appointments to its membership.

Background

2. The Council makes appointments at its Annual Meeting, to Committees for the coming year. However, the Health and Wellbeing Board is able to appoint to or update its membership separate of Full Council. Therefore the following changes are put forward for the Board's endorsement:

3. To appoint Gillian Laurence, Head of Clinical Strategy (Yorkshire & the Humber) NHS England, as NHS England's representative on the Health and Wellbeing Board. This appointment has been brought to the Board to allow for its confirmation.

4. To appoint Shaun Jones, Head of Assurance and Delivery, NHS England as the first substitute for the clinical representative for NHS England. This appointment has been brought to the Board to allow for its confirmation.

Consultation

5. As these are appointments to the existing Health and Wellbeing Board membership no consultation has been necessary.

Options

6. There are no alternative nominations for the appointments.

Council Plan 2015-19

7. Maintaining an appropriate decision making structure, together with appropriate nominees to that, contributes to the Council delivering its core priorities set out in the current Council Plan, effectively. In particular, appointments to the Health and Wellbeing Board ensure that partnership

working is central to the Council working to improve the overall wellbeing of the city.

Implications

8. There are no known implications in relation to the following in terms of dealing with the specific matters before Board Members:

- Financial
- Human Resources (HR)
- Equalities
- Crime and Disorder
- Property
- Other

Legal Implications

9. The Council is statutorily obliged to make appointments to Committees, Advisory Committees, Sub-Committees and certain other prescribed bodies. The Board's terms of reference also make provision for substitutes.

Risk Management

10. In compliance with the Council's risk management strategy, the only risk associated with the recommendation in this report is that an appropriate replacement would fail to be made should the Board not agree to this appointment.

Recommendations

11. The Health and Wellbeing Board are asked to endorse the appointments as set out in Paragraphs 3 and 4.

Reason: In order to make these appointments to the Health and Wellbeing Board.

Author:	**Chief Officer Responsible for the report:**
Angela Bielby Democracy Officer Telephone: 01904 552599	Andy Docherty Assistant Director, Legal and Governance

Report Approved ✔ **Date** 11 January 2018

Specialist Implications Officers
Not applicable

Wards Affected: **All** ✔

For further information please contact the author of the report

Background Papers
None

Annexes
None

This page is intentionally left blank

Health and Wellbeing Board 24 January 2018
Report of the Director of Public Health (Living and Working Well Health and Wellbeing Board Theme Lead)

Progress on the Living and Working Wellbeing Theme of the Joint Health and Wellbeing Strategy 2017-2022 (including performance)

Summary

1. This report asks the Health and Wellbeing Board (HWBB) to note the update on progress made against delivery of the Living and Working well theme of the Joint Health and Wellbeing Strategy 2017-2022.

Background

2. At their meeting in March 2017 Health and Wellbeing Board (HWBB) launched the new Joint Health and Wellbeing Strategy 2017-2022. The strategy is based around a life course approach with Living and Working well as one of the key priorities.

Context

3. There are approximately 200,000 residents in York of which two thirds are of working age (16-64).

4. 3.8% of York's population live in areas that are among the most deprived in the country. Poverty is associated with much poorer health and wellbeing outcomes and there are also poorer outcomes for certain vulnerable groups, e.g. the gypsy and Roma community and the lesbian, gay, bisexual and transgender (LGBT) population.

5. Although York has generally good levels of employment. Not all residents have this experience. The rate of unemployment in the most deprived wards is three times that of the least deprived wards. Additionally, the likelihood of staying unemployed for more than a year is five times greater in the most deprived

wards. The health outcomes for these groups of people are likely to be worse as a result.

6. Over 20% of working people in York earned less than the living wage (as recommended by the living wage foundation). Additionally, a large proportion of working families on low incomes rely on tax credits to supplement their income.

7. Screening programmes and health checks are an important way of raising awareness of health risks and identifying problems early. Take up of bowel cancer screening in adults in York is lower than the England average, as is take up of health checks.

8. Excess weight is a risk factor for a wide range of long term health conditions and a reduced life expectancy. York has a lower proportion of adults who are overweight or obese than the national average, but this still means that over half of adults in York are either overweight or obese.

Main/Key Issues to be Considered

9. The table at Annex A sets out the priorities within the living and working well theme of the joint health and wellbeing strategy 2017-2022 and gives examples of some of the ongoing work and the progress made to date in delivering against this theme.

10. A performance summary is attached at Annex B based on the agreed indicators for this theme.

11. An initial meeting was set up to bring together partners to consider what work is already ongoing to help deliver against this theme and where the gaps existed. Due to the diversity of this theme it is considered that a better approach would be to have task and finish groups to look at areas where further work needs to be developed.

Consultation

12. Extensive engagement and consultation took place with residents and stakeholders when the joint health and wellbeing strategy 2017-2022 was being developed.

Options

13. There are no specific options for the Health and Wellbeing Board; they are asked to note and comment on this report.

Analysis

14. Not applicable.

Strategic/Operational Plans

15. This report has direct links to the living and working well element of the joint health and wellbeing strategy 2017-2022.

Implications

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

Risk Management

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

Recommendations

17. The Health and Wellbeing Board are asked to note and comment on the report.

Reason: to keep the Health and Wellbeing Board informed as to progress on delivery against the Living and working well theme of the joint health and wellbeing strategy 2017-2022

Contact Details

Author:	**Chief Officer Responsible for the report:**
Fiona Phillips Assistant Director of Public Health City of York Council Tel: 01904 565114	Sharon Stoltz Director of Public Health City of York Council

Report Approved ✓ **Date** 02.01.2018

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
Joint health and wellbeing strategy 2017-2022

Annexes
Annex A – Table of ongoing work: living and working well theme of the joint health and wellbeing strategy 2017-2022
Annex B – Performance summary

Glossary
HWBB – Health and Wellbeing Board

Priority	Progress/update
Top Priority: Promote workplace health and remove barriers to employment	• Internally CYC have been scoping out a workplace health strategy . • Working with local businesses the Yorwellbeing service has been offering mini health checks • Public Health Grant funding has been supporting the CYC trading standards/environmental health team to promote workplace health standards with local employers • The Financial Inclusion Group gave funding for the delivery of workshops in Tang Hall for residents aged 50+ and unemployed /at risk of redundancy/ returning to work, to help with employment prospects e.g. work on self esteem, CVs, mock interviews in 2017. • Recent grant funding from DWP is supporting United Response, a charity supporting people with learning disabilities, autism and health conditions, to work with the City of York Council to offer employment support to individuals. Individuals will be referred to the service, through the City of York Council. The individual will then be introduced to United Response and an individual Job Coach assigned to support and work with the person. United Response's Job Coaches will assess the needs of the person, identify support needs and begin to source the right type of work at the right time for the person. Support includes CV building, interview preparation, in-work support as well as signposting and identifying other areas of development for the individual which enables increased independence with improved health and wellbeing. Regular reviewing and tracking of outcomes and progression is undertaken with the individual. The plan in the initial proof of concept 18 months is to support 94 people.
Other Priorities:	
Reduce inequalities for those living in the poorer wards and for vulnerable groups	• The Local Area Co-ordinators are able to provide one to one support for people who are vulnerable due to age, frailty, disability or mental health issues to connect to support within their local communities. Support is targeted to those communities most in need. • The work of the Yorwellbeing Service is targeted at vulnerable groups

Priority	Progress/update
Help residents make good choices	• The Yorwellbeing Service works across York to support healthy lifestyle choices. Offering health checks to residents is one way of raising awareness of the impact of lifestyle choices and can be used a tool to facilitate behaviour change. The team are able to provide advice and support to help people to achieve their health goals. Further work is required to ensure uptake of this service. We are currently working to facilitate invitations to a health check from GPs through text messaging and need GPs to work in partnership with us on this.
Support people to maintain a healthy weight	• The York Public Health Team are in the process of developing a healthy weight strategy for the City. We are working with colleagues across the Yorkshire and Humber Region to look at signing up to a Healthy Weight Declaration for York. The Declaration will capture the priorities that the Local Authority will lead on to prevent obesity and secure the health and wellbeing of our residents.
Help people to help themselves including management of long-term conditions	• There is quite a lot going on in the city around this, but more work is required to build health literacy. Residents also need to know what support groups are available, and this could link with the work that is being carried out under the Ageing Well element of the Strategy. There are also links to the Learning Disability Strategy which is currently in development.
Work with the Safer York Partnership to implement the city's new alcohol strategy	• Work began some time ago to develop an alcohol strategy for the City of York. This work has been led by the Safer York Partnership. However, the vision and direction that was previously set is now outdated and agencies such as the Police and Safer York have their own strategies. There is however a need to have a better understanding of the health impacts of alcohol in the City and to identify how we move forward to address these. The plan is to undertake further work through the JSNA working group and develop a public health alcohol strategy that is focused on reducing alcohol-related harm.

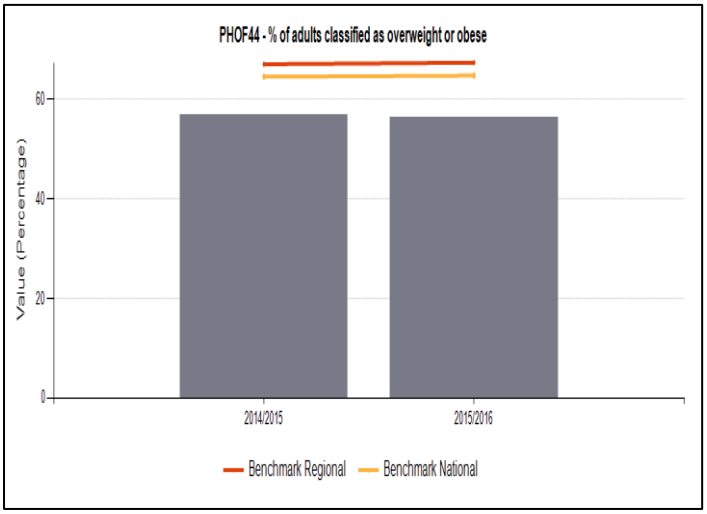
Living and Working Well Performance Report

Produced by the Strategic Business Intelligence Hub January 2018

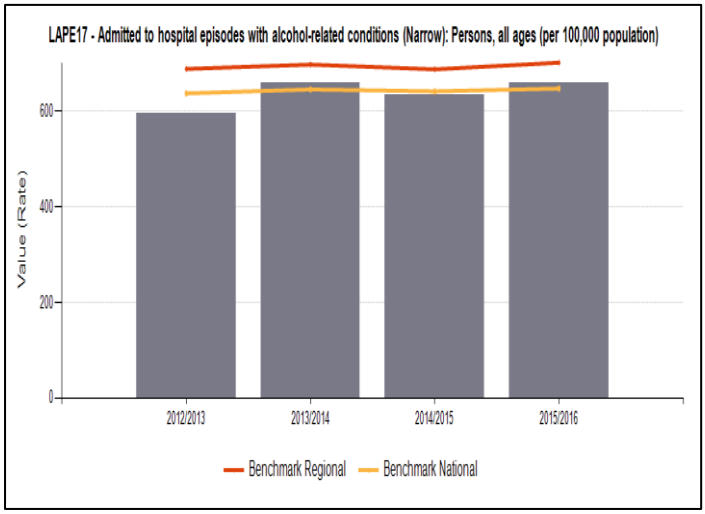
Annex B

We are monitoring progress on:

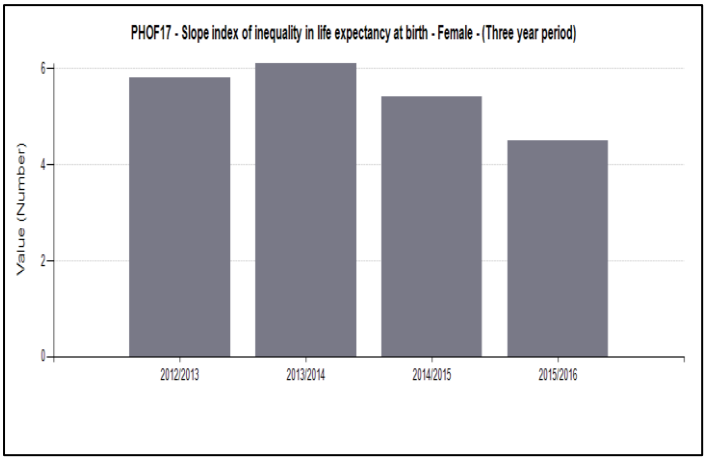
- Reducing the number of adults classed as overweight or obese;
- Sustaining a reduction in the rate of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause;
- York being nationally recognised as a more equal city, with a measurable reduction in the gap in outcomes between different wards;
- Improving uptake of all screening programmes;;
- More people, particularly from vulnerable groups, telling us they are happy with their health and wellbeing;
- Increasing the number of people with a learning disability or mental health condition in employment;
- Workplace wellbeing



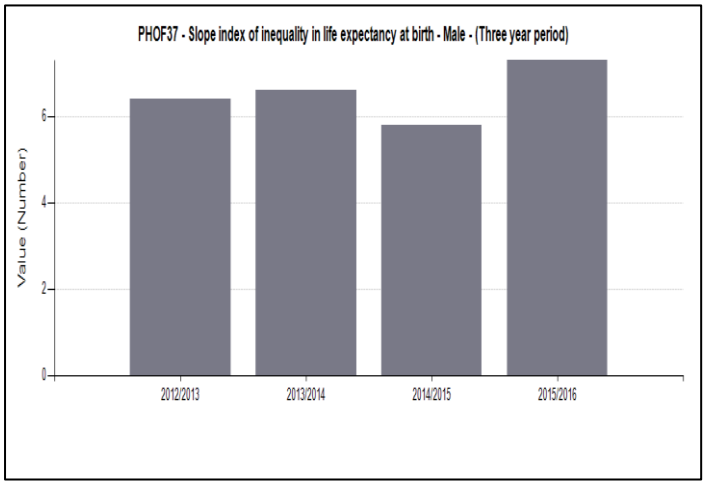
	2014/2015	2015/2016
% of adults classified as overweight or obese	56.88%	56.40%
Benchmark - National Data	64.59%	64.80%
Benchmark - Regional Data	67.09%	67.40%
Regional Rank (Rank out of 15)	1	1



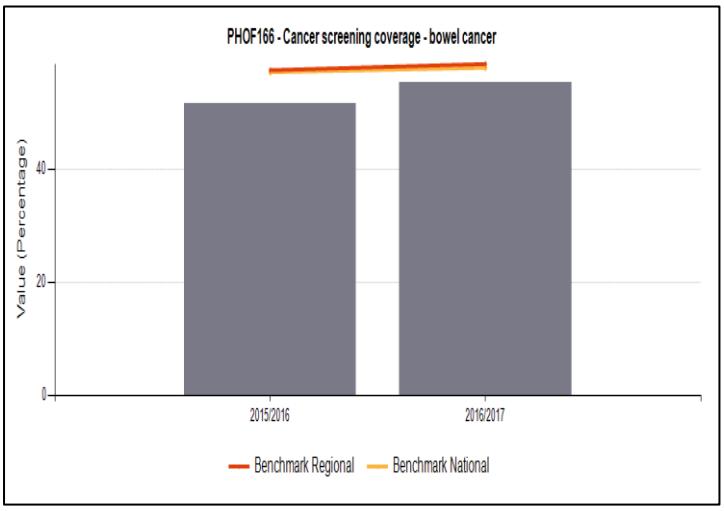
	2012/2013	2013/2014	2014/2015	2015/2016
Admitted to hospital episodes with alcohol-related conditions (Narrow): Persons, all ages (per 100,000 population)	594.09	658	634	658
Benchmark - National Data	636.85	645	641	647
Benchmark - Regional Data	687.88	697	687	701
Regional Rank (Rank out of 15)			1	5



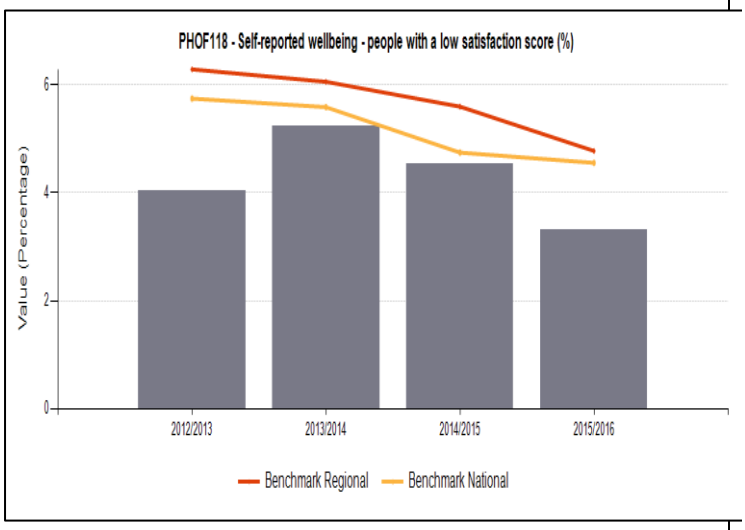
	2012/2013	2013/2014	2014/2015	2015/2016
Slope index of inequality in life expectancy at birth - Female - (Three year period)	5.8	6.1	5.4	4.5
Regional Rank (Rank out of 15)	3	3	3	2



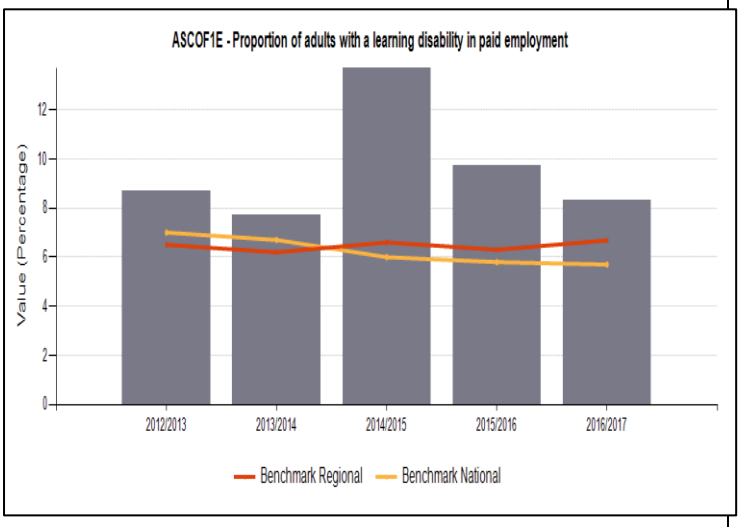
	2012/2013	2013/2014	2014/2015	2015/2016
Slope index of inequality in life expectancy at birth - Male - (Three year period)	6.4	6.6	5.8	7.3
Regional Rank (Rank out of 15)	2	3	2	3



	2015/2016	2016/2017
Cancer screening coverage - bowel cancer	51.52%	55.17%
Benchmark - National Data	57.09%	57.89%
Benchmark - Regional Data	57.45%	58.55%
Regional Rank (Rank out of 15)	14	12



	2012/2013	2013/2014	2014/2015	2015/2016
Self-reported wellbeing - people with a low satisfaction score (%)	4.04%	5.23%	4.54%	3.30%
Benchmark - National Data	5.74%	5.58%	4.74%	4.55%
Benchmark - Regional Data	6.28%	6.05%	5.59%	4.77%
Regional Rank (Rank out of 15)	1	3	4	2



	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017
Proportion of adults with a learning disability in paid employment	8.70%	7.70%	13.70%	9.70%	8.33%
Benchmark - National Data	7.00%	6.70%	6.00%	5.80%	5.70%
Benchmark - Regional Data	6.50%	6.20%	6.60%	6.30%	6.68%
National Rank (Rank out of 152)			9	30	40
Regional Rank (Rank out of 15)	3	3	1	4	5
Comparator Rank (Rank out of 16)			1	4	7

Performance narrative and update on actions

Excess Weight in Adults.
The % of adults classified as overweight or obese in York (56.4%) is significantly lower than regional (67.4%) and national (64.8%). Clients attending face to face health checks with the YorWellbeing team have their BMI calculated and are given appropriate advice regarding diet and physical activity levels.

Alcohol Admissions
Alcohol Admissions in York (658 people per 100,000 of population) remain lower than the regional average (701) but slightly higher than the national average (647). Support and treatment for those dependent on alcohol in York is provided by Changing Lives

Inequality in Life Expectancy
Inequality in Life Expectancy across the city is measured by the 'slope index'. A higher figure means a greater disparity in life expectancy between more deprived and less deprived areas of the city. The index in York is 4.5 years for women and 7.3 years for men. The figures in York are lower (better) than the national averages (7.1 years and 9.2 years respectively). The trend in York for females is an improving one. Circulatory conditions and Cancer account for around 60% of the difference in male life expectancy between the most and least deprived quintiles in York. For Women, respiratory conditions are the largest single factor (24.6%). The Yorwellbeing service will promote healthier lifestyle choices via the provision of targeted health checks in deprived areas of York.

Workplace Wellbeing
It was originally intended that we would monitor the number of major employers signed up to the Workplace Wellbeing Charter. This has subsequently been amended to monitoring the number of employers in York who have engaged with the workplace health element of the Yorwellbeing service. 14 employers have participated so far and approximately 400 employees in these organisations have received a mini health check and a number have gone on to do online and face to face health checks. Anonymous and aggregated feedback on the results of the mini health checks is provided to the employers so they can better understand the health profile of their workforce.

Screening Coverage.
The screening rates for breast cancer, cervical cancer and abdominal aortic aneurysm in York are significantly higher than the national average. Although the screening rate for bowel cancer increased in York from 51.5% in 2015 to 55.2% in 2016 it remains below the national average (57.9%).

Employment for people with learning disabilities.
Improving employment and accommodation outcomes for adults with mental health and learning difficulties are linked to reducing risk of social exclusion and discrimination. Supporting someone to become and remain employed is a key part of the recovery process, while stable and appropriate accommodation is closely linked to improving people's safety and reducing their risk of social exclusion. The proportion of adults with a learning disability in York who were in paid employment in 2016/17 was 8.3%, higher than the national (5.7%) and regional (6.7%) averages.

This page is intentionally left blank

Health and Wellbeing Board **24 January 2018**

Report of the Corporate Director of Housing, Health and Adult Social Care & the Accountable Officer NHS Vale of York Clinical Commissioning Group.

Draft All Age Mental Health Strategy for York 2018-2023

Summary

1. This report presents the near final draft of an all age mental health strategy for York. The strategy has now been designed and the Health and Wellbeing Board are asked to provide their final comments on the draft attached at **Annex A**.

2. Additionally this report provides the Health and Wellbeing Board with an update on establishing a new mental health delivery partnership for the city.

Background

3. The joint health and wellbeing strategy for 2017-22 identifies four principal themes to be addressed. One of these themes is Mental Health and Wellbeing with the key priority for that theme being 'to get better at spotting the early signs of mental ill health and intervening early'. Other aims in the joint health and wellbeing strategy in relation to mental health are:

- Focus on recovery and rehabilitation
- Improve services for young mothers, children and young people
- Ensure that York becomes a Suicide Safer city
- Ensure that York is both a mental health and dementia-friendly environment
- Improve the services for those with learning disabilities (to be addressed in its own strategy)

Consultation

4. Consultation on the draft mental health strategy ran from Tuesday 8th August to Sunday 8th October 2017 and feedback from this was reported back to Health and Wellbeing Board at their meeting in November 2017. Feedback received has been incorporated into the attached draft strategy.

Delivering the All Age Mental Health Strategy for York

5. At the July 2017 meeting Health and Wellbeing Board agreed to split the Mental Health and Learning Disabilities Partnership Board into two discrete groups; one focusing on learning disabilities and one on mental health (each to be the delivery mechanism for their related strategies).

6. Since then the Mental Health and Learning Disabilities Partnership Board has held two workshops to look at how this can be achieved.

7. An appropriately skilled and experienced independent chair is being sought and a potential candidate has been identified to establish and lead the new delivery partnership.

8. It had been suggested at the workshops that service users, minority groups and carer representatives should be an integral part of the new group. Once identified the new chair and membership for the delivery partnership will be invited to set meeting dates for the year ahead. Additionally Terms of Reference and governance arrangements will need to be developed by the new partnership and reported back to the Health and Wellbeing Board.

9. Following this, one of the initial pieces of work for the new delivery partnership will be to create an action plan and performance framework to deliver against the strategy.

10. The above paragraphs are provided as assurance to the Health and Wellbeing Board that work to establish a new partnership is almost complete.

Options

11. Health and Wellbeing Board are asked to:

- Provide their final comments on the all age mental health strategy
- Agree to delegate final sign off of the new all age mental health strategy to the Chair of the Health and Wellbeing Board in conjunction with the two Health and Wellbeing Board lead members for mental health
- Note the progress on establishing a new mental health partnership
- To receive the action plan and performance framework at a future Health and Wellbeing Board meeting once the mental health delivery partnership has been established

Implications

12. It is important that the new all age mental health strategy for the city is written in clear and accessible language; is fully inclusive and promotes parity of esteem with physical health.

Recommendations

13. The Health and Wellbeing Board are asked to:

- Provide their final comments on the all age mental health strategy
- Agree to delegate final sign off of the new all age mental health strategy to the Chair of the Health and Wellbeing Board in conjunction with the two Health and Wellbeing Board lead members for mental health
- Note the progress on establishing a new mental health partnership
- To receive the action plan and performance framework at a future Health and Wellbeing Board meeting once the mental health delivery partnership has been established

Reason: To give the Health and Wellbeing Board oversight of the creation of an all age mental health strategy associated action plan and formation of a new mental health delivery partnership.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Paul Howatson Head of Joint Programmes NHS Vale of York Clinical Commissioning Group 01904 552 809	Martin Farran Corporate Director, Housing, Health and Adult Social Care City of York Council Phil Mettam Accountable Officer. NHS Vale of York Clinical Commissioning Group.

Report Approved ✓ **Date** 16.01.2018

Specialist Implications Officer(s)
None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes

Annex A – Draft All Age Mental Health Strategy

All Age Mental Health Strategy for York 2018-2023

Vision:

For every single resident of York to enjoy the best possible emotional and mental health and wellbeing throughout the course of their life

Contents

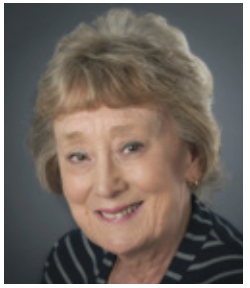
Foreword

From the chair and vice chair of the Health and Wellbeing Board

Imagine a city where everybody's mental health and emotional wellbeing is a matter of pride across the community; where services support people in need, collaboratively, respectfully and without delay; where stigma and discrimination against people of all ages, with emotional and mental health difficulties are no more. This strategy is our opportunity to achieve parity of esteem for mental health. This means tackling mental health issues with the same energy and priority as physical issues. Public attitudes towards mental health are changing and we need to build on this to develop community assets and resilience in the city.

This strategy is important and establishes a city wide mental health partnership to work with all stakeholders. It is the start of our transformational journey learning from other places both nationally and internationally. Although there remains financial uncertainty, there is a greater determination amongst partners to improve mental health and wellbeing for the city's residents.

On behalf of the Health and Wellbeing Board we are delighted to present this new strategy for the five years to 2023.



Cllr Carol Runciman
Chair, York Health and Wellbeing Board

Keith Ramsay,
Vice-Chair, York Health and Wellbeing Board

Introduction from Health and Wellbeing Board leads for mental health

The national context is summarised in the Five Year Forward View for Mental Health, a report from the Independent Mental Health Taskforce to the NHS in England:

> 'Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK.'
> February 2016

Martin Farran
Corporate Director of Health, Housing and Adult Social Care

Phil Mettam
Accountable Officer of NHS Vale of York Clinical Commissioning Group

People with mental health conditions have a lower life expectancy and poorer physical health outcomes than those that do not. Evidence suggests this is due to a combination of clinical risk factors, socioeconomic factors and health system factors.

This new strategy is 100% focused on mental health and complements and expands on the joint health and wellbeing strategy 2017-2022 which clearly prioritises mental health and wellbeing across all life stages.

The top priority is to get better at spotting the early signs of mental ill health and to intervene earlier. The other priorities are:

- focus on recovery and rehabilitation
- improve services for mothers, children and young people
- ensure that York becomes a Suicide Safer City
- ensure that York is both a mental health and dementia friendly environment
- improve the services for those with learning disabilities (and in response to feedback this will be addressed in its own focused strategy delivered and led by a new learning disabilities focused partnership.)

A newly formed mental health partnership will lead and co-ordinate the delivery of this strategy as part of a transformation and integration approach giving York a fit for the future system for mental health care and support in line with the aims of the Five Year Forward View.

York's long term ambition

In the long term we aspire to a whole person, whole life, whole community approach appropriate for York and modelled on that in Trieste, Italy, where there has been 40 years of development towards social inclusion, empowerment and citizenship in mental health.

To apply the lessons from Trieste in York, we will need to take a community based approach, enhancing our housing offer and support for the voluntary and community sectors to: -

- place less emphasis on in-patient beds so that fewer people with mental ill health are in hospitals or care homes
- support people to maintain their independence by investing in more supported accommodation
- further develop the voluntary and community sectors in particular to support people with mental health needs into employment, training and volunteering.

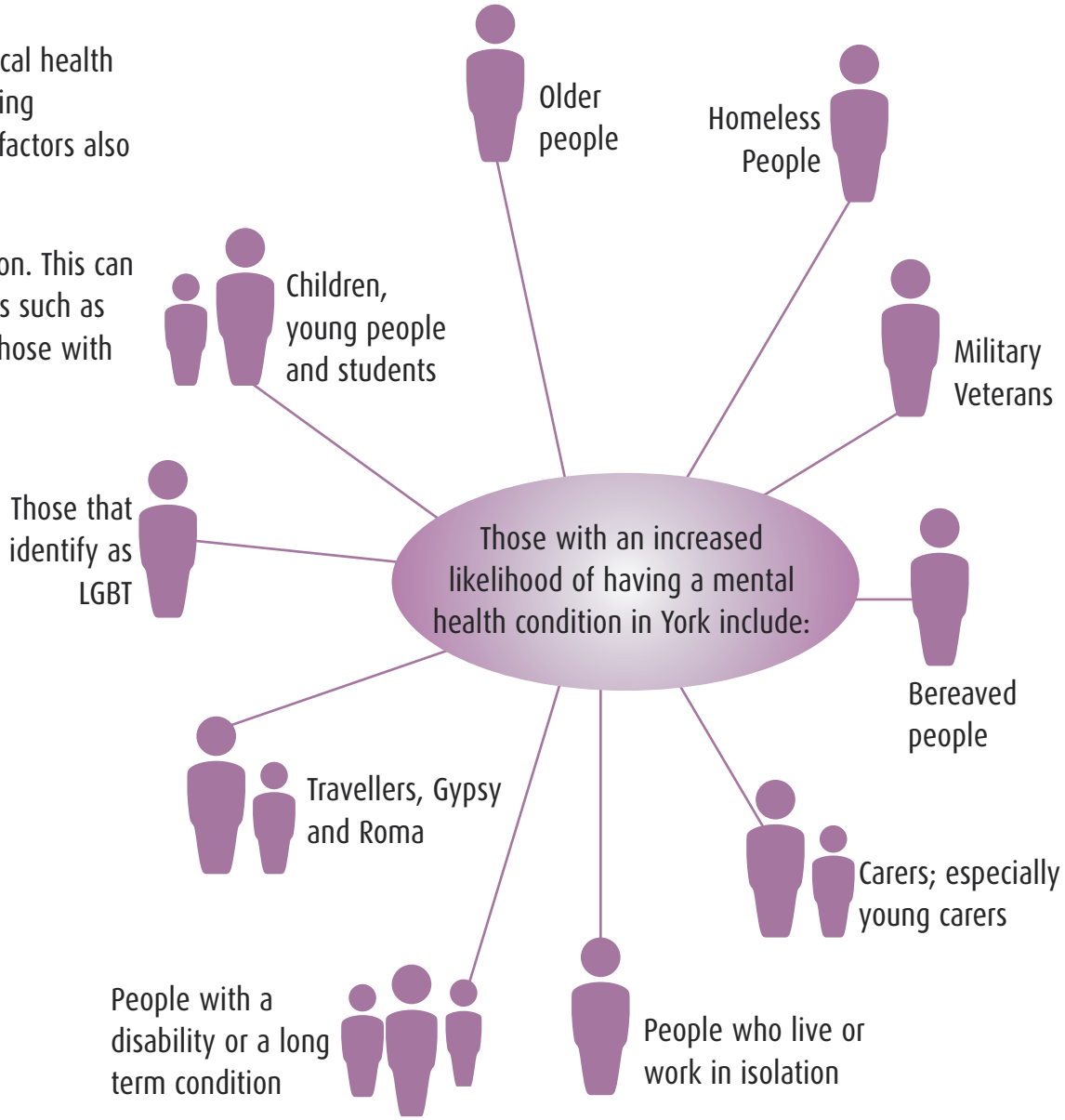
To achieve this ambition we will need to work together to build an integrated system and focus on the priorities in this strategy to take the first step on a longer journey.

In York we want to apply the lessons from Trieste.

Factors affecting a person's emotional and mental wellbeing

The likelihood of having a mental health issue is affected by a combination of factors including personal circumstances; physical health and the environment a person lives in. Things like poverty; living conditions and housing; relationships, employment and other factors also impact on mental health and wellbeing.

Stigma is a major issue for those with a mental health condition. This can lead to social isolation or exclusion which can impact on things such as relationships and employment. This adds to the barriers that those with mental ill health already experience.



Wider determinants of a person's emotional and mental wellbeing

Areas of particular inequality in York

The Joint Strategic Needs Assessment identifies two areas where improvements are required:

Accommodation – Among adults in York who use secondary mental health services, there are some who do not live in 'stable and appropriate' accommodation.

Homelessness – homelessness and mental health are intertwined issues. In 2016/17 well over half of people who were referred to York homelessness services through the single point of access scheme were judged to have a mental health vulnerability by the professional making the referral.

This strategy recognises the need for system partners to work together for the benefit of people with multiple and complex needs; especially with regard to housing. We need to commit to developing a housing and support pathway for people with mental ill health that will enable them to access the right type of accommodation, with the right level of support, at the right time to meet their needs, regardless of diagnosis.

Pathways Together is a project which supports individuals who regularly come into contact with emergency services. These people often have a range of other disadvantaging factors including substance misuse, trauma, abuse or homelessness. Pathways Together has evidenced a reduction in contact with emergency services and an improvement in people's lives.

As a Human Rights City and a City of Sanctuary York is already on a journey to become a more inclusive, non-discriminatory, diverse, fair and safe place for its residents regardless of their race, gender, sexual orientation or whether they have a disability, physical ill health or mental ill health.

ANNEX A

Themes and priorities on a page

Top Theme: Getting better at spotting the early signs of mental ill health and intervening early	Priorities: technology; positive workplaces; mental health first aid training; information and advice; increase community resilience; increase timeliness of diagnosis; encourage the uptake of support; Crisis Care Concordat; signposting and support for carers
Theme 2: Improve services for mothers, children and young people	Priorities: Future in Mind; resilience and good mental wellbeing; access to support in schools; support for those who are vulnerable or in crisis; transitions; support during and after pregnancy; alignment with student mental health strategy; links to families and carers
Theme 3: Ensure that York becomes a Suicide Safer City	Priorities: Suicide Safer City; reduce the rate of suicide; encourage participaion in training; improve services for those affected by suicide; raise awareness of the impact of suicide; support for positive mental health and wellbeing; public sector equality duties; improve links with student support services
Theme 4: Focus on recovery and rehabilitation	Priorities: building self resilience; promoting self help and self management; development of peer support networks; access to help; recovery college; early intervention and prevention; reduce reliance on statutory services; work with drug and alcohol services; working alongside carers and families
Theme 5: Ensure that York is both a mental health and dementia friendly city	Priorities: recognition as a mental health and a dementia friendly city; develop the work of the Dementia Action Alliance; work with employers; consider the needs of people with a mental health condition (including dementia) and their families and carers; develop a joint strategy for improving dementia diagnosis and support services

Key priorities for implementing whole life approach across the short, medium and long term

Long term implementation of whole person, whole life, whole system approach

Top Theme: Get better at spotting the early signs of mental ill health and intervene early

Not everyone is able to stay well and we know that the sooner someone can get help the more likely they are to be able to recover or at least reduce the impact of any illness on their quality of life. This is why we need to get better at spotting the early signs of mental ill health and intervene at an earlier stage. The newly developed Safe Haven provides a level of support out of hours in a community based non-clinical setting with a welcoming environment for people with escalating needs or who are in crisis. A core 24 Psychiatric Liaison Service has also been developed and is based at York Hospital.

We need to help people to develop personal resilience to sustain good mental health; promoting good mental health for all, across the life course from childhood to old age including families and carers and work in schools. We need to increase capacity in the community to support early intervention and prevention and prevent crisis situations.

We want to encourage a positive attitude to mental health and wellbeing and work towards prevention and early intervention to support lifelong good mental health being everybody's priority. We want mental health to be as important as physical health.

Good health, both physical and mental, begins with the individual. We are committed to promoting the Five Ways to Wellbeing approach to help people improve their own mental health.

The Five Ways to Wellbeing				
Connect – connect with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community.	**Be active** - Go for a walk or a run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good.	**Take notice** – Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Reflecting on your experiences will help you appreciate what matters to you.	**Keep learning** – Try something new. Rediscover an old interest. Sign up for that course.	**Give** – Do something nice for a friend, or a stranger.

Priorities within this theme

- Promote the use of technology to encourage self care /self management to improve early intervention
- promote positive workplaces, schools and colleges
- encourage organisations to run mental health first aid training
- signpost people and their families and carers to information and advice
- increase individual and community resilience to reduce social isolation across all life courses
- increase timeliness of diagnosis across all conditions and ages
- encourage the uptake of support at the time of diagnosis
- continue the work across the Crisis Care Concordat.

Long term: Work towards a longer term early intervention and prevention focused delivery model which will require services to organise and professionals to behave in very different ways

We will report

- The extent of recorded dementia diagnosis in primary care practice disease registers
- changes in the percentage of social care users saying they have as much social contact as they would like.

Theme 2: Improve services for mothers, children and young people

We know how important it is to support good emotional and mental wellbeing for children and young people. Our aim is to build and maintain high emotional resilience and protect children and young people from harm, including self harm, whilst tackling those factors that damage self esteem and cause emotional and mental distress, including bullying in all forms.

The York Strategic Partnership for Emotional and Mental Health is working to achieve outcomes for children and young people focused around early identification and signposting in universal services; improving recovery and positive experience of care for all children and their families and carers including those in care and in the youth justice system; overseeing the wellbeing worker project in York schools to ensure all children and young people can access rapid support; smooth transition at schools and for those who will need to access adult services provision as they approach adulthood.

There are around 31,000 students that attend University of York, York St John University, York College and Askham Bryan College. In a recent student health needs assessment mental health has overtaken more traditional student health issues such as sexual health and alcohol as the topic of most concern. Local health service data shows the prevalence of anxiety and depression has rapidly risen amongst students in the past five years and a student mental health strategy now sets the direction for support and access for this group.

We also recognise the importance of good mental health support for mothers during pregnancy and after giving birth. Unidentified or poorly managed mental ill health can have lasting effects on maternal self esteem, partner, family and carer relationships as well as the mental health and social adjustment of children. Whilst very few women from York require peri-natal in-patient mental health services we recognise that more could be done locally to support women during the peri-natal period in the community through joint working between maternity, health visitor and early years support services.

Priorities within this theme

- Build and further develop the local Future in Mind initiatives and the priorities of the Strategic Partnership for Emotional and Mental Health
- focus on resilience and good emotional and mental wellbeing at key life stages for children and young people
- broaden access to support in schools and other settings outside specialist health services
- ensure good access to support for those groups of children and young people who are particularly vulnerable or in crisis and their families and carers
- ensure that children and young people smoothly transition between child and adult services
- improve access to support for families and carers during and after pregnancy to maintain positive mental wellbeing
- further develop peri-natal mental health services
- ensure alignment with the student mental health strategy.

We will report

- Changes in the percentage of school pupils with social, emotional and mental health needs
- the number of hospital admissions for self harm amongst young people aged 10 to 24.

Theme 3: Ensure that York becomes a Suicide Safer City

The suicide rate in York for 2014-16 was 12.7 suicides per 100,000 of population; this is higher than the national and regional rates (9.9 and 10.4 per 100,000 respectively).

Some groups are known to be at relatively high risk of suicide. Middle aged men, for example and people with untreated depression. There was also a series of student deaths over a period of 14 months in 2015-16 six university students took their own lives which highlighted the need for us to take action.

Risk factors can include:

- Gender (men are three times more likely to die by suicide)
- Age – the high risk age group is 45-59
- Bereavement
- Sexual orientation and gender identity
- Mental illness
- Socioeconomic status – defined by job, class, education, income, education or housing
- Behavioural – some patterns of behaviour can indicate a risk of suicide. These include use of alcohol, substance misuse, self harm and involvement with the criminal justice system
- Psychological and attitudinal – risk factors include perfectionism, over-thinking, feelings of defeat, hopelessness and being trapped
- Long term conditions

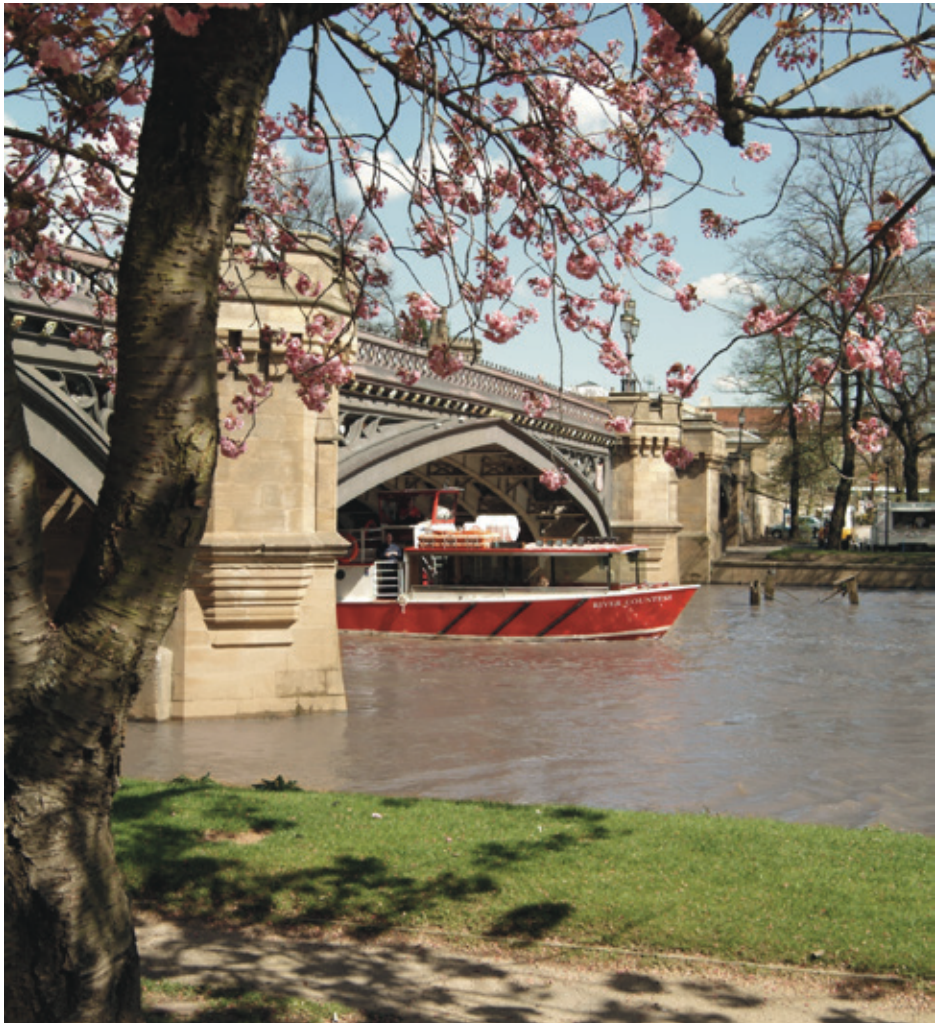
A multi-agency partnership has been established to address the higher rate of suicide in York and work towards Suicide Safer City status.

Priorities within this theme

- Develop York as a Suicide Safer City
- reduce the rate of suicide in York
- encourage participation in the safeTALK and the Applied Suicide Intervention Skills Training (ASIST) programmes
- improve support for people bereaved or affected by suicide
- raising awareness of the impact suicide has and that certain people are more at risk
- support for positive health and wellbeing through factors such as social inclusion and positive social networks
- a commitment from statutory agencies to address their obligations under the public sector equality duty and duties to reduce health inequalities
- improve links with student support services at colleges and universities.

We will report

- The suicide rate per year
- the number of hospital stays because of self harm amongst the general population.



Theme 4: Focus on recovery and rehabilitation

For people with mental ill health the focus on recovery needs to be part of their care and support from the outset. Evidence suggests that stable employment and housing are key factors towards recovery.

We need to enable people to recover and to be as well as possible. We need to work alongside people to support them and their families and carers on their recovery journey to ensure care is personalised to their needs. The adult mental health recovery team at 30 Clarence Street provides support to people recovering from mental ill health.

Building on York's Skills Plan 2017-20 we need to support more opportunities for work experience and employment for people with mental ill health and recovery colleges like Converge will help us to do this.

We know that we need to work with employers and other agencies to challenge discrimination and de-stigmatise mental health in the work place and other settings by accessing more mental health focused training and education such as Mental Health First Aid training.

Social isolation can be a barrier to recovery; especially for older people; overseas students; lone workers; the homeless; minority groups and harder to reach communities. We need to work with representative agencies of these groups to overcome the barriers and reduce levels of isolation.

For those with the most complex mental health needs, where a number of factors have impacted their lives over a longer time period it is acknowledged that more intensive support helps to rebuild and stabilise their lives; this will include working with services that treat drug and alcohol misuse.

We recognise that recovery is different for everyone and we need to further develop the health and social care system to help people to recover from day one of their journey and that they are challenged and helped to achieve this.

Priorities within this theme

- Help people to build self resilience and facilitate their recovery journey
- promote ways for people to self help and self manage their own mental health
- further develop peer support networks to reduce social isolation
- Enable access to help and support when required
- promote the work of the recovery college
- build on early intervention and prevention services to reduce and avoid the development of more complex needs
- reduce reliance on health, social care and emergency services
- work with services that treat alcohol and drug misuse.

We will report

- The rate of access to psychological therapy referrals
- the percentage of those undergoing Improving Access to Psychological Therapies reporting imrpovement
- the percentage of opiate users successfully completing treatment
- the percentage of those in treatment for alcohol misuse successfully completing treatment.

Theme 5: Ensure that York is both a mental health and dementia friendly city

York aims to be both a mental health and dementia friendly city. This means that everyone living and working in York shares the responsibility for ensuring that people with mental ill health (including dementia) and their families and carers, feel understood, valued, safe and able to contribute.

In order for the city to become more mental health friendly we need to be:

i. more open

ii. have a range of options to keep well

iii. make reasonable adjustments

iv. encourage a work/life balance

v. work against stigma

vi. build mental health into conversations

vii. lead by example

viii. encourage Mental Health First Aid training

ix. encourage wellbeing at work

x. aware of how to access help and support

For dementia we need to raise awareness and tackle discrimination; include and involve people with dementia; be a hub for communication and improve services.

We need to continue to support the work of our local Dementia Action Alliance and carers and family members by:

- making York as easy as possible to move around and enjoy, with uncluttered and clear signage and making public transport comfortable and easy to use.
- encouraging people in key roles in the wider community to access training to improve customer service, understanding of needs to remove stigma
- consider the needs of people with dementia when developing all services not just health and social care
- Improve dementia diagnosis rates

Priorities within this theme

- To become recognised as a city that is both mental health and dementia friendly
- further develop the work of the Dementia Action Alliance to improve diagnosis rates and post diagnostic support
- work with employers and other organisations to take up training opportunities
- consider the needs of people with a mental health condition (including dementia) when making changes to the city environment
- develop a joint strategy for improving dementia diagnosis and support services.

We will report

- The percentage of mental health service users in paid employment
- the extent of recorded dementia diagnosis in primary care practice disease registers.

Transformation and cultural change

This is what you told us you wanted

- More joined up services
- Person centred care
- Removing stigma
- Changing the culture
- Improving communication
- Building local communities
- Support for carers
- Single point of access for all
- Improving out of hours provision
- Early intervention
- Shorter waiting times
- Focus on innovation
- Continuity of care

Short Term:

By mid way through the life of the strategy we would expect more people to:

- recognise their own mental ill-health and wellbeing and access support appropriate to their needs
- feel able to talk about how they feel with their loved ones, friends and colleagues
- be responsible for their own recovery journey, with support where required
- identify themselves as carers and feel valued
- have accessed mental health first aid training through school, colleges, work or other organisations they are linked with
- Additionally, commissioners will be working more closely together and potentially looking at mechanisms like the Better Care Fund

Medium Term:

- At the end of the five year period covered by the strategy there will be:
- more focus on early intervention and prevention
- reduced reliance on crisis and emergency services
- a noticeable and positive change in attitudes towards mental health from initiatives in schools and workplaces
- greater shared accountability, cost effectiveness and efficiencies in service delivery
- more people with access to a personal budget

Long Term:

- Beyond the life of this strategy we recognise the need to continue to transform and evolve our mental health services to create a York version of Trieste – with a whole person, whole life, whole community approach.

Delivering and measuring progress

Delivery of this strategy will be through a newly formed multi-agency mental health partnership. The partnership will be responsible for creating co-produced and detailed action plans to ensure that the strategy is delivered and makes a difference to people's lives.

A suite of performance indicators will be compiled which will help to monitor progress to achieve our vision. To complement the long term impact of the strategy, periodic qualitative surveys of service users, carers, staff groups, voluntary sector organisations and other interested parties will be undertaken by the mental health partnership. Narrative based updates will help tell the story of York and the quest towards its own version of Trieste.

Health and Wellbeing Board Secretariat
Tel: 01904 551714
E-mail: healthandwellbeing@york.gov.uk

This strategy is the start of a journey; come on board and join us to achieve our vision

Partners who sit on the York Health and Wellbeing Board

ANNEX A

Independent Care Group

Tees, Esk and Wear Valleys NHS Foundation Trust

York Teaching Hospital NHS Foundation Trust

NHS Vale of York Clinical Commissioning Group

yorkcvs

healthwatch York

NHS England

City of York Council

If you would like this information in an accessible format (for example in large print, in Braille, on CD or by email) please call (01904) 551550

This information can be provided in your own language.

Informacje te mogą być przekazywane w języku ojczystym.
Polish

Bu bilgi kendi dilinizde almaniz mümkündür.
Turkish

此信息可以在您自己的语言。
Chinese (Simplified)

此資訊可以提供您自己的語言。
Chinese (Traditional)

01904 551550

Health and Wellbeing Board **24 January 2017**

Report of the Corporate Director of Health, Housing and Adult Social Care, City of York Council and the Accountable Officer, NHS Vale of York Clinical Commissioning Group (CCG)

Mental health housing and support

Summary

1. This report outlines a direction of travel for the development of a housing and support pathway for people with mental ill health. It recognises that there are challenges within the current system which can only be addressed in a 'whole system' way with collaborative working between health, housing, social care, the voluntary and community sector, private sector landlords, service users, carers, and communities.

2. Our vision is to develop a continuum of accommodation and support options that will ensure people with mental ill health can access the right type of accommodation, with the right level of support, at the right time to meet their needs, regardless of diagnosis.

3. The report highlights the current key challenges in mental health housing and support, including gaps in provision, and captures feedback from a multi-agency workshop held on 29 September 2017 to help plot a way forward. It outlines the three key areas for development to emerge from the workshop, and the work that needs to be done in the coming months in order that a more detailed report – with costed options and proposals – can be brought to the Board in the early summer.

4. The fact that this report has been prepared with input from City of York Council, Tees, Esk and Wear Valleys NHS Foundation

Trust, and the NHS Vale of York Clinical Commissioning Group, serves to demonstrate a 'whole system' commitment and approach to tackling this priority issue for the city.

5. The report asks that the Health and Wellbeing Board agree to receive a further, more detailed report in early summer which will include costed options and proposals; and to note that developing a housing and support pathway for people with mental ill health is likely to require changes to the way that health, housing, and social care work together and, potentially, a redistribution of resources within the 'whole system'.

Background

6. The Centre for Mental Health's report 'More Than Shelter' (June 2016) neatly summarised the importance of housing and support for people with mental health problems:

7. "Having somewhere to live in which we feel secure is essential to our physical and mental health...and for people who have experienced mental health problems, it is a key to their long-term independence, stability and recovery....The provision of support for people with mental health problems to assist them to live an independent life is central to the delivery of comprehensive mental health support."

8. In October 2016, two projects joined together that had previously been looking separately at issues relating to mental health housing and support in York. A review initially focused on services and support commissioned and provided by City of York Council (CYC) was widened to include the full accommodation pathway, including plans to develop a service aimed at individuals presenting with complex needs - with mental health problems and substance misuse.

9. The aim of the newly combined project was:

   - To develop a housing and support pathway for people with mental-ill-health that will enable them to access the right type of accommodation, with the right level of support, at the right time to meet their needs, regardless of diagnosis.

10. This multi-agency project group, chaired by the Head of Commissioning, Adult Social Care – City of York Council, developed a picture of the current accommodation and support pathway which highlighted the key gaps and shortfalls in provision – see Figure 1 below.

11. This project group is focussed primarily on the needs of those aged 18-65 years old with functional illness. The accommodation and support needs for older people, including those living with dementia, are being reviewed and addressed as part of the Older Persons Accommodation Project.

12. There is a cohort of young people who are being supported through the Pathway team and/or have been looked after children who are likely to benefit from access to 'Housing First' or 24/7 supported housing. In some cases this may include young people aged 16-18 who have mental health and other needs which cannot always be met in existing young people's supported accommodation at Howe Hill or in SASH (safe and sound homes). Currently these young people may be placed out of area at significant cost to the local authority, or may move between placements at Howe Hill and adult resettlement placements at Arclight and Peaseholme following exclusions. This creates a pattern of unstable accommodation, whereas the ability to access suitable accommodation and support could help these young people to achieve stability and independence and to prevent long term reliance on support services. The potential positive impact on the lives of young people is such that it would be appropriate to consider access for 16-18 year olds in exceptional circumstances, and with appropriate packages of support.

13. In addition there is a cohort of young people aged 18 with Aspergers and mental ill-health or young people with chronic mental health difficulties or severe eating disorders who have had stays at Mill Lodge inpatient unit or other residential inpatient facilities as a result of ill-health. These young people have complex needs, and have not had experience of living independently. They may be placed at residential colleges or in supported housing out of area. Access to an assessment period in 24/7 supported housing would help to build skills and to

determine the long term housing and support needs of these young people, in order to ensure they are supported to access the most independent accommodation in the longer term.

14. The housing pathways for looked after children are currently being reviewed, in order to ensure appropriate accommodation and support is available. The mental health accommodation project will maintain links with this work in order to ensure that a new mental health housing and support pathway is able to meet the needs of young people transitioning from children to adult services.

Figure 1 – Mental Health accommodation – current York resources

Hospital/ MH Unit	Rehab / Recovery House	Assessment & intermediate support	Supported housing – complex needs	Supported housing – 'move-on' accomm	General needs housing
Inpatient	Building based rehabilitation, recovery, residential	Via Single Access Point	High levels of support	Low levels of support	Visiting support
Peppermill Court, YDH, etc	Private sector	22 The Avenue	Limited private sector availability	York Housing Association	
Acute services, not a housing option	Limited availability, some use of out of area facilities	Accommo-dation	Min of 15-20 supported units of accomm required	Not suitable for complex needs	No co-ordinated Housing First service at present

15. Most people experiencing mental ill-health have a suitable home to live in or return to but for those who do not the current approach is falling short in terms of individual outcomes and system-wide efficiencies in the following ways. This includes some people:

- Becoming stuck in a ‘revolving door’ between homelessness and inpatient services.

- Becoming ‘stuck’ in the homeless resettlement route, unable to progress.

- Being placed in accommodation where the environment and/or staffing is unable to meet their mental health needs, with associated risks to self or others.

- Without stable accommodation or lifestyles being more likely to struggle to engage with appointment based services, and therefore miss out on services.

- With mental ill-health finding it difficult living in the shared environment of a hostel, with possible non-engagement or risk to self/others as a result.

- Becoming delayed discharges from hospital, or being placed in expensive out of area placements, due to a lack of appropriate accommodation and support.

- Displaying anti-social behaviour (ASB) which can impact on other tenants in general needs properties if appropriate accommodation/support is not available.

16. One of the key gaps in current provision is appropriate accommodation and support for people with complex needs - that is people with mental health problems **and** substance misuse. It is estimated that at any one time there are around 15-20 individuals with complex needs who find themselves in a ‘revolving door’ – between homelessness, hospital, prison, and supported housing – because York does not currently have the right type of accommodation and support available to properly meet their needs. This ‘revolving door’ is often referred to in research literature as a new form of institutionalisation which creates a dependency on services.

17. This carries huge costs both for the individuals, in terms of quality of life and any hope for a better future, and financially for the

'whole system' given the high cost of hospitalisation and prison compared to supporting people in the community.

18. Appendix 1 provides more detail on the challenge of meeting the housing and support needs of people with complex needs as well as some individual case studies that illustrate the personal costs to the individual, and the financial cost to the whole system.

19. The project group has considered a range of options for addressing this gap in provision for people with complex needs – and undertook a high level financial and options analysis of each option. These options were then presented and discussed at a workshop event with a wide range of stakeholders with an interest in, and commitment to, improving mental health housing and support – see the Consultation section below.

Main/Key Issues to be Considered

20. The main/key issues to be considered include the challenges and gaps in provision faced by the current system, as outlined above in the Background section; and the resulting areas for development identified by a multi-agency workshop event held in September 2017, which are outlined below in the Consultation section.

Consultation

21. Workshop event – 29 September 2017

A Mental Health Housing and Support Workshop held at Priory Street Centre on 29 September 2017 was attended by over 70 delegates with a wide range of partner agencies represented including service users and carers, City of York Council (Adult Social Care, Community Safety, Housing) Housing Associations, Tees, Esk and Wear Valley NHS Foundation Trust, Vale of York Clinical Commissioning Group, and organisations from the Voluntary and Community Sector. See Appendix 2 for an executive summary of the workshop report from the event

The workshop was divided into two sessions. In the first session, a number of presentations highlighted some of the key, current

challenges within mental health housing and support. This included Converge's 'In the Moment' theatre company giving a powerful performance representing some service users' experiences of accessing housing and support. Before the coffee break, six options were presented for addressing a particular gap in provision – housing and support for people with complex needs.

In the second half of the workshop, delegates were assigned to eleven discussion groups designed to ensure a mix of representation from different organisations. Each group had a facilitator that guided the group through a series of questions and delegates' thoughts and comments were captured in a variety of ways.

22. Key workshop feedback and areas highlighted for further development

A workshop report capturing all of the feedback provided by the eleven discussion groups was distributed to all delegates on 20 October 2017– it pulled the feedback together under a series of headings that reflected the questions asked. The executive summary at Appendix 2 captures the key messages to emerge from the workshop.

The only option discussed that received absolutely no support at the workshop was the 'Do nothing' option. The shortage of housing, coupled with increasing need and all of the evidence that the current system is not working for people with very complex needs, means that to 'do nothing' is not a viable option.

The three key areas for further development that emerged from the discussions were as follows:

23. Area 1- Improving the way we work together now

Relevant workshop feedback included:

- Health, Housing, and Adult Social Care professionals all find it hard to navigate their way through each other's systems. How can we expect service users and families to do it without support?

- There is a high level commitment to joint working across all partners, but this does not always translate in practice to the front-line – current services and support can feel “fragmented” and there is a lack of consistency.
- There needs to be better planning and more support around transition – home from hospital or between services.

Further work in the short-term should focus on how we work together to achieve better:

- Planning and support around hospital discharge.

- Ongoing information sharing between partner agencies.

24. Area 2 - Understanding what more we need to do to make a ‘Housing First’ approach work for as many people as possible.

Housing First is a model originally pioneered in New York, to help chronically homeless people to access housing. The idea is that people are provided with permanent housing with no requirement to prove that they are ‘housing ready’ and personalised, intensive wrap-around support is then provided to help them develop and retain their independence, and maintain a tenancy.

The workshop feedback recognised that a Housing First approach could be the best option for some people, and should be part of the pathway. However, it has to be designed in the right way and offer enough wrap around support.

Further work is required to establish how a Housing First approach could be adopted in York, building on current experience, and what accommodation and levels of support (from where) will need to be in place to ensure it can work for as many people as possible.

25. Area 3 – Doing further work on modelling the smaller, more dispersed supported housing schemes (for service users with complex needs) preferred by the workshop.

Whilst many at the workshop felt that the Housing First model was what we should be aspiring to, it was also generally felt that it would not be appropriate for some people, because of their complex needs or their impact on others. For these people, we should be looking to develop some specialised supported housing with on-site support.

Further work should focus on modelling the smaller, more dispersed supported housing schemes (with 24/7 support) preferred by the workshop. What could/should they look like? What staffing will be required? What other support needs to be available?

26. Wider working group and service user/carer involvement

The workshop delegates were invited, on three separate occasions, to express an interest in being involved in a wider working group that would help shape, and input to the detailed work – at the workshop itself, as part of the post-workshop feedback survey, and when the workshop report was distributed. 23 people – helpfully from a good range of organisations – have volunteered to be part of this wider working group.

The wider working group first met on 23 November 2017. It discussed the workshop report and agreed that the three key areas for development outlined above were the right areas to be doing further work on. The group identified key individuals and organisations that would need to involved in the sub-groups charged with taking the detailed work forward, to inform the next report to the Executive in early summer.

In addition to the wider working group, the project is committed to ensuring that service users' and carers' voices are heard, and have real influence, throughout the project. We aim to tap into existing involvement and engagement forums, including TEWV's Service User Network and the Mental Health Carers' Forum, as well as exploring other ways of securing the input of harder to reach individuals and groups, for example, via their support workers.

Options and analysis

27. A previous section has outlined the three key areas for development to emerge from the workshop, and the further work that needs to be done over the coming months to inform the follow-up report that will include costed options and proposals. The following project structure has been put in place to oversee, steer, and do the work that is required. This involves:

    - A multi-agency project board to oversee the project.

    - A core project team, with identified resource within each of the key partners, to help drive the work forward.

    - A wider working group with volunteer representatives from the CCG, CYC, TEWV, Voluntary and Community Sector, and a carer. Sub-groups will be tasked to look at each of the three key areas for development.

    - Service user/carer involvement – via existing, standing forums and specific approaches and events targeted at involving and engaging with harder to reach groups and individuals.

Strategic / Operational Plans

28. This report directly relates to all three of the Council Plan 2015-19 priorities:

    - **A prosperous city for all**, where local businesses can thrive and residents have good quality jobs, housing and opportunities;

    - **A focus on frontline services** – to ensure all residents, particularly the most disadvantaged, can access reliable services and community facilities.

    - **A Council that listens to residents** – to ensure it delivers the services they want and works in partnership with local communities

29. The report also relates directly to priorities highlighted in **York's Joint Health and Wellbeing Strategy 2017-2022** and the **All Age Mental Health Strategy for York 2018-2023:**

30. "We also want to focus our efforts on recovery and rehabilitation wherever this is possible, recognising people's need for ongoing support and the importance of housing, education and employment."

York's Joint Health and Wellbeing Strategy 2017-2022 – Mental Health and Wellbeing (p.8)

York's Long Term Ambition

31. "To apply the lessons from Trieste in York, we will need to take a community based approach, enhancing our housing offer and support for the voluntary and community sectors to:

- Place less emphasis on inpatient beds so that fewer people with mental health problems are supported in hospital or care homes.

- Support people to maintain their independence by investing in more supported accommodation.

- Further develop the voluntary and community sectors in particular to support people with mental health needs into employment, training and volunteering.

Wider determinants of a person's emotional and mental wellbeing

Areas of particular inequality in York

The Joint Strategic Needs Assessment identifies two areas where improvements are required:

Accommodation – among adults in York who use secondary mental health services, there are some who do not live in 'stable and appropriate' accommodation.

Homelessness – homelessness and mental health are intertwined issues. In 2016/17 well over half of people who were referred to York homelessness services through the single point of access scheme were judged to have a mental health vulnerability by the professional making a referral.

This strategy recognises the need for system partners to work together for the benefit of people with multiple and complex needs; especially with regard to housing. We need to commit to developing a housing and support pathway for people with mental ill health that will enable them to access the right type of accommodation, with the right level of support, at the right time to meet their needs, regardless of diagnosis.

Theme 4: Focus on recovery and rehabilitation

For people with mental health problems the focus on recovery needs to be part of their care and support from the outset. Evidence suggests that stable employment and housing are key factors towards recovery.

For those with the most complex mental health needs, where a number of factors have impacted their lives over a longer time period it is acknowledged that more intensive support helps to rebuild and stabilise their lives; this will include working with services that treat drug and alcohol misuse.

All Age Mental Health Strategy for York 2018-2023

32. The need for an improved mental health housing and support pathway has also been reflected as a key priority in the York Homelessness Strategy 2013-2018, the Supported Housing Strategy 2014-2019, and the Joint Strategic Needs Assessment.

33. This report also links to partners' commitment, across York, to the **Trieste model**'s 'whole person, whole life, whole system' approach - and to applying the lessons from Trieste (in Italy) in

York by taking a more community based approach. Safe, secure and appropriate housing is an integral part of this approach, in particular in ensuring people can access the support and stability that they need in the community, rather than in institutions. There is a shared recognition that to achieve the full vision we will need to go on a journey that will involve system and culture change from the providers of services, people accessing services, and the wider community. This will take time and involve steps on the way to achieving the vision, in realigning services beyond traditional areas of responsibility and expertise.

34. Finally, this report also fits completely within the council's approach to providing care and support in a way that is focused on preventing, reducing, and delaying the need for more intensive, or more restrictive, options.

Implications

Financial

35. The case studies at Annex 1 give an indication of the financial cost to the whole system of our not currently being able to meet the complex needs of a cohort of individuals that find themselves in a 'revolving door' situation – moving between homelessness, hospital, prison, and supported housing.

36. The range of options for addressing this gap in provision would indicate that whole system investment is likely to be required or, at the very least, a redistribution of resources within the whole system – for example, disinvesting in buildings in order to invest more resource into community support, or diverting resources from out of area placement into investment in local options.

37. Further work is required to ensure that we better understand the possible financial implications of taking forward the options preferred by the workshop delegates. It is therefore proposed that a more detailed, costed options analysis is brought to a future meeting of this committee.

Human Resources (HR)

38. At the present time staff at 22 The Avenue (City of York Council) have been made aware that a whole system review of the housing and support pathway for people with mental ill health will be undertaken in the coming months. Staff will be kept informed and given the opportunity to participate in engagement events to help inform the future pathway.

One Planet / Equalities

39. Ensuring that people experiencing mental ill-health are able to access appropriate housing and support is a significant equalities issue. The project team recognise that further work is required to ensure that people experiencing mental ill-health have the right support and pathways in place to enable them to access, and meet, this basic human need. A full analysis of the project's impact upon the One Planet Principles and Equalities & Human Rights will be undertaken using the Better Decision Making Tool and will be included in the detailed options report to follow in early summer.

Legal

40. Section 117 of the Mental Health Act describes the duty to provide aftercare services in some circumstances following hospital admission. The Care Act defines "after care services" as services which (i) meet a need arising from or related to the person's mental disorder; and (ii) reduce the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for the disorder). Establishing a supported housing pathway would help to meet the section 117 duty, prevent re-admission and support long term recovery.

41. The Housing Act 1996 provides instances where the local authority has a duty to provide accommodation to homeless persons, including some instances where an individual is considered to be in "priority need". Priority need includes several categories of individual, including persons who are vulnerable as a result of mental illness. Without a pathway with suitable accommodation for people with complex needs there is a risk that

this duty will not be able to be met, due to a lack of appropriate accommodation.

Crime and Disorder

42. A small number of individuals with mental ill-health and complex needs have a disproportionate impact on crime and disorder. This may be through anti-social behaviour which can have a devastating effect on neighbours and communities, or through criminal behaviour (see case studies in Appendix 1. The provision of appropriate accommodation and support, able to meet the needs of people with complex needs, would help provide the stability required for them to develop their recovery and independent living skills. This is likely to reduce the impact on crime and disorder of a small number of high impact individuals.

Information Technology (IT)

43. There are no identified implications at this stage.

Property

44. Mental health accommodation is currently provided in a range of settings (see Figure 1 on page 4 of this report) including 22 The Avenue, which is a Council managed service, and a number of supported housing schemes commissioned by the Council and provided by York Housing Association.

45. The building at 22 The Avenue is old and in need of significant repair. The team there is actively planning to move the short-term support element of its service out of the old building at 22 The Avenue, and to provide it at a different location in the city. Given the condition and set-up of the buildings at 22 The Avenue, its role within a housing pathway for people with mental ill-health will need to be carefully considered by the project.

46. Likewise, the supported housing accommodation currently provided by York Housing Association (YHA) is a mix of short term and permanent tenancies but it is aimed at customers who are able to maintain a tenancy with intensive housing management support and professional mental health input when needed. YHA has had increasing concerns that some people

have been referred to the schemes in recent years whose needs have been too great for the schemes to cope with. This is further evidence of the gap in York provision for people with particularly complex needs. If this gap in provision can be addressed in other ways it would free up capacity in the YHA accommodation to be used appropriately as part of the housing pathway.

Other – TEWV's strategic approach

47. TEWV NHS Trust is working hard to move from a traditional reliance on bed based services to enhance recovery focussed community provision that reflects the 'whole person, whole life, whole system' principles. This paradigm shift has led to:

    - Dedicated capacity to proactively manage complex mental health placements which may be managed out of the York locality

    - Enhancement of community teams to enable more proactive care in the area

    - Piloting of new ways of working to maximise the delivery of evidence based rehabilitation care models

    - Working closely with service users and carers to better understand their experiences and to inform the delivery of recovery focussed care.

Risk Management

48. There are a range of risks attached to doing nothing to address the challenges highlighted in this report. We are currently struggling to provide all people with mental ill health the right type of accommodation, with the right level of support, at the right time. This is due to a number of factors including

    - The lack of a range of options to meet the range of needs
    - System pressures
    - Increasing demand

- Fragmented services
- Ageing buildings

49. As the project unfolds a risk register will be developed to ensure that the key risks to the project are identified and managed so as to eliminate or minimise their potential impact.

Recommendations

50. The Health and Wellbeing Board is asked to:

a) Agree to receive a further report in early summer which will include costed options and proposals focussed on three key areas for development that emerged from a multi-agency workshop event held on 29 Sept 2017.

- **Better joint working** - improving the way that health, housing and social care work together now.

- **'Housing First'** – understanding what more we need to do to make a Housing First approach work for as many people as possible.

- **Complex needs** – doing further work on modelling the smaller, more dispersed supported housing schemes (with 24/7 support) preferred by workshop delegates.

b) Note that developing a housing and support pathway for people with mental ill health - that will ensure access to the right type of accommodation, and the right level of support, at the right time - is likely to require changes to the way that health, housing, and social care work together and, potentially, a redistribution of resources within the 'whole system' – for example, disinvesting in buildings in order to invest more resource into community support. More specific information on the resource implications for the whole system will form part of the follow-up report.

Reason: To keep the Health and Wellbeing Board informed of progress in relation to the development of a housing and support pathway for people with mental ill health

Authors:

Gary Brittain
Head of Commissioning,
Adult Social Care, CYC
Tel No. 01904 554099

Chris Weeks
Commissioning Manager,
Adult Social Care, CYC
Tel No. 01904 554066

Louise Waltham
Housing Management Service
Manager, CYC
Tel No. 01904 551680

Paul Howatson
Head of Joint Programmes
NHS Vale of York CCG
Tel No. 01904 552809

Chief Officer Responsible for the report:
Martin Farran
Corporate Director of Health, Housing and Adult Social Care, City of York Council

Report Approved ✓ ☐ **Date** 04/01/18

Phil Mettam
Accountable Officer, NHS Vale of York Clinical Commissioning Group

Report Approved ✓ ☐ **Date** 08/01/18

Wards Affected: **All** ✓ ☐

For further information please contact the author of the report

Annexes

Annex 1 - How the current system is falling short for individuals with complex needs in terms of both individual outcomes and system-wide efficiencies

Annex 2 – Workshop Report, Executive Summary: Mental Health Housing and Support Workshop held at Priory Street Centre on 29 September 2017

This page is intentionally left blank

Annex 1

How the current system is falling short for individuals with complex needs in terms of both individual outcomes and system-wide efficiencies

An overview of the key issues

1. Most people experiencing mental ill-health have a suitable home to live in or return to but for those who do not the current approach is falling short in terms of individual outcomes and system-wide efficiencies in the following ways:

2. **The 'revolving door' is institutionalisation for the post- care in the community age**. People moving between hospital, prison and unstable or hostel based accommodation are likely to lose the skills associated with living in a stable and independent home, to become increasingly reliant on support, and to have greater reliance on high cost interventions such as hospitalisation and prison.

3. **The links between homelessness and mental health are complex and non-linear**. However, without a stable home people are more likely to miss appointments, lose skills, self-medicate with alcohol or illicit substances, have poorer physical health outcomes, have poorer mental health outcomes, and use acute, rather than prevention based, health services.

4. **Inappropriate placements in accommodation with lower levels of support or in homeless accommodation**. There is a high rate of exclusion or eviction associated with this, as well as local case studies demonstrating specific harm to individuals through self harm or harm to others.

5. **Homeless hostels, and lower level Mental Health supported accommodation, do not have staff with specialist mental health training**. People with complex needs are more likely to have unstructured lifestyles which mean that they engage badly with appointment based services. However, the reactive support they can access in hostels is unable to meet their need due to the lack of specialism in the accommodation and staffing.

6. **Some people with mental ill-health may find it difficult living in the shared environment of a hostel**, which may cause them to be

particularly vulnerable, or in some cases (especially if they have complex/multiple needs) may have a particular impact on others. A homeless hostel can be a very stimulating environment due to the variety of individuals and needs it has to accommodate, and if the balance is disrupted by attempting to accommodate someone who is not able to engage in the resettlement program this can impact on the recovery and progress of a number of individuals.

7. **Some people with mental ill-health may be very vulnerable to abuse (financial, verbal etc) from others, and there may be some geographic areas where this is a higher risk due to demographics etc.** There is currently not a co-ordinated approach to managing and reducing this across partner agencies, (e.g. through telecare solutions, concierge type blocks etc).
8. **There are currently a small number of people in CYC general needs housing with disproportionate needs, causing significant neighbour issues and anti-social behaviour.** Paranoid thoughts, disordered thoughts, and delusions have a particular impact on neighbour relations and ASB. Current services are appointment based, focussed on one aspect of the person (health/housing/crime). This leads to heavy staff input across partners, with current gaps in the joint working process between the ASB hub and mental health/social work teams. This leads to poor outcomes for the individuals as well as affected neighbours, to dissatisfaction and increased stigma in communities, and, in the worst cases, to eviction.

9. **The formal support provided to people who have moved into a general needs tenancy but who are struggling is likely to come from a range of providers** (mental health community team, floating support, housing provider, community addiction services). It is likely to be largely or exclusively appointment based, focused on one area or some areas of the individual's life, and be provided via different teams. Communication between teams is not consistent.

10. **Individuals who do not engage (or do not attend appointments) are likely to be signed off services.** There are no shared non-engagement protocols across partners to ensure that those who have stopped engaging due to worsening health are able to re-engage with support easily/in other ways, or to prevent admissions and other negative outcomes.

11. **Inappropriate placements in homeless accommodation lead to 'blocking' the resettlement route, as individuals are unable to**

progress through the resettlement program. This also prevents or slows vital access to the resettlement route for newly homeless people - it is well documented that every night of rough sleeping significantly increases the challenges in helping someone to get out of homelessness.

12. **Delayed discharge from hospital while accommodation is sought, with associated negative outcomes and high cost.** Whilst attempts have been made to put a discharge protocol/procedure in place this is not currently followed consistently, exacerbating the delays.

13. **Higher use of out of area placements for specialist accommodation**. With associated high costs, and difficulty in maintaining support networks.

Three individual case studies

Please see below, three case studies of individuals with complex needs that help illustrate (a) the 'whole system' financial cost of not being able to provide the right type of accommodation and support (Case studies P1 and P2), and (b) the benefits to the individual, and in turn the 'whole system', of closer joint working and extensive outreach support (P3).

Case Study - P1

P1 - diagnosis / background:

- Diagnosis: 'Schizophrenia/schizo-affective disorder, with numerous inpatient admissions over 4 decades, P1 experiences delusions, paranoid thoughts, suicidal ideation, can present as disinhibited and grandiose.
- When unwell P1 is often verbally or physically aggressive and violent towards others.
- Long history of illicit drug use including a range of drugs.
- Tenancy at recent community based property ended due to threats and aggressive behaviour towards neighbours
- Remains in forensic placement.

P1 – whole system costs: total = £183,026

Health - inpatient admissions: £150,320

- 4 acute inpatient admissions totalling 86 days
- 3 psychiatric intensive care unit (PICU) admissions totalling 78 days (approx £700 per day)

Housing: £25,842

- This includes time living out of area, 'sofa surfing' at a range of addresses in York, living in resettlement hostels and in temporary accommodation.

Other health costs: £5,664

- This includes 5 emergency department admissions, 2 planned hospital contacts, and known contacts with community mental health services (please note that contacts with community mental health services are incomplete in this case study).

Police: £1,200

- This is made up of reports from neighbours, staff and contact direct from P1.

Social services: costs not known/provided.

Case Study – P2

P2 - diagnosis/background

- Schizophrenia. P2 experiences auditory, visual and tactile hallucinations of a very disturbing nature, and P2's reaction to these causes significant noise nuisance to neighbours which has resulted in numerous complaints, tenancy action, and moving other neighbours whose health has suffered as a result of noise nuisance.
- At the time P2 moved in to the property there were concerns from health and social care services that the property was not appropriate.
- P2 has spent a significant amount of the time they have held the tenancy in hospital and unable to return to it due to ill-health.
- At the time of writing this individual is in a locked rehabilitation ward.

P2 – whole system costs: total = £191,562

Health - inpatient costs: £156,225

- 8 months in an acute ward - £12,000 per month
- 5½ months in 'locked rehabilitation ward' £10,950 per month

Other health costs: £18,732

- Made up of 1 emergency department visit, 1 planned hospital appointment, and known community mental health contact (as above these are incomplete)

Legal costs: £12,022

- These are approximate costs, based on the hours spent on the case and barrister costs, however they do not reflect housing officer time spent on this case, which is not recorded but has been significant.

Housing: £2,633

- Detached general needs bungalow being held by social services: £73.14 pw.

Police contacts: £1,950

- This included 11 contacts for assault, theft and a number of calls from neighbours regarding disturbing behaviour and/or noise nuisance.

Social services: costs not known/provided.

Case Study – P3

P3 – diagnosis/background

- Diagnosis of psychotic illness, underlying personality issues and significant history of substance misuse. Involved with mental health services for many years and risk history dates from 1990.

Challenges

- 13 years in hospital (including forensic inpatient care and Psychiatric Intensive Care), B&B's, prison and homeless hostels.
- 2009 – 2017: 16 hospital admissions, 12 homeless hostels, 2 prison stays, 1 incident of rough sleeping.
- Risk incidents include physical and verbal aggression to family, staff and police, public order and ASB offences. Disinhibited behaviour.
- Physically frail, with conditions requiring long term management.
- History of difficulties in maintaining a tenancy
- Shared living exacerbated ill health.

Costs

- P3's loss of hope and optimism for a settled future
- Loss of skills to manage daily needs
- Negative effect on physical health
- Lack of sense of belonging and control
- Extended length of stays in hospitals & hostels at a significant financial cost
- Lack of opportunity to maintain and establish family and social networks.

Plan

- P3's aim was to live independently
- Joint approach from Community Health & Housing to facilitate this.
- Social care assessment completed in out of area hospital to identify discharge requirements
- Clear plan constructed with P3 by homeless & health staff
- Health met with housing staff before and after each visit with client for any updates / feedback.

- P3 seen daily for 4 weeks, gradual reduction to 3x's per week
- Joint harm minimisation mitigation plan. Inc. service user and all staff involved
- Health intervention around benefits, planning for future tenancy, medication management
- Frequent communication with all involved
- Honest and open relationships with key people including the hostel manager
- If P3 in crisis - no one panicked, the plan was revisited
- Health responded immediately on a number of occasions to concerns.

Independent flat identified Feb 2017

- Supported with tenancy skills
- Beesom project helped with furniture
- Settling into flat, describing feeling "proud of it"
- 3 visits a week from health
- Joint visits with homeless hostel workers.

Outcome

- Permanent tenancy offered
- Skills increased in managing tenancy, no bills outstanding
- Independently managing both mental & physical health
- Reduced alcohol intake
- P3 proud of themself and this has made a significant impact on their recovery
- No inpatient stays for 1 year
- P3 participated in decision about their housing - which was successful
- P3 has now has choices in their everyday life.

This page is intentionally left blank

Annex 2

Mental Health Housing and Support Workshop
Friday 29 September 2017 – Priory Street Centre

WORKSHOP REPORT – EXECUTIVE SUMMARY

We Are All People
by Jamie Towey

We are all people and we need
Shelter, security and space.
We are all people and we need
Cooperation, community and connection.
We are all people and we need
More social housing.
More halfway houses.
And less finger-pointing.
Fingers cannot just be clicked
But the correct path can be picked.
We are all people and we need
Shelter, security and space.
Cooperation, community and connection.
We are all people and we don't ask for much.
These pleas are for our basic needs.
We are all people.

At the workshop, Jamie recited this poem to conclude the performance by Converge's 'In the Moment' theatre group.

Executive Summary

Introduction

1. The Mental Health Housing and Support Workshop held at Priory Street Centre on Friday 29 September 2017 was attended by over 70 delegates with a wide range of partner agencies represented including service users and carers, City of York Council, Housing Associations, Tees, Esk and Wear Valley NHS Foundation Trust, Vale of York Clinical Commissioning Group, and the Voluntary and Community Sector.

2. The workshop was divided into two sessions. In the first session, a number of presentations highlighted some of the key, current challenges within Mental Health housing and support. This included Converge's 'In the Moment' theatre company giving a powerful performance representing some service users' experiences of accessing housing and support. Before the coffee break, six options were presented for addressing a particular gap in provision – housing for people with very complex needs. A copy of the full slide-pack is available on request.

3. In the second half of the workshop, delegates were assigned to eleven discussion groups designed to ensure a mix of representation from different agencies. Each group had a facilitator that guided the group through a series of questions. Delegates' thoughts and comments were captured in a variety of ways. Each facilitator took notes of the discussion, whilst some delegates also provided their own written comments either (a) in booklets handed to every delegate and collected at the end, or (b) on post-it notes which they could add to flip-charts displayed around the room. All delegates were also given two stickers to represent a 1st and 2nd choice 'vote' for the options that had been presented.

4. This workshop report captures **all** of the feedback provided by the eleven discussion groups – pulling it together under a series of headings that reflects the questions asked. We have tried to group

similar comments and themes and highlight where the same point was made multiple times (e.g. x5). This executive summary attempts to pull out the key messages to emerge from the workshop. However, please read the full report to get a feel for the wide range of points made and issues raised.

Key messages about our current ways of working

5. The following key messages emerged about our current ways of working:

Calls for better joint working and information sharing

a. Current services and support are “fragmented”. There are examples of good practice and support but there is a lack of consistency – not everyone gets the same opportunities or level of support. It can be “hit and miss”.

b. There seems to be a high level commitment to providing quality joined up services but this isn’t always translated to front line services. There needs to be a partnership commitment and approach and recognition that this would relieve everyone’s workload and provide a better service for the customer.

c. There is a lack of understanding in mental health services about what accommodation is available and what is on offer (terms of occupancy, what support is available etc). Could we pull together a simple directory setting out what accommodation is available, criteria for entry and services available to the tenant so that people are clearer about what is right for the individual when making a referral?

d. It is incredibly difficult for professionals to navigate the health and social care system. How can we expect service users and families to do it without support? An easy, quick win is better

communication to all partners/ stakeholders of what is available now.

Calls for a greater focus on early intervention and prevention

e. Service users need more support earlier. There needs to be more proactive outreach support - the right support at the right time, to help ensure that when a person is on a downward trend this is spotted early enough to prevent it becoming a crisis.

Calls for better planning and support for transitions

f. We should invest more resource (transition workers/team?) in better planning and management of transitions from hospital back into the community, or between different levels of supported housing. Providing the right level of support up front greatly increases the chance of success. There was a general plea was for “greater pro-activity and less fire-fighting”.

Key messages from the discussion of the options presented

6. The following key messages emerged from the discussion of the six options presented for the provision of housing for people with very complex needs:

   a. **Option 1 – Do nothing.** The shortage of housing and increasing need means this is not a viable option. We know the current system doesn’t work for those people with very complex needs.

   b. **Option 2 – ‘Housing First’ approach**. The general view was that this was not an option on its own, but needs to be part of a wider range of options. The principles for ‘Housing First’ are absolutely right and could work for some people but this approach can, and will, fall down if we do not provide sufficient out-reach support. Many felt that it would not be appropriate for all people with very complex needs.

c. **Option 3 – 2 x 6 person schemes + outreach support.** Good size – shouldn't feel too institutional, but falls short of the capacity required for people with very complex needs.

d. **Option 4 – 1 x 20-25 person scheme.** Some felt this to be a good option if designed properly (building and support) as it provides a one-stop approach and is the most cost effective option with all resources being concentrated in one place. The big concern, voiced by many, was that the risks of putting so many people with very complex needs together – in terms of potentially creating a stigmatising, institutional environment – would outweigh the benefits. "It feels like going backwards".

e. **Option 5 – 2 x 10 person schemes.** Good design was again recognised as being crucial. Generally felt to be preferable to Option 4 as it opens up the possibility of either male/female facilities or higher/lower intensity.

f. **Option 6 – 2 x 6 and 1 x 4 person schemes.** Recognised as offering greater flexibility than Options 4 and 5 with potential for different levels of support across each site. Also the most expensive option though with revenue costs high.

Voting results

7. All of the options attracted some votes, with the exception of 'Option 1 – Do nothing'. The clear front-runners, however, were Option 6 (with 38 points) and Option 12 (with 37 points). Option 12 was an alternative option suggested by one of the discussion groups – comprising of a mix of all the options, including 'Housing First'.

Other issues we need to be mindful of when considering options

8. Some of the other key issues raised within the discussion of the various options and the principles that need to underpin the service design, included:

    a. The importance of building design - creating self-contained accommodation within a scheme for several people.

b. Peer support needs to be a key element of service design.

c. The issue of ongoing support and how this will be resourced and co-ordinated.

d. Having the ability to flex levels of support up and down.

e. More detailed work required to consider the right balance of qualified and unqualified staff within the options.

f. The importance of sticking with people through a crisis. Giving people the chance to fail, and offering second chances.

g. Work with the wider community to develop and encourage a culture of tolerance.

Conclusion and next steps

9. The workshop was well attended by representatives from a wide range of organisations with an interest in improving Mental Health housing and support. The discussion groups generated a great deal of debate and valuable feedback which has been captured within this report. This feedback will inform and shape the next steps.

10. A Project Board with representatives from City of York Council (CYC), Tees, Esk and Wear Valley NHS Foundation Trust (TEWV), Vale of York Clinical Commissioning Group (VoY CCG), and York Housing Association will oversee and steer the programme of work required to move this agenda forward.

11. Workshop delegates were asked to volunteer to be part of a wider working group (and sub-groups) that will be pulled together to help input to, and shape, the detailed work. The first meeting of this working group should happen in late November.

12. CYC, TEWV and VoY CCG have committed to taking a report to the Council's Executive Committee (25 Jan 2018), the Health and Wellbeing Board (24 Jan 2018), and the Mental Health Partnership (date tbc) which will outline a high level way forward, and seek approval to develop a more detailed options appraisal / business case for a couple of options.

This page is intentionally left blank

Health and Wellbeing Board **24 January 2018**
Report of the Assistant Director of Public Health

Results of the York Older People's Survey

Summary

1. This report asks the Health and Wellbeing Board (HWBB) to note the results of the York Older People's Survey and respond to the recommendations in the report.

Background

2. At their meeting in September 2017 the Board received the early results of the York Older People's Survey. Full analysis of the survey has now been completed and the Steering Group leading on the survey has made some recommendations based on the survey results.

Main/Key Issues to be Considered

3. The report from the survey is attached at Annex A. Whilst the survey indicates that overall the health of older people in York is good, there are a number of issues that the Board are asked to consider.

4. The recommendations in the report relate to the availability of information and advice, social interaction, health, independence and safety.

Consultation

5. The survey was conducted in partnership between City of York Council, York Older People's Assembly, Age UK York, Healthwatch York, York CVS, The Police and Crime Commissioner North Yorkshire, The Vale of York Clinical Commissioning Group, York Blind and Partially Sighted Society

and York Hospital Trust. The survey represents the views of older people in York.

Options

6. There are no specific options for the Health and Wellbeing Board; but the Board are requested to consider the recommendations in report and consider the options that are available to ensure these recommendations are acted upon.

Analysis

7. Not applicable.

Strategic/Operational Plans

8. This report has direct links to the Ageing Well element of the joint health and wellbeing strategy 2017-2022.

Implications

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

Risk Management

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

Recommendations

17. The Health and Wellbeing Board are asked to note and comment on the report and to consider which groups or organisations should take responsibility for the actions in the report.

The Board are also asked to provide direction on whether they would like to see future surveys of this nature.

Reason: to ensure that the results of the survey are acted on and that local people are reassured that their opinions are valued and acted upon.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Fiona Phillips Assistant Director of Public Health City of York Council Tel: 01904 565114	Sharon Stoltz Director of Public Health City of York Council

Report Approved ✓ **Date** 12.01.2018

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes

Annex A – Report of the Findings from the survey of older people in York.

This page is intentionally left blank

Annex A

FINDINGS FROM THE SURVEY OF OLDER PEOPLE IN YORK

December 2017

CONTENTS

Summary

The Older People's Survey was carried out during the summer of 2017 and contained a wide range of questions considered to be of interest to older people in the city of York, covering topics such as getting information and advice, their health, what they felt about their local area and planning for the future.

Around 900 people responded to the survey. They were completed by a demographically diverse group, covering those from ethnic minorities (although there were very few people of non-white ethnic origin responding to the survey), those under the age of 50, those over the age of 90, those saying they still worked and of various sexual orientations. Respondents from all areas of the city contributed, with them being fairly equally distributed in the areas covered by each of the city's three Local Area Teams.

The most positive answers tended to be from the younger age groups (those under the age of 60) and from married people. The most negative responses tended to be from those described themselves as "widowed", and from those aged 90 or over. Neither of these findings could be described as particularly surprising, but it does suggest that more needs to be done to help these groups.

More detailed information about the responses is listed in the "Questions Asked and Survey Responses" section. However, an overall summary would be that, on the whole, older people do not always find it easy to find information; they are quite sociable; they generally feel safe; their health is reasonably good; they feel public transport is good in York but could be improved; they do not feel particularly well-off financially; and that they need might need help with planning for the future.

Introduction

A meeting of the York Health and Wellbeing Board (YHWBB) held on 20 July 2016 heard a request to support the carrying out of a survey of older people, similar to the one that was carried out in 2008. The YHWBB agreed to this and work commenced through a steering group in October 2016. The steering group had representatives from a number of organisations which exist to help older people in the city: York Older People's Assembly, Age UK York, Healthwatch York, York Community and Voluntary Service, North Yorkshire Police, the Vale of York Clinical Commissioning Group, York Hospital Trust and City of York Council.

The purpose of the survey was to discover what issues older people find important in York, and to identify what helps to keep them well and independent. The survey results were intended to be of use to local agencies when planning services in order that these could focus more on supporting good health and helping to keep people happy and healthy for longer. The survey was divided into nine sections, in order to obtain information about the various issues considered to be of most relevance to older people:

- Getting information and advice
- Social Life
- Health
- Independence
- Local community / area
- Transport
- Finances
- Planning for the future
- Demographic information about the respondent

The survey was distributed in May/June 2017 and data entry and initial analysis was conducted during July/August 2017. The survey was available to complete online and partner agencies distributed paper

copies to their membership lists. The survey was also available in Braille, large print and audio format.

The survey comprised of 71 questions across the various topics. Most of the questions were of the "multiple choice" variety, with some of the questions being "free text" responses.

In total, 912 completed surveys were returned – 142 were online and 770 were paper submissions.

The analysis which follows contains details of the overall response to each question, along with some further commentary where appropriate about the difference in responses between men and women, the various age bands of respondents and the "marital status" of respondents. Describing differences by ethnic origin, as could occur in other local authorities, is not feasible in York because of the very low numbers of people describing themselves as being from an ethnic minority background (see Q61). As postcode information was given by most respondents (see Q69) it could have been possible to analyse information by ward but the numbers of people living in some wards responding were quite small. We have therefore looked at the answers by Local Area Team, and where there are differences we have reported these.

Questions Asked and Survey Responses

Percentages and proportions mentioned in the answers below are, unless otherwise stated, always given as a percentage/proportion of all those who gave a response to the question, rather than of all surveyed (912 people). It is assumed – as is standard statistical practice - that those people who did not response to a question would answer in broadly the same manner as those who did.

Getting Information and Advice

Q1 – Where do you get information about activities, events and services in your local area?

Respondents were given a range of options as to where they receive information – and were allowed to cite more than one option - and could suggest other sources if none of them applied. The most commonly cited sources were local newspapers and friends (both cited by over half of those asked), followed by the internet, community newspapers, radio and television. From this, it would seem that local information is of high importance to older people.

Q2 – How do you prefer to receive information?

Again, respondents were given a range of options as to how they prefer to receive their information, with more than one allowed to be chosen. Almost two-thirds said that they prefer to be contacted by post. Around one-third of respondents said that they would be happy to receive information in a face-to-face manner. More recent information communication methods (email, social media, text messaging) were cited by respondents but in lower numbers.

Q3 – What format do you prefer information to be in?

This question asks whether respondents want information to be in print, large print, audio or Braille – which can also be used as a proxy for hearing or sight issues. Almost three-quarters of the respondents said that print would be their preferred format, about one-fifth said large print, and only 4% said either audio or Braille.

Q4 – Are there any areas where you think there is a lack of information in York?

Respondents were given a list of areas that it was perceived they might require information about (local social groups, health services, adult care services, housing and so on) and were invited to tick at least one box. The most commonly cited area that there was thought to be a lack of information was adult care services, cited by around one-fifth of respondents. The next most often cited areas were transport, local social groups, health services, support groups, financial / benefits advice and leisure activities. It is notable that information about access to statutory

services (adult care, transport and health) was thought to be lacking by some older people.

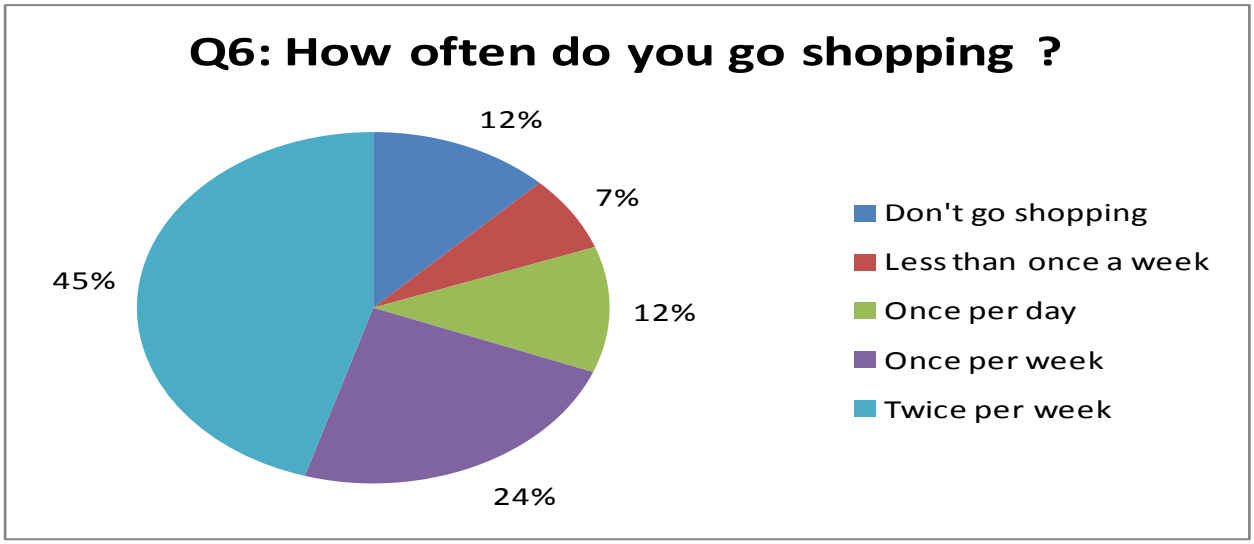
Social Life

Q5 – Are you a member of any social groups?

Respondents to this question were allowed to give a “Yes/No” answer, with those giving a “Yes” answer being free to state what their social group is. Overall, just over half (55%) of those giving a response said that they were a member of a social group. There were no major differences discovered amongst the various age groups, both sexes and the “marital status” of respondents. A wide range of answers were given, with local church groups, the Women’s’ Institute, University of the Third Age amongst frequent responses.

Q6 – How often do you go out shopping?

Five possible answers were given to this question, ranging from “Never” to “Every day”. The most common answer given was “Twice per week”, given by 45% of those answering this question. Only 12% said they never went out shopping, so the vast majority of older people go shopping, even if it’s less often than once per week. The ability to go shopping, perhaps unsurprisingly, does decline with age, however; only 5-6% of those in each of the “under 80” age bands said they never went shopping, but 40% of those aged 90 or over said they did not go shopping. Likewise, those who had been widowed were more likely to say they never went shopping (20%).



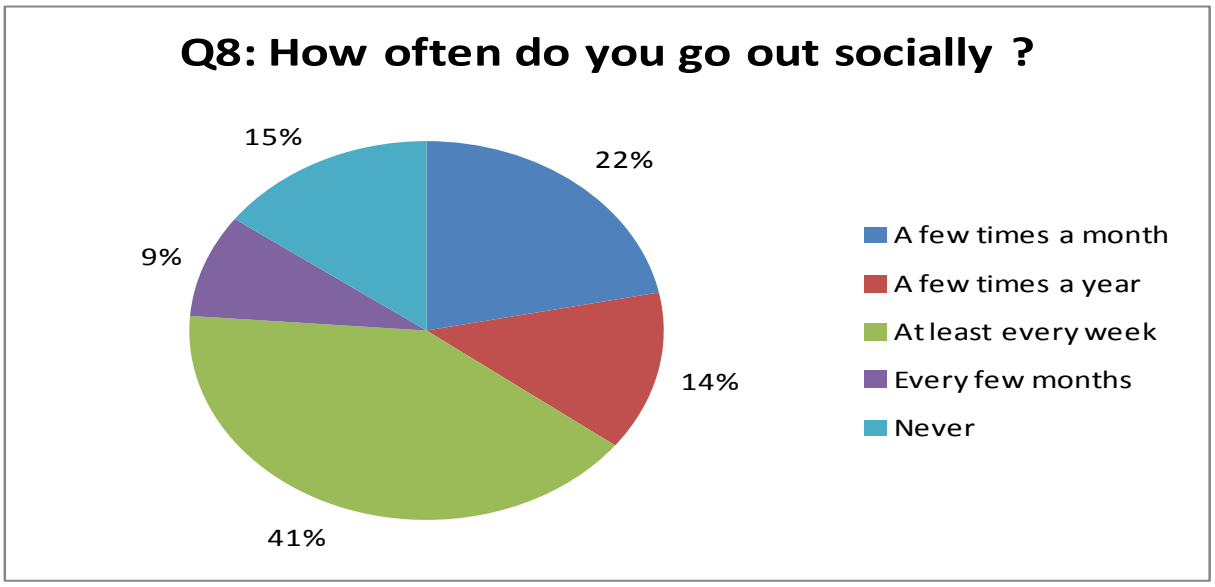
Q7 – Do you require assistance with your shopping?

People could respond “Yes” or “No” to this question, with a free text box given so those wanting to could elaborate on the nature of their assistance. Around a third of responders said they needed assistance. Women (39%) were much more likely than men (23%) to say they needed assistance, and assistance needed increased with age (61% of “over 90” responders said they needed help), compared with 19-22% of the younger age groups (under the age of 70). Encouragingly, many of the responders saying they needed help appeared to get it from other family members, typically a spouse, son or daughter. Those who lived in the city’s North area were more likely to need assistance (46% said they did) than other areas; those in the East of the city were less likely to need it (27% said they did).

Q8 – How often do you go out socially?

A range of potential answers to this question were available, from “never” to “at least every week” (in ascending order of frequency). Encouragingly, the most popular answer given was “at least every week”, mentioned by 41% of respondents. Only 15% of respondents said that they “never” went out socially. There is a bit of a decline with age in going out, with only 2% of those in the 50-59 age band saying they never went out, but this rose to 31% amongst those aged 90 or

over. Those who had been widowed were also the least likely to go out every week and the most likely to never go out.



Q9 – Thinking about how much contact you have, how would you describe your social situation?

This question is analogous to one asked by CYC's Adult Social Care User Survey, with four possible statement options to respondents; the least positive being "I have little contact with people and feel socially isolated", and the most positive being "I have as much social contact as I would like". Respondents were also allowed to state, in a free text box, if there was anything preventing them from having more social contact, if that applied. Encouragingly, 42% of respondents said they had "as much social contact as I like", with a further 35% saying they had "adequate social contact". Social contact did appear to decline with age, but not particularly significantly. Divorced people seemed to have the least social contact (only 65% gave a "positive" response, compared with 86% of married responders). "Transport" was the most frequently cited reason why people did not have more social contact, although that covers "not having a car" to "public transport not available". Those in the city's North area were much less likely to say they had "as much social contact as I like" (32% gave this response) than in other areas.

Q10 – Is there a difference in how much social contact you have depending on the season (e.g. less in winter?)

Almost two-thirds (63%) of respondents said “No” to this question, although interestingly it was the “60-69” age group who were least likely to say no (55% of them did). There were no significant differences found between the sexes or the various “marital status” bands. Unsurprisingly, people tended to say they went out less in the winter than in the summer (a free text box was available for people to explain why if they say “Yes” to this question). Most of the reasons centred on the weather, fear of falling and some medical conditions feeling worse in winter.

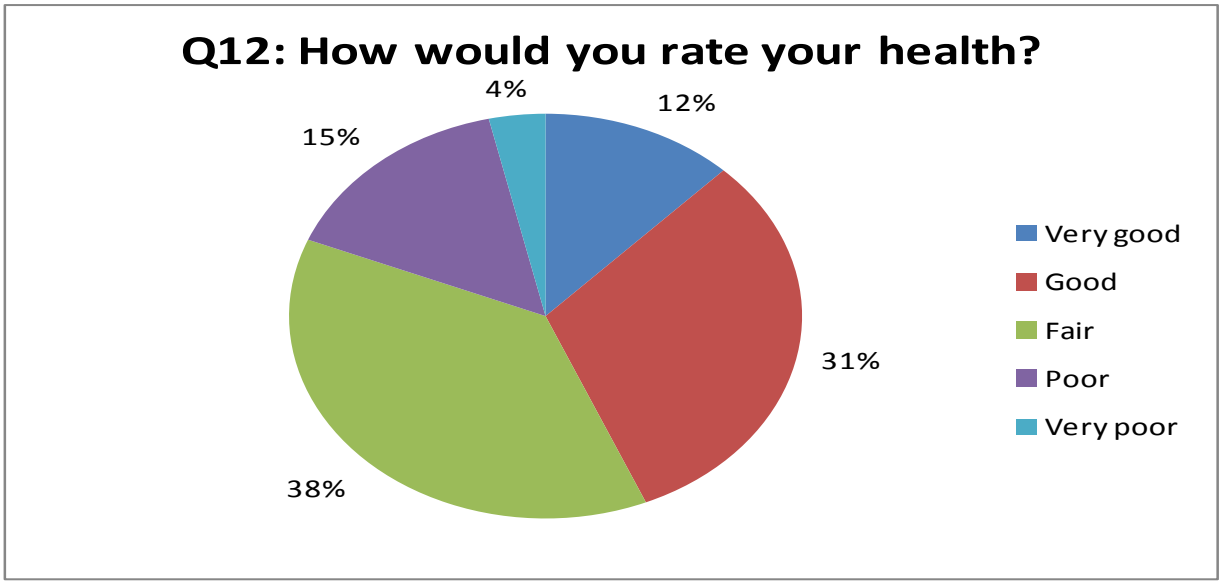
Q11 – What time of day would you choose to go out?

There were three possible answers listed for this question – Morning, Afternoon and Evening, although people were allowed to choose one, two or all three options. Almost three-quarters (71%) said they would like to go out in the afternoon, with 64% saying the morning and only 31% in the evening. There is a sharp decline with age for evening-related activities: over 70% of those under 60 are happy to go out in the evening, which declines to just 17-18% in the two “over 80” age bands. Women (77%) say they are happy to go out in the afternoon, compared with just 63% of men. Widowed people are less happy to go out in the evening (just 17% said they would do).

Health

Q12 – How would you rate your health in general?

The possible answers given to respondents ranged from “Very poor” to “Very good”. Approximately four-fifths (81%) of respondents said that their health was at least “Fair” and it was only the very old (those aged 90 or over) and Single people who deviated from this proportion, and even then it was not particularly significant. Given the likelihood of people under-reporting their true health condition, this is an encouraging response. However, those in the North area were less likely to say that their health was “Very good” or “Good” (33% did, compared with 44% in the city as a whole).



Q13 – In an average week, how many minutes of physical activity do you do?

A free text box was provided for respondents to this question, and a wide variation of answers were given, ranging from 0 to 70 hours per week; some of the answers were in ranges (e.g. “10-15 hours per week”) and some indicated exercise without being specific about the time taken on the activity (e.g. “I play golf twice per week”). The percentage that reported doing the recommended levels of physical activity in a week (i.e. over 150 minutes per week) was 68%. This is similar to the proportion doing the recommended level of physical activity in the adult population in York (69.8%), which is higher than the England rate of 57%.

The median amount of time given by respondents was 180 minutes (3 hours), indicating around 26 minutes per day. As could be expected, there is a decline with age in physical activity – 300 minutes was the median answer given by those aged 60-69, but this was only 60 minutes amongst those aged 90 or over. Those who had been widowed were

also less likely to be active for as long as other groups, the median for this group was 100 minutes.

Q14 – In an average week, on how many days are you physically active?

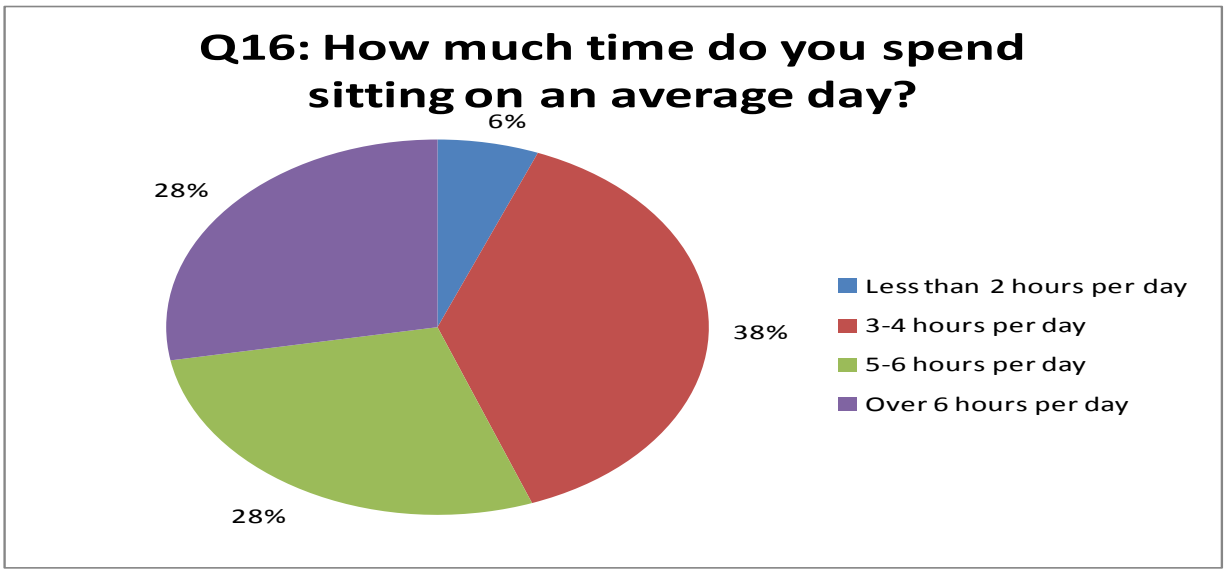
Again, a free text box was provided, but – as one might expect – the answers ranged only from 0 to 7. Half of respondents said that they were active on all 7 days each week, with a further 25% saying that they were active 4-6 days per week. There was little difference in the responses across the sexes or the various "marital status" groups, although it is noticeable that the "over 90s" choose either to be physically active each day (47% of them said they were) or not at all (33% said this, compared with just 11% overall).

Q15 – Do you do any strength activity in a usual week? (This includes digging, carrying shopping, lifting weights, dancing, etc.)

The options for this question were "Yes" and "No". Just over half (54%) of people said that they did some strength activity in a usual week. Not surprisingly, this declined with age – 72% of those aged 50-59 did some, but only 24% of those aged 90 or over did. Those who were married (63% said "Yes") were much more likely to do some than those who had been widowed (43% said "Yes"). There was little difference found between the sexes. National guidelines recommend that people should do strength based activity at least twice per week.

Q16 – How much time do you spend sitting on an average day?

Four choices were given to respondents for this question – "Less than 2 hours per day", "3-4 hours per day", "5-6 hours per day" or "Over 6 hours per day". The most popular answer given was "3-4 hours per day", cited by 38% of respondents, although it is perhaps a concern that 56% of respondents said that they sit for at least five hours per day. Not surprisingly, the amount of time spent sitting does appear to increase with age. Divorced and Single people appear to sit for the longest periods of time (68% of both groups said they sat for over 5 hours per day). Men and women sit for broadly similar amounts of time.



Q17 – What do you do to keep yourself healthy?

The answers given to this question were of a “free text” nature, so this is difficult to analyse quantitatively. The broad categories that answers fell into, along with some examples are shown in the table below.

Diet	**Eat healthily, diet with fresh fruit and vegetables, include nuts and fruit, eat properly, balanced diet.**

Physical Exercise	Gently exercise, keep doing physiotherapy exercises, swimming, walking, keep fit classes, cycling, upper body exercises, gardening, dog walking
Mental Exercise	Crosswords, play bridge, keep up with current affairs, sewing and knitting, book club, continuing in employment or volunteering
Outdoor activities	Walking (including dog walking, shopping, cycling)
Indoor activities	Knitting, housework, choir, cooking
Socialising	Keep socially active, looking after grandchildren
Lifestyle	Drinking alcohol to sensible limits, not smoking
Sleep	Sleep well, at least 7 hours sleep.

Q18 – What things would you like to do but don't?

Again, the answers to this question were of an open-ended nature, but interestingly it tended to be only the people who gave answers to Q17 who answered this question, suggesting that those who had an interest in their health and fitness were aware that they had limitations to what they could do, whereas those who did not answer Q17 perhaps had little interest in keeping themselves healthy. A lot of people cited being "more active" as answers, particularly going swimming. Some quotes from the

survey are shown below as an illustration to the type of comments that were made.

“I cannot find a professional and business women club, which I would like to join. I am hoping to become a member of some society later. I may re join the historical society”

“I am a carer and cannot engage in many social activities. I should like a 'mumsnet' for carers - not just a charity forum.”

“Friday club is only every other week. Something similar on another day would be helpful.”

“I would like to join clubs but meetings are often evenings and buses are few and far between later on and car parking in centre of York is not easy and I am increasingly reluctant to venture out especially at night.”

“Pub quiz at lunch times or early evenings.”

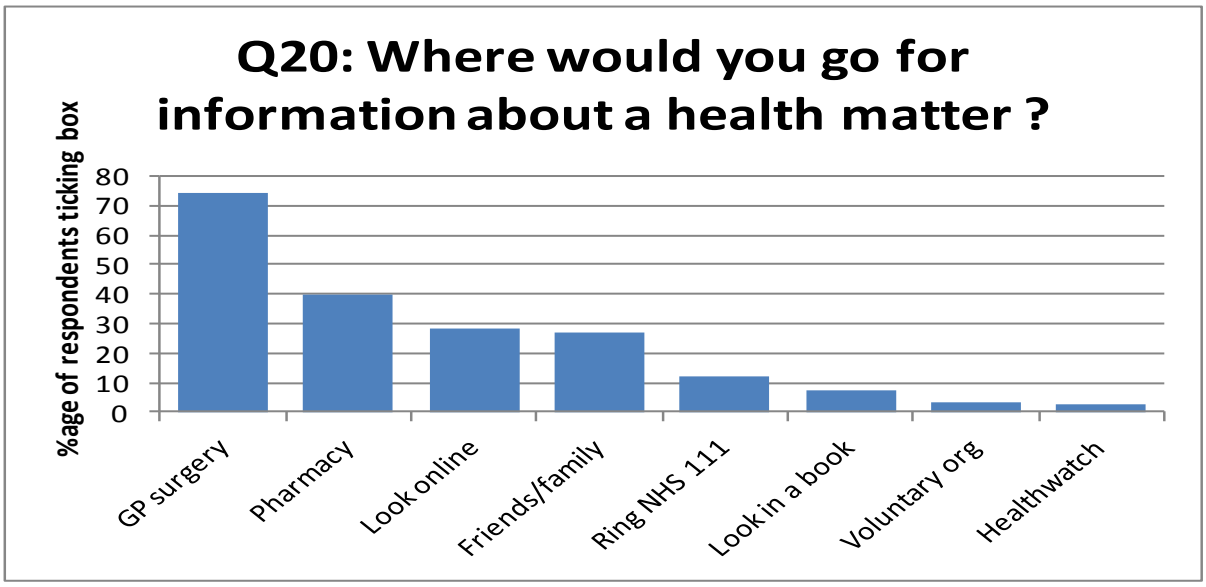
“Anything which helps me socialise. Everything seems aimed at younger generation.”

Q19 – What is preventing you from being able to do this?

Free text boxes were also provided for this question, and thus quantitative analysis is difficult. Many of the respondents cited one or more existing health issues (back pain, poor eyesight, depression) as reasons why they were unable to stay healthy. Some mentioned affordability and others said that there were no groups in their local area that were able to assist with their issues.

Q20 – Where would you usually go first if you wanted some information about a health matter?

A range of options were given to respondents to choose (they could pick more than one). The most commonly given response was “GP surgery”, which was given by almost three-quarters (74%) of those surveyed. The graph below gives details of how often other possible answers were given. A free text box for “Other” responses was provided, but very few people gave an answer not in the existing range of options.



Q21 – Other than going to a pharmacy to collect prescriptions or buy over the counter medicines, do you use any other services at your pharmacy?

Various options were given to respondents to indicate which services at pharmacies they used (they could choose more than one if they wished). “General advice about health issues” was the most commonly chosen answer, given by 27% of respondents. The next most popular answers were “I am not aware of any other services my pharmacist offers” (selected by 25% of respondents), “Medicines use review (18%) and “Getting a vaccination” (15%). Very few people selected more than one answer.

Q22a – Do you do any regular health monitoring of yourself at home? (Such as taking your blood pressure, monitoring blood sugars).

Only a quarter of respondents indicated that they did regular health monitoring at home. There was little difference in the pattern of responses to this question by sex, age band or “Marital Status”.

Q22b – If yes, do you feel confident doing this?

Those answering “Yes” to Q22a were then invited to state a “level of confidence” in which they applied their health monitoring, with the options “Very”, “Fairly” or “Not very”. The majority of responders (57%) said they were “Very” confident, although this declined with age as this peaked at 68% amongst 70-79 year-olds and was only 32% amongst those aged 90 or over. Confidence amongst those widowed was lowest also (only 48% said they were “Very confident”). Men (67%) were more likely to answer “Very confident” than women (54%).

Q23 - How would you feel about doing more monitoring of your health at home?

People were given three options for this answer: “I would rather do this”, “I would be happy to do this for some things” and “I would not like to do this”. Perhaps not surprisingly, just over half (51%) of people responded that they “would be happy to do this for some things”. A further 37% said that they “would not like to do this” suggesting that they are happy to leave this to qualified professionals. Resistance to health monitoring was highest amongst widowed people (50%) and those aged 90 or over (64%). There was virtually no difference between the sexes in their responses. A free text box was also provided for people to explain their answer, and a wide range of answers were given that proved difficult to analyse quantitatively.

Q24 – Do you feel that health professionals allow you to take control of your own health?

Over three-quarters (78%) of respondents felt that health professionals allow them to control their own health, with little variation between the age groups. Single people felt this happened less (68% said “Yes” to this

question), and women (80% said “Yes”) felt this happened more than men (74%).

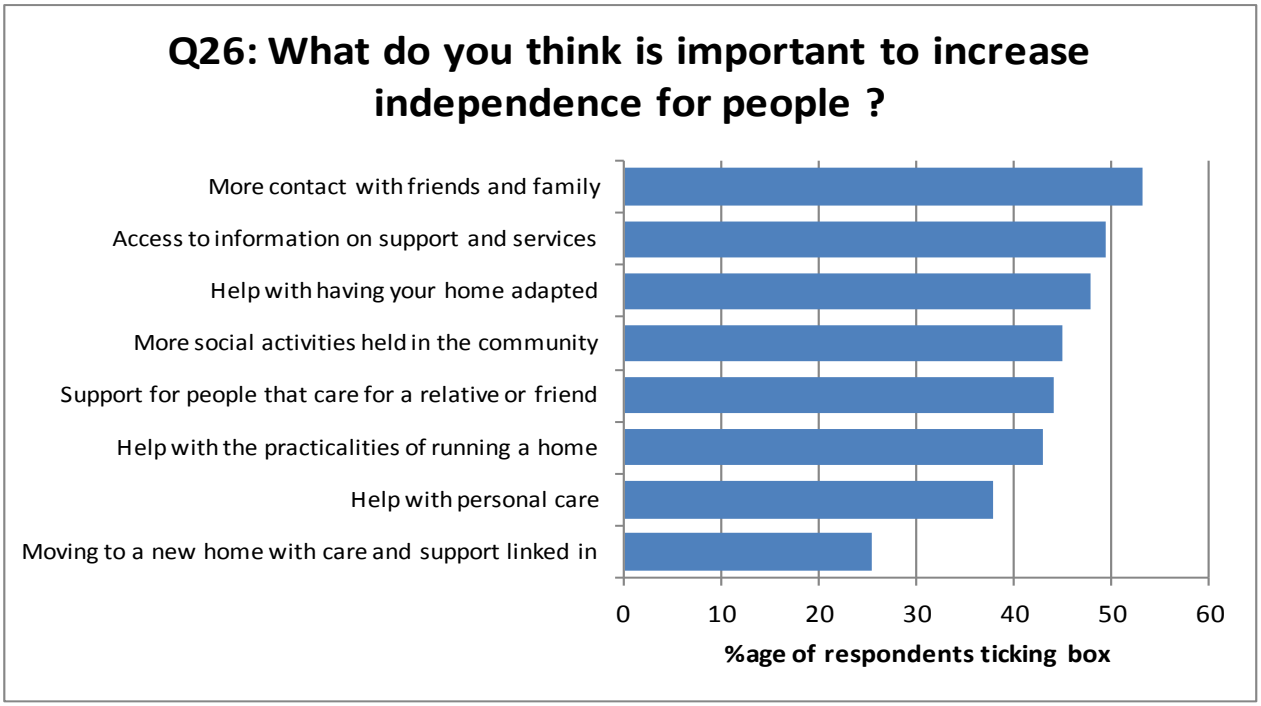
Independence

Q25 – Could you benefit from technology in the home that could support you as a carer?

Just over three-fifths of those asked responded to this question, indicating that they may have been carers. As well as “Yes” and “No” responses, “Not Sure” was also given as an option. The majority (55%) said that they did not feel they could benefit from technology, with only 15% indicating that they could. Those over 90 were far more likely (25% of that group who responded) to say they would benefit, otherwise there was little difference between the various martial status groups, other age bands and between the sexes.

Q26 – What things do you think are important in helping to increase peoples’ independence, helping them to live in their own homes for longer?

A list of options was available to respondents, who could tick more than one option if they wished to. The most common response was “More contact with friends and family”, which was given by 53% of those surveyed. Other frequently-given responses (cited by between 44% and 49% of those surveyed) included “Access to information on support and services”, “Help with having your home adapted”, “More social activities held in the community” and “Support for people that care for a relative or friend”. A free text box was offered to those who wished to expand on their, or give a different, answer, but relatively few people completed it.



This question was asked in the previous 2008 York Older People's Survey and it is interesting to see that there has been a shift to more people citing the importance of social contact.

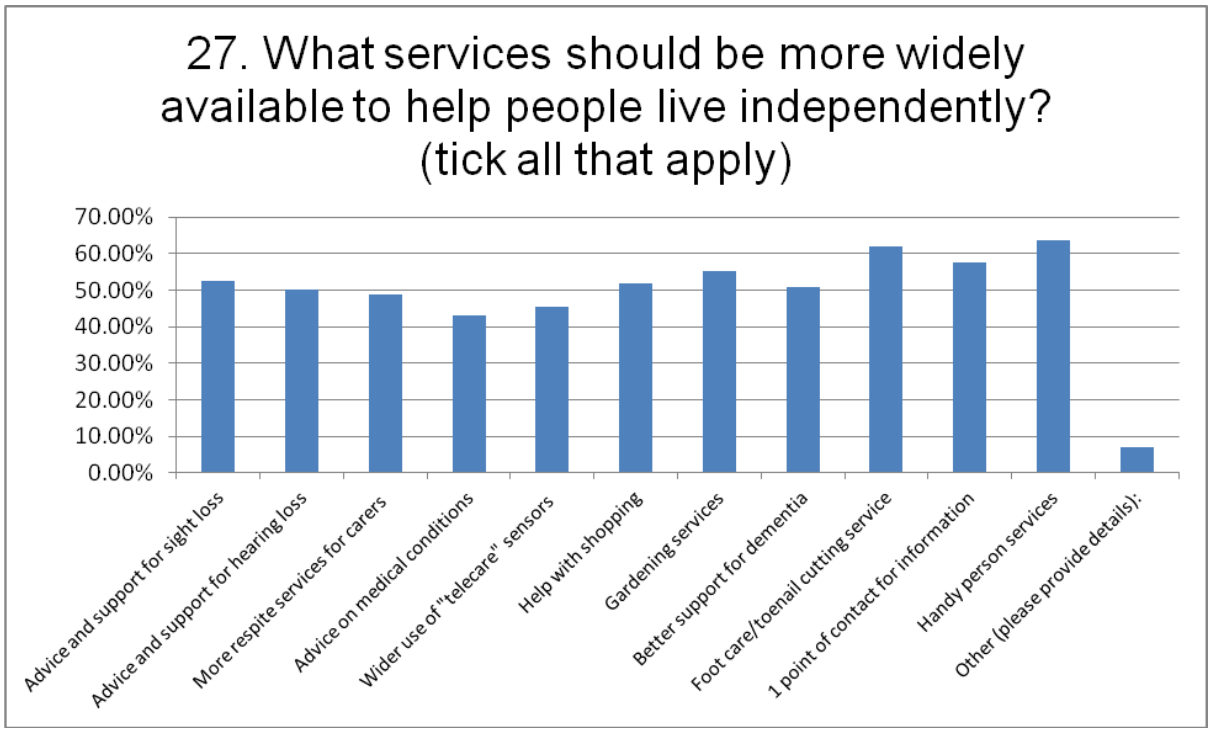
What keeps people indepent responses from 2008 survey and 2017 survey

Answer Choices	Responses 2017/2008	
More social activities held in the community	52%	40%
More contact with friends and family	62%	43%
Moving to a new home with care and support linked in	30%	34%
Support for people that care for a relative or friend	52%	60%
Help with the practicalities of running a home	50%	70%
Help with personal care	45%	70%
Access to information on support and services	58%	not asked

Help with having your home adapted	56%	73%

Q27 – What services should be more widely available to help people live independently?

A range of potential services were offered to respondents, along with a free text box if they felt that none of those services covered what they needed; they were allowed to tick more than one box. Of those offered, the most popular choice was “Handy person services” (chosen by 54% of responders). There is a clear need for services to serve older people, as each of the 11 options was chosen by at least 37% of responders. The next most popular services sought were “Foot care / toenail cutting services”, “One point of contact to get information about help, advice and activities” and “Gardening services”. There were very few responses in the free text box.



Local Area

Q28 – Please list three positive things about where you live.

As respondents to this question were given three free text boxes to answer this question, it is difficult to analyse quantitatively, but answers felt into three categories, covering connectedness (e.g. transport, local facilities like shops, health services, etc), the people (good neighbours, near friends and family), the environment (e.g. clean, safe, open spaces and parks).

Q29a – Do you do anything to help others in the city (e.g. neighbourhood watch, snow warden, etc.)

Just over a quarter (27%) of those answering this question said that they did “something” to help others in York, although there was a fairly wide range of responses amongst the various groups. Only 19% of those widowed said they helped others, compared with 33% of married people. There was a decline with age, too: 44% of those aged under 70 said they helped, but only 10% of those aged 90 or over did. Men (31% said they helped) were more likely to do so than women (27%). People in the East of York were more likely to say they helped others (32% did) than in the North of York (22% did). A free text box was given for people to say what they did – volunteering was the most common answer.

Q29b – If no (to Q29a), would you like to?

Of those that answered this question, only 22% said they would like to help, which suggests that a lot of older people do not have the time, the ability or the inclination to assist others. There were some big differences amongst the population responding: 35% of the divorced and 31% of single people said they would like to help, as would the younger age groups (34% of those aged under 70). It is quite striking that women (27% said they would like to help) are over twice as likely as men to want to help (13%).

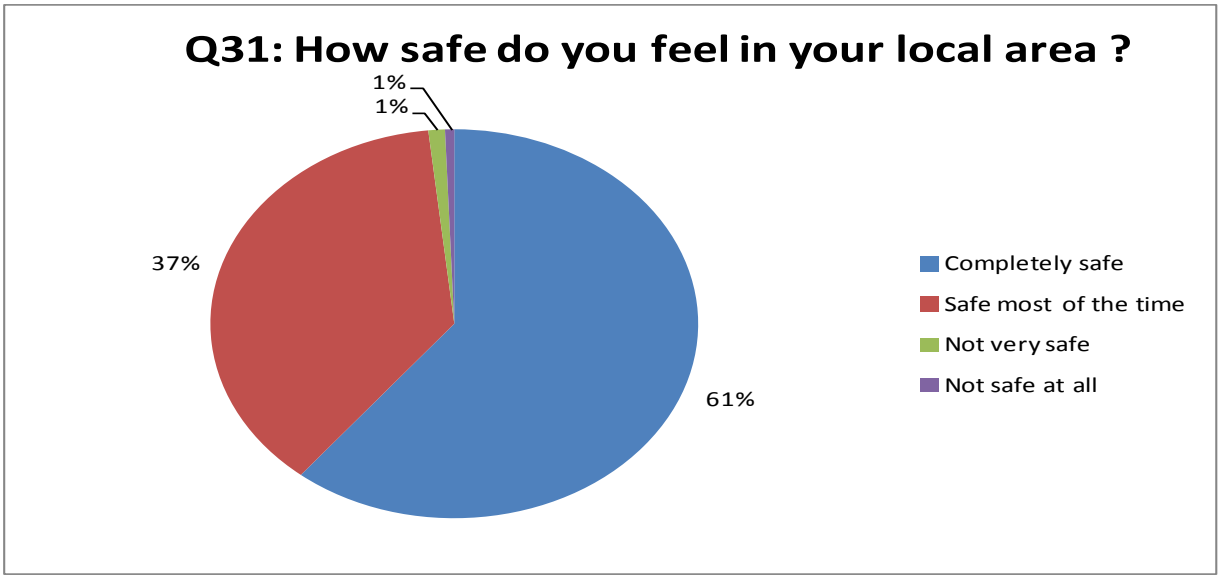
Q30 – How could York city centre be improved?

Respondents were asked to complete a free text box with their suggestions. A high proportion of those answering mentioned the

provision of extra seating and / or toilet facilities. There were also comments about the provision for disabled people and the state of the pavements.

Q31 – How safe do you feel in the area where you live?

Encouragingly, 98% of those who responded to this question felt that their local area was either “completely safe” or “safe most of the time”. There were no real differences in this pattern by sex, age band or marital status. A free text box was offered for people to say why they felt unsafe (if they did), and most gave answers relating to their own fear of crime. Those that answered that they did not feel safe were spread geographically across the City and not clustered in one area.



Q32 – How safe do you feel in your own home?

Around three-fifths (62%) of those responding to this question said that they felt safe in their own home. There was little difference between the various age bands and marital status groups but men (67%) said they felt safer in their own home than women (60%). There was a free text box offered to people to say why they might have felt unsafe but relatively few people gave opinions. Again those that answered that they did not feel safe were not clustered in one area.

Q33 – Are there any particular issues that you worry about in your home or neighbourhood?

A range of issues that were considered to be of interest to older people were listed, and respondents were allowed to choose more than one option if they wished. The most popular answers given were “Fear of falling” (cited by 31% of those surveyed), “Road traffic”, “Theft / burglary” and “Fraud / scams”. A free text box was offered to people to list other issues but not many people gave answers.

Q34 – Do you feel confident that you know how to protect yourself from fraud and/or scams?

Over two-thirds (69%) of those responding to this question said that they “knew how to protect themselves” from fraud / scams, although the percentage of single people saying they did was somewhat lower (60%). There is also something of a decline with age, with 81% of those under 70 responding that they could protect themselves, compared with only 59% of those aged 90 or over. There was little difference between the sexes.

Q35 – Do you feel that the police understand your needs and concerns?

Just under four-fifths (80%) of those responding said “Yes” to this question, so there is confidence amongst older people that North Yorkshire Police take their needs and concerns seriously. There was little difference from this overall proportion amongst the various age groups, marital status groups and between men and women. A free text box was given for people who answered “No” to state why: many of those who answered mentioned that the police were rarely seen in their local area. There was however, no one area of the City where this seemed to be more of an issue than in others.

Q36 – Are you confident the police would respond appropriately if you reported a crime or incident?

Approximately three-quarters (78%) said “Yes” as a response here. Interestingly, there was more faith in the police amongst those aged 90

or over (84% said “Yes”) than amongst those aged 50-59 (65% said “Yes”), and more faith was expressed by women (80% said “Yes”) than men (72% said “Yes”). There was a free text box provided for those who said “No” to this question to explain further, and many of them expressed uncertainty that they would respond in a timely manner.

Q37 – How do you feel about your local neighbourhood?

This question asked whether the respondent knew “lots of” or “a few” people as a proxy for their satisfaction with their local neighbourhood. Just over half the respondents said that they knew “a few people”, with 40% saying they knew “lots” and 10% saying “I just live there”. Single people (19%) and those under 50 (18%) were more likely than others to say “I just live there”. The very elderly, those aged 90 or over (64%) were most likely to say that they “knew only a few people”. There was no geographic clustering of people that answered “I just live there”.

Q38 – How long have you lived in this area?

Respondents to this question were allowed to give a “free text” answer which has been translated into years of residence. The range of responses was, unsurprisingly, quite wide, from 6 weeks to 87 years. The median answer given by respondents (see graph on next page) was 25 years, although this varied amongst the groups – for single people it was 16 years and for widowed people it was 30 years. An interesting discovery was that the median for women (22 years) was less than for men (30 years), suggesting that women were more likely to have settled in their current area later than men did.

Q39 – Is there anyone to whom you could go and call on?

Encouragingly, the vast majority (87%) of those responding to this question said that they had someone they could call on, and, interestingly, this appeared to increase with age – only 73% of the under-60s said they could call on someone, compared with 89% of those aged 80 or over.

Transport

Q40 – What is your most frequent form of transport?

People were given a range of transport modes to choose from, and could choose more than one. The mode of transport chosen by most respondents was the bus (53% ticked this box). The next most common transport modes were to travel by car (selected by 49%), walking (chosen by 43%) and a taxi (picked by 27%). Car use declined with age: 70% of those under 60 drove, compared with only 33% of those over 90. Another interesting finding is that 71% of married people said they drove, but only 37% of divorced, single and widowed people drove. Bus use is highest amongst 70-79 year-olds (72% of them said they use them), and lowest amongst widowed people (only 46% used them).

Q41 – Do you have use of a car?

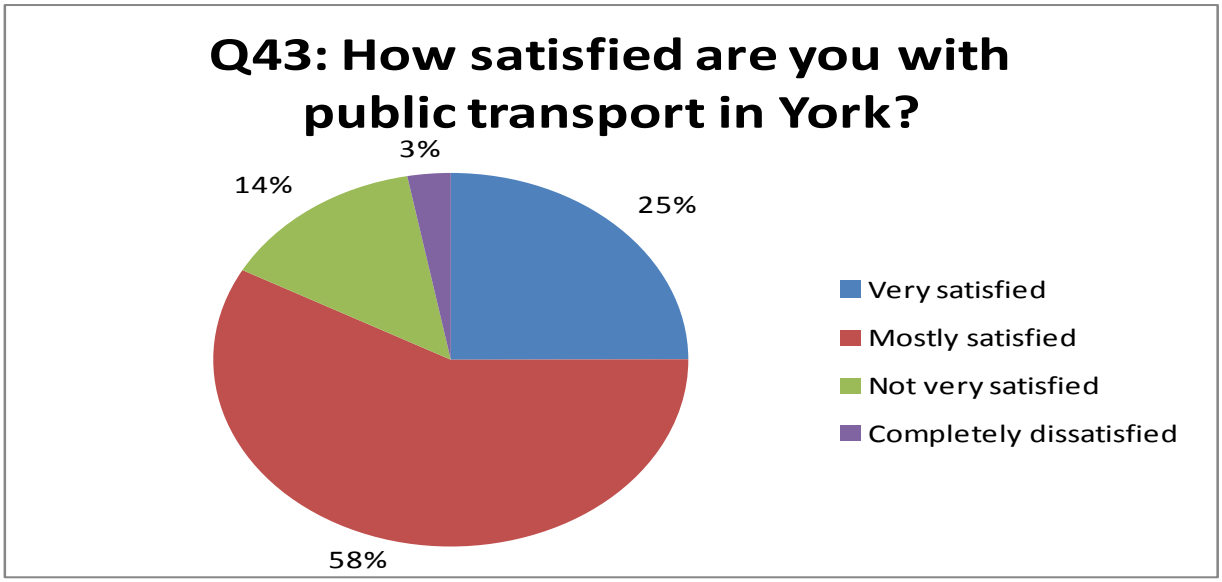
Just over half (56%) of those responding to this question said they had use of a car. There was a decline with age in use, with 85% of those under 60 saying they had use of one, declining to just 32% of those aged 90 or over. Almost half (47%) of those aged 80-89 used a car. Overwhelmingly, married people (81%) who said they used a car, rather than widowed or single people (both 36%) and divorced people (just 29%) who used one; married people are more likely to have access to the finances necessary to run a car. Men (65%) were more likely than women (52%) to say they used a car.

Q42 – Do you have a Disabled Person's Blue Badge?

Just over a third (35%) of those responding to this question said that they had a Blue Badge, and there was some variation amongst the groups: 47% of those widowed said they had one, compared with just 26% of single people; 62% of those aged 90 or over said they had one; however, just 18% of those under 60 did and this percentage declined amongst the younger age bands. The rate of those saying they had a Blue Badge was much higher in the North of the city (47%) and lower in the East of it (29%).

Q43 – How satisfied are you with the public transport in York?

The majority of those responding say they are at least “mostly” satisfied with public transport in York (83% said “Very” or “Mostly” satisfied). The least satisfied group were those aged 50-59, where only 68% of those responding gave one of these answers. There was little variation between the sexes or the various “marital status” groups. A free text box was given for comments about public transport – many of the comments were positive about the frequency of buses but there were many negative comments about the lack of services in the evening.



Q44 – Are there any other barriers to getting about in York (e.g. health condition, car parking facilities, lack of seating, lack of public toilets etc.)?

This was offered as a free text box to respondents, and thus is difficult to analyse quantitatively, but many of the responses made references to the lack of seating, car parking (references were made to how expensive it is) and public toilets in the city centre, and many cited having a health condition as a barrier.

Finances

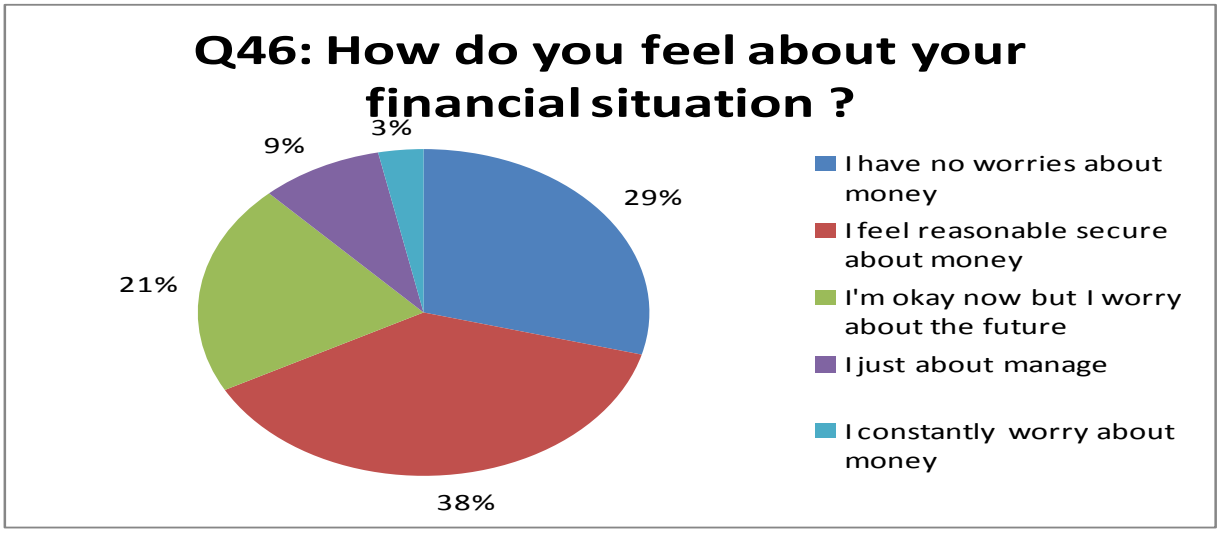
Q45 – Do you work?

Given the audience for this survey, it is little surprise to discover that only 93 (10%) of the respondents said they worked, either full-time or part-time, and 85% of those were under the age of 70. The majority (66%) of those under the age of 60 said they worked to some degree, but only 20% of those aged between 60 and 69 worked. Women (72% of those working) were much more likely to be working part-time than men (52% of those working). Of married people, 16% said they worked, compared with just 1% of widowed people. The finding that two-thirds of those working were doing so on a part-time basis was generally commonly found by age and marital status.

Respondents could also say if they were retired or volunteered. The highest percentage of retirees were widowed people (72%) compared to 65% in the group as a whole, which is not that surprising. One in every ten of those surveyed said they volunteered, with the highest rates of volunteering found amongst 60-69 year-olds (19% said they did) and divorced people (17% said they did).

Q46 – How do you feel about your financial situation?

A range of responses were offered to this question, from having “no worries” about money to “constantly” worrying about it. The most frequent answer given was “I feel reasonably secure about it” (see graph on next page), with 38% of those responding giving this. Just 12% said that they “just about manage” or they “constantly worried” about it, but this was higher amongst divorced people (22%) and single people (21%). There was an increase in financial security with increasing age, with younger people tending to worry more about it than the very elderly. There was no difference found between men and women.



Q47 – What is your total weekly income before paying bills (including benefits)?

Those surveyed were given a range of income bands – over £400, between £201 and £400, between £81 and £200, £80 or less, and they were also allowed to state that they would "rather not say" what it was; this proved to be the most frequently cited answer (given by 42% of respondents). Of those that gave an income band, the most frequent one was "between £81 and £200" (given by 22% of those responding). Not surprisingly, incomes appeared to be highest amongst married people (18% of them said they had over £400 of income per week, compared to 12% of the whole group) and lowest amongst single people (4% had income of over £400 per week). The percentage saying they had over £400 per week declined with age, and men (18%) were much more likely than women (10%) to earn the highest amounts.

Q48 – Do you claim any benefits? If so, what are they?

A list of benefits was provided to respondents, along with a free text box for people to say if they received any others, and people were allowed to select more than one option. A council tax reduction was the most frequently cited benefit that people claimed – stated by 25% of those replying (particularly in the North of the city – 36% of responders said they claimed it). Attendance allowance was claimed by one-sixth of those surveyed. Attendance allowance was the most frequently "other"

benefit mentioned by respondents (17% did so, but this rose to 26% amongst those resident in the city's North area).

Q49 – Where would you go for advice about benefits?

Those surveyed were given a range of options as to how they could find advice about benefits, and were given the option to tick more than one box if they needed to. They could also say if they did not know how to go about finding advice about benefits. Around one-third of respondents said that they would contact Age UK; the main other providers of advice mentioned were "Friends / family" and the Citizen's Advice Bureau, which were mentioned by around one-quarter of respondents. Only 10% of respondents said that they did not know how to access advice about claiming benefits, so it would seem that knowledge about how to claim benefits is pretty widespread amongst older people.

Q50 – Are you reluctant to claim benefits?

Most people appear to be quite happy to claim benefits, with 69% of those responding saying "No" to this question. There were few differences discovered in this pattern of response amongst the various age bands, marital status groups or between sexes. A free text box was provided for people to add further comments, and some of the responses cited that there were "too proud", or similar, to claim them.

Planning for the future

Q51 – Have you moved house to better meet your needs in older age?

Only one-third of those responding to this question said they had moved house. This did vary amongst the age bands, with only 20% of those under 60 saying they had, compared with 43% of those aged 90 or over. Women (35% saying they had moved) were likely to have moved than men (27%). There was little variation by "marital status" in responses to this question.

Q52 – Have you had adaptations or aids fitted in your home?

Just over half (51%) of those responding to this question said that they had fitted adaptations or aids. Those who had been widowed were far

more likely to have done so (70% of them had) than other groups; only 40% of those who were married had done. Perhaps unsurprisingly, the likelihood of having adaptations / aids increased with age, with 84% of those aged 90 or over having done so, compared with just 23% of those aged under 60. There was little difference in response between the sexes. There was a much higher percentage answering that they had in the North of the city (63% of those responding said they had adaptations / aids) and a lower percentage in the city's East (40% gave this response).

Q53 – Have you made a will?

The vast majority (85%) of those answering this question said that they had made a will, with widowed people being the most likely to have done so (91% of them did), and single people being the least likely (71% of them said they had). Likewise the percentage having done so rose with increasing age, with only 61% of those under 60 having made a will, compared with 97% of those aged 90 or over. There was no difference in the percentages reported between the sexes.

Q54 – Have you made an advanced directive?

The majority of people (59% of those responding) said that they had not made one, although the next most popular answer was "I don't know what that is", cited by 24%. Widowed people were most likely to have made one (24% compared to 17% of all respondents); married people least likely (70% of all respondents). As could be expected, the likelihood of people making one increased with age, with only 5% of those aged under 60 having made one, compared with 24% of those aged 80 or over; interestingly those aged 90 or over were most likely to say they did not know what an advanced directive was. The pattern of answers given by men and women were broadly similar.

Q55 – Have you organised power of attorney?

The answers were broadly evenly split between "Yes" (49%) and "No" (48%) with 3% of responders saying that they "Did not know" if they had organised it. Those who had been widowed were far more likely to have organised it (67% of that group had) than divorced (37% of that group

had) or single (38% of that group had) people. Unsurprisingly, the likelihood of a “Yes” response increased with age, with only 20% of those under 60 saying they had organised it compared with 74% of those aged 90 or over. There was no significant difference in the response between the sexes.

Q56 – Have you talked to family / friends about your wishes if you become unwell?

Almost two-thirds (63%) of responders said that they had talked to family / friends about what to do in this instance, but this masks considerable variation within the groups. Only 43% of single people said “Yes” to this question, compared with 77% of widowed people. As with many questions in this survey, the likelihood of a “Yes” answer increased with age, with just 39% of those aged under 60 saying so, compared with 78% of those aged 90 or over. Women (64%) were more likely to say “Yes” to this question than men (57%).

Demographics

Q57 – Are you male / female or do you prefer not to say?

Of the 912 responses received, 577 (63%) were from females, 236 (26%) were from males, 3 (0.3%) ticked the “Prefer Not to Say” box and 96 (11%) did not give an answer. This pattern of responses is broadly in line with what could be expected, given the demographics of older people in the city which show that women outnumber men by almost a 2:1 ratio amongst those aged 80 or over.

Q58 – What is your age?

Although the survey was aimed at those of an “older age”, there is no clear definition of what age that could be considered as such. The survey was distributed by a number of organisations working with older people in the city, but that does not mean that it was exclusively answered by those that would normally be thought of as being of an “old age”. The ages were grouped into bands: 17 (2%) of replies came from those under the age of 50, 50 (5%) were from those aged 50-59, 177 (19%) were from those aged 60-69, 210 (23%) were from those aged 70-79, 267 (29%) were from those aged 80-89 and 100 (11%) were from

those aged 90 or over. 91 (10%) of those replying did not have their age recorded. People responding in the North of the city tended to be older (81% were aged 70 or over, compared with 69% in the East and West of the city).

Q59 – What is your marital status?

Six choices were given to respondents to state their marital status. The most frequent answer given was “Married”, stated by 347 (38%) respondents. The next biggest group was “Widowed”, stated by 274 (30%). There were 90 (10%) single and 86 (9%) divorced people who participated. Co-habiters and those in civil partnerships provided answers to 25 (3%) of the surveys. No answer to this question was given by 90 (10%) responders. As the number of co-habiters and those in civil partnerships is low, they have been excluded from the analysis given above because the percentages for them tended to be more extreme from those given by other groups.

Q60 – What sexual orientation do you identify as?

Unsurprisingly, given the answers to Q59, 738 (95%) of the 777 responders to this question said they were “Straight / heterosexual”. 22 (3%) of the responders preferred not to say their sexual orientation, whilst 9 (1%) said they were “Lesbian, gay / homosexual”. The other 8 (1%) said they were “Bisexual, Not sure” or “Other”. Some 135 (15%) of those surveyed chose not to answer this question, which is a higher rate of non-response than for other questions, suggesting that the true rate of those who do not identify as “Straight / heterosexual” may be slightly higher than given here. People were invited, via a free text box, to add comments to this and most people gave comments that were analogous to “Straight / heterosexual”. A few found it intrusive.

Q61 – What ethnic origin do you identify as?

The Census categories for ethnic origin were used in the survey, and 794 (87%) people responded with an answer of some description. Those who did were overwhelmingly “White British”: 767 (97%) gave this answer, with a further 15 (2%) stating they were “White Other” and 6 (1%) “White Irish”. Only six responses were received from those

indicating a “non-white” ethnic origin. There were 118 surveys returned with no ethnic origin stated. This explains why there are no breakdowns to any of the questions above by ethnic origin, the “non-white” group being too small to conduct any meaningful analysis.

Q62 – Do you have any long-term health conditions (e.g. diabetes, heart disease, depression, sight / hearing loss)?

Given the population surveyed it was not surprising to discover that 76% of those responding said they had a long-term health condition. The highest rates of those saying “Yes” to this question were to be found amongst widowed (84%) and divorced (83%) people; married (70%) were less likely to have said “Yes”. As with so many health-related questions, the likelihood of a “Yes” answer here increased with age, with just 49% of under 60s giving this answer compared with 88% of those aged 90 or over. Men (83%) were more likely to have had one than women (73%).

Q63 – How many long-term health conditions do you have?

This follows on from Q62 and most of those saying “Yes” are likely to have answered it. An open-ended response was offered; the answers ranged from 0 to 16, with the most frequently given (and median) answer being 2. Only 7% of responders said they had more than four long-term health conditions. Only the relatively young (those aged under 60) and married people deviated significantly from this pattern of response; they were more likely to have had only have one long-term health condition. There were some interesting geographical variations found; although the median in all three areas was 2, in the East the most frequently given answer was 1, in the North it was 2 and in the West it was 3.

Q64 – Do you provide regular care for a relative or friend?

Less than one in every five (18%) responses to this question were “Yes”, although there were significant variations amongst the groups. Of married people, 32% said that they provided regular care, but just 3% of widowed people did so. The ability of people to provide care appears to decline with age: 33% of the under-60s mentioned that they helped someone else, but this was just 6% amongst those aged 90 or over.

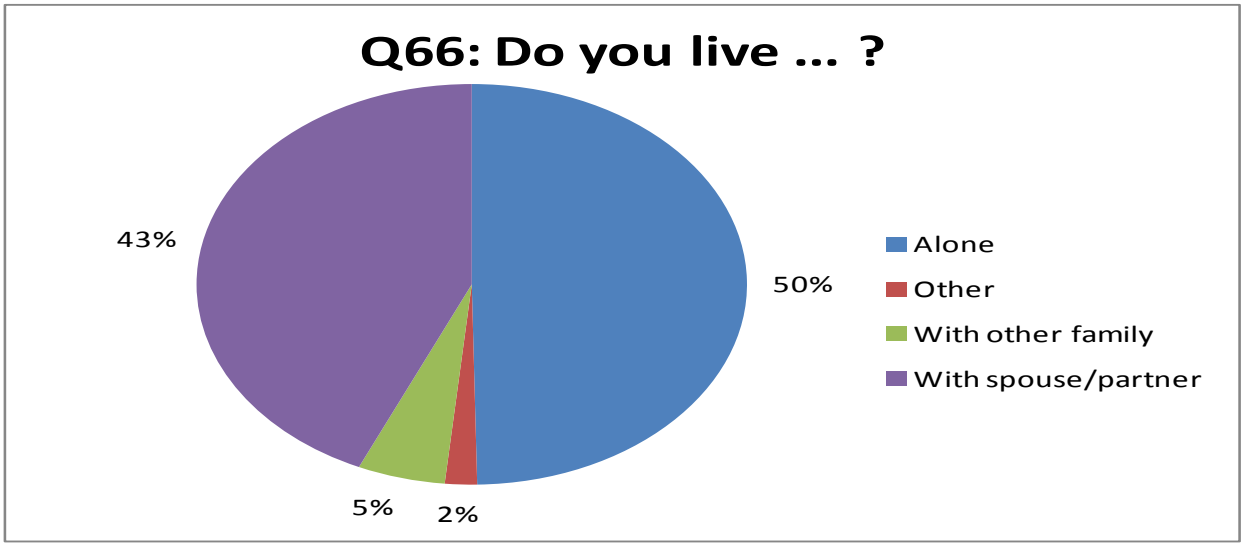
There was no difference reported between the sexes as to whether they cared for someone else or not. There was also a box provided for those who do provide regular care to state how long they cared for someone on average per week. Although relatively few people gave an answer, the most common answer was that they cared for someone “constantly”.

Q65 – What type of accommodation do you live in?

Of those that responded to this question, 80% of them said that they lived in accommodation that they “owned”, 11% said that they rented (either from the council or privately), and the remainder were in a housing association property or in sheltered accommodation / extra care housing. Married people were most likely to “own” their property (90% said they did), with single people being least likely (only 52% reported they did). Single people were also most likely to be renting from the council (20% of those did) and be in sheltered accommodation / extra care housing (11% said they did). Age appeared to make little difference to the type of accommodation lived in, and there was no real difference between the sexes either.

Q66 – Do you live alone, with other family, with a spouse / partner or with other people?

Almost exactly half of those responding to this question said that they lived “Alone”, with a further 43% living with a spouse/partner. (It is possible that some of those responding may live in some form of residential accommodation and thus may live in a building occupied by other people, but this is how they chose to consider themselves). The vast majority (89%) of those describing themselves as “divorced”, “single” or “widowed” lived alone. The likelihood of living alone appears to increase with age: 16% of those under 60 lived alone, compared with 81% of those aged 90 or over; correspondingly the likelihood of living with a spouse/partner similarly declines with age (64% amongst the under-60s; 11% amongst those aged 90 or over). Women are much more likely than men to live on their own (57% compared with 33%); men are much more likely to live with a spouse/partner (62% compared with 36% of women). The pattern is slightly different in the North of the city, where 59% lived alone and only 36% with a spouse/partner.



Q67 – Do you have children near by who would be able and willing to support you if needed?

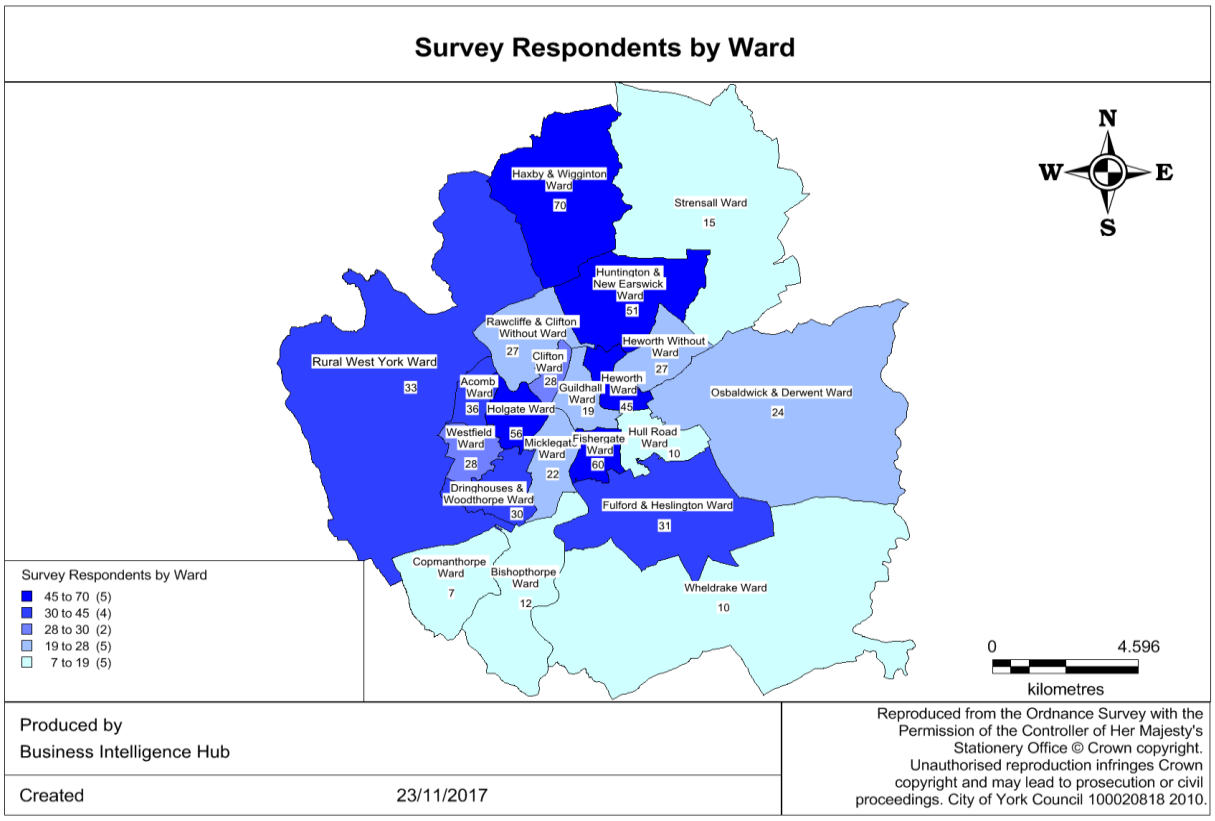
The responses to this question were almost exactly split between "Yes" and "No" responses. Widowed people were the most likely group to say "Yes" (62% did), single people the most likely group to say "No" (89% did). The pattern amongst the various age groups was not noticeable different from the overall pattern, and there was little difference found between men and women in the likelihood of children living nearby.

Q68 – Are you linked to any kind of personal assistance alarm?

Just over one-third (34%) of those responding to this question said they had a personal assistance alarm. There was considerable variation amongst the "marital status" groups, with 58% of those widowed saying that they had one, compared to just 15% of those who were married (but widowed people are more likely to live alone (see Q66)). Only those aged 90 or over (76% of them did) were more likely to answer "Yes" than "No" to this question, with comparatively few under the age of 70 seeming to have the need for one. Women (37% said "Yes") were more likely than men (28% said "Yes") to say they had one. People in the North of the city were more likely to have had an alarm (47% did) than elsewhere.

Q69 – Your post code?

The purpose of collecting the postcode would be to allow further analysis of these results by area to see whether there are any further differences in the analysis given above by local area level. The post code information was mapped to each of the city's 21 wards (see map on next page). Of the 912 respondents, it was possible to match the post code, where it was given, to wards in 641 (70% of) instances. Approximately half of the respondents lived in six wards: Acomb, Fishergate, Haxby and Wiggington, Heworth, Holgate and Huntington and New Earswick. Every ward in the city had at least seven respondents to the survey. Although there was variation between the wards, there was a reasonably equal split of responses received amongst the city's three Local Area Teams – see table below.



LAT / Ward	Responses
East LAT	**209**
Fishergate	60
Fulford & Heslington	31
Heworth	45
Heworth Without	27
Hull Road	11
Osbaldwick & Derwent	24
Wheldrake	11
North LAT	**216**
Clifton	28
Guildhall	20
Haxby & Wigginton	73
Huntington & New Earswick	51
Rawcliffe & Clifton Without	28
Strensall	16
West LAT	**226**
Acomb	36
Bishopthorpe	12
Copmanthorpe	7
Dringhouses & Woodthorpe	30
Holgate	56
Micklegate	23
Rural West York	33
Westfield	29
No postcode given / no match	**271**

Q70 – Do you use the internet?

Just over half (53%) of respondents to the survey said they used the internet. Only 32% of widowed people said they used it, compared with 66% of married people. There was a decline in the likelihood of use with age: 89% of those under 60 said they used it, but just 16% of those aged 90 or over mentioned that they did. Men were more likely than women to have used it (60% compared to 51%). Internet use was a lot lower in the North of the city (only 41% said they used it) compared with the East (57% said they did).

Q71 – Please use this space to add any further comments that you would like to make about how life could be improved in York.

As this is a free text box, a rather eclectic range of comments resulted from those answering the question and thus cannot be quantitatively analysed.

Conclusions

The responses to this survey show that, although the experiences of older people living in York contain much that is positive – they generally feel safe, they are fairly sociable and are in good health – they tell us that there is a lot more that could be improved in the city: things such as providing seating in the city centre; making public transport more accessible; and making information and advice more easily available.

The most positive answers to questions were given by those who were relatively young and / or married; negative answers were mainly given by those who were elderly (particularly those aged 90 or over) or widowed (there is a big cross-over in these two groups), suggesting that there is more that could be done to help these groups of people.

There was little analysis that could be done looking at responses for ethnic minorities or for those of non-heterosexual sexual orientation because of the low numbers of people defining themselves as being part of these groups. This reflects, in part, the small population of those older people who are of non-white ethnic origin in the city.

Responses in different geographic areas (at Local Area Team level) have been given in the commentary where significant variances between these areas have been found; in many instances the differences between areas were insignificant. The responses would suggest that those older people living in the area covered by the North Local Area Team were less likely to feel positive about their lives. It would also be interesting to further cross-analyse responses between some of the questions given here, to see whether, as an example, those living alone are in poor health; or examining whether more could be done to encourage widowers to use the city's buses.

Recommendations

The results from the survey have highlighted a number of issues that the partner agencies involved in the survey would like to make the following recommendations on:

Information and advice

- All organisations should have the means of providing information in written format.
- It is noted that the City of York Council are taking on board the difficulty in finding information on social care services through their Future Focus work programme. This will address a number of comments made by people within this survey and must continue.
- City of York Council and York Hospital Trust should take a full page advert in the local phone book setting out phone numbers, locations, and contact details for all services provided including for CYC, Sheltered Housing, Extra Care and Residential Schemes. Older people cited the entry for East Riding of Yorkshire Council as being more accessible

Social interaction

- City of York Council should re-look at the provision of the park and ride service in the evening.
- The MS society should consider the findings from this study in the work they are leading on in the provision of community transport in York.
- Bus services in York should have audio visual information provided on board to increase accessibility in accordance with section 17 of the Bus Services Act.
- The Business Improvement District (BID) and CYC should take note of the results of the survey and consider how access to seating and toilets can be improved in the City Centre. For example such as Eastbourne Community Toilets https://eastbournecommunitytoilets.accessibleeastbourne.net/abou

t and what can be done to improve the quality of pavements in the City Centre.

- The results of the survey should be shared with Make it York to help them in tailoring the cultural offer to York's older residents.
- York CVS and partners, in delivering their volunteering strategy, should particularly consider how older men can be engaged in volunteering.

Health

- The City of York Yorwellbeing Service should develop information on physical activity guidelines for older people, particularly the importance of strength based activities and ensure older people have information on local clubs and activities.
- Community Pharmacy North Yorkshire should take note of the results of the survey and work with local pharmacies to promote their use and the range of services they offer, especially for older people.
- The CCG and City of York Council should consider how use of self monitoring can be promoted within primary care and Social Care.

Independence

- It is noted that the City of York Council have taken on board the results of this survey and increased capacity of the handyman service. In addition it is noted that the gardening service has been sustained, minimising impact from required efficiencies and creating a more equitable service. This needs to be maintained.
- The toe nail cutting service is valued by older people. Partners across the City should work together to consider how access to toe cutting can be sustained.

- CYC should promote and market the Handyperson, Gardening and Toe cutting services and ensure the resources are available to meet demand.

- 30% of older people are concerned about falls. Partners should work together to consider how falls can be prevented and to ensure that consistent messages about falls prevention are given to older people.

- The findings within the survey on telecare have been passed onto the City of York's Adult Commissioning Team for consideration when re-tendering the service. CYC, CCG and the York Hospital Trust should promote and market the services offered by the new provider in sustaining older people's independence at home.

Safety

- The responses to safety in York were very positive and this good work needs to continue. As scams and frauds change older people need to be kept aware of these.

Health and Wellbeing Board 24 January 2018

Report of the Head of Joint Commissioning Programme, NHS Vale of York Clinical Commissioning Group (CCG) and City of York Council.

Better Care Fund Update

Summary

1. This report is for information. It sets out the following:

- An update on the Better Care Fund (BCF) assurance process.

Background

2. The Health and Wellbeing Board has received regular reports from the joint chairs of the Better Care Fund Performance and Delivery Task Group. These reports have informed the board of planning requirements and assurance processes for the 2017-19 period. This report includes an update on the current position.

Main/Key Issues to be Considered

Better Care Fund

3. The Integration and BCF Narrative Plan 2017-19 was submitted on 11th September 2017, in line with the prescribed timetable.

4. The Better Care Fund assurance process is carried out at both the regional and national levels. York's plan was included in the national assurance and escalation process. This was ongoing at the time of the previous report to the Health and Wellbeing Board. The wording of the BCF narrative plan 2017-19 has been amended to reflect the outcome of the escalation process relating to the Delayed Transfers of Care target and the coding of certain schemes. The plan is unchanged in relation to the funding of schemes. (Final version attached at Annex 1).

5. We received written confirmation that the York Plan was approved on 20th December 2017, (letter attached at Annex 2).

CYC and the CCG may now proceed to sign the section 75 agreement to pool the BCF fund, in accordance with the plan. The agreement is being updated to reflect the current governance arrangements.

Consultation

6. None.

Options

7. Not applicable.

Analysis

8. Not applicable.

Strategic/Operational Plans

9. As above:

- Integration and Better Care Fund Plan

Implications

10. One of the key challenges facing partners is our stated desire to progress shared initiatives and grow the level of pooled resource whilst managing the on-going system pressure. Movement towards an accountable care system with localised planning and delivery provides a platform to develop this intent.

Risk Management

11. Risks which have been previously reported to the board in relation to BCF remain relevant.

Recommendations

12. The Health and Wellbeing Board is asked to note this report.

Reason: To keep the Health and Wellbeing Board informed of progress.

Contact Details

Author:

Pippa Corner
Head of Joint Commissioning Programme.
CYC / NHS VOY CCG
01904 551076

Chief Officer Responsible for the report:

Martin Farran
Corportae Director: Health Housing and Adult Social Care
City of York Council

Report Approved ✓ **Date** 16.01.2018

Phil Mettam
Accountable Officer
NHS Vale of York Clinical Commissioning Group

Report Approved ✓ **Date** 16.01.2018

Specialist Implications Officer(s) *List information for all i.e*
None

Wards Affected: **All** ✓

For further information please contact the author of the report
Annexes

Annex A – Final Better Care Fund Plan
Annex B – Better Care Fund Approval Letter

This page is intentionally left blank

ANNEX A

CITY OF YORK COUNCIL

NHS Vale of York Clinical Commissioning Group

INTEGRATION & BETTER CARE FUND NARRATIVE PLAN 2017/19

ANNEX A

Contents

Introduction

We start this year in a great place…

- ❖ We have a jointly agreed plan
- ❖ We have a balanced plan
- ❖ We have had some successes in 2016/17 and are building on these
- ❖ We have better partnerships that are more resilient
- ❖ We are collectively committed to integrating services and removing obstacles
- ❖ We recognize the connections across the different parts of our local system and continue to try and work through barriers

These are great achievements for any system but are especially significant given the position we started from last year. We intend to carry on building on our success to make things better for people living in the footprint of the York HWB.

The Better Care Fund (BCF) 2016/17 plan focused on the move to jointly commissioned activities contributing towards a set of shared strategic objectives. The plan for 2017/19 continues this intent and includes existing BCF schemes, system wide pilots that require on-going funding and new schemes to address areas that require greater focus as part of the integration agenda locally.

There is a high level of consensus about the characteristics of an integrated health and social care system for York. We believe that the progress made to date from the existing BCF arrangements gives us a platform to build on and move towards fuller integration by 2020. The areas that we are already working on but would want to see strengthen include:

- ✓ Integrated place based commissioning
- ✓ Integrated service delivery teams
- ✓ Local area co-ordination
- ✓ More self-care, self-management
- ✓ A greater focus on well-being, emotional and mental health

Delivering this is not without challenge – the current key features of the York HWB health and social care landscape are:

- ➢ A long standing challenging financial picture across the commissioner and provider base
- ➢ A high level of reliance on hospital based services by the public driven by historic underfunding of community-based alternatives
- ➢ An acute trust provider that has historically delivered good performance but is now facing significant financial challenge and deteriorating performance

- A high level of self-funders using care home services
- A fragile domiciliary and home care market
- A vibrant retail and tourism sector which impacts on the available workforce in the health and social care sector
- An articulate and well-informed population who demand access to statutory services

Despite adult social care being one of the largest spending areas of the council (£73.1m gross and £47million net, which is 39% of total net budget for the council), spend per head of population is low (bottom quartile) compared to using statistical neighbours[1] as a benchmarking tool. Demographic, demand and cost pressures are reaching critical levels. Workforce and provider cost pressures are having an impact during the current financial year (2017/18). Plans are in place to achieve £1.783m efficiency savings in current financial year. These savings, in addition to use of the Adult Social Care precept and funding from iBCF, will go some way to assisting with these pressures. Most importantly however is the work to transform the nature of care and support within York and manage demand by tapping into the assets of the local community and promoting approaches based on early intervention and prevention.

Vale of York CCG is currently operating under the special measures regime and legal directions from NHS England, put in place effective 1 September 2016. The CCG was required to produce an Improvement Plan outlining how it would improve the capacity, capability and leadership in the CCG alongside delivering the changes needed to recover the financial position to one that is sustainable for the future. Building on this, the CCG has developed and approved a Medium Term Financial Strategy (MTFS) which has been shared widely with partners and sets a course for financial balance by 2020/21.

To address these challenges, we want to harness our shared assets to create a different response to managing demand. We will do this by developing whole community, shared system solutions. Partners recognize the difficulty in meeting individual organizational pressures whilst working collaboratively but understand that sustainable solutions to the challenges we face requires partners to work together to address the health and social care pressures in the local system.

[1] Local authorities that Chartered Institute of Public Finance and Accountancy (CIPFA) have grouped together as sharing similar characteristics therefore providing a cohort that can benchmark against each other.

Our local vision and model of delivery

Our local vision is embodied within the Joint Health and Wellbeing Strategy which has been reviewed and updated for the period 2017 to 2022 (***https://www.york.gov.uk/downloads/file/12806/joint_health_and_wellbeing_strategy_2017_to_2022***). The review has taken into account the views of local residents, intelligence from the Joint Strategic Needs Analysis (JSNA),local plans and wider system plans.

Our ambition is for every single resident of York to enjoy the best possible health and well-being throughout the course of their life: by promoting greater independence, choice and control, building up community support; by supporting self-care and management; with greater use of early help through targeted/short term interventions; by imaginative use of new technology; with fewer people using statutory services.

Ref: Joint Health & Wellbeing Strategy (2017-2022)

The Joint Health and Wellbeing Strategy (JHWS) concentrates on four themes: mental health and wellbeing plus three life stages. Within each theme a top priority has been set out with additional key priorities under each theme (see Table 1).

The York BCF is based on shared system outcomes overseen by the York Health & Wellbeing Board (HWB) within the wider context of the Vale of York population from a CCG perspective; and neighboring authorities (North Yorkshire and East Riding) from a social care perspective. The York BCF sits within the emerging footprint of the Humber, Coast and Vale Sustainability and Transformation Plan.

The vision for the Humber, Coast and Vale Sustainability & Transformation Plan (STP) reflects similar themes to that of the local HWB strategy:

To be seen as a health and care system that has the will and the ability to help people 'start well, live well and age well'

To achieve the STP vision we aim to move our health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves. The STP plan focuses on the wider determinants of health in our footprint, with all public services working together to support people to take more responsibility for their own health.

The wider system (STP) approach is to develop new models of care across the constituent population, supported by strategic commissioning across the acute health system. This builds on the ideas put forward in the Five Year Forward View

and best-practice national and international examples of whole population management and outcomes-based commissioning for health and social care. (*https://www.hey.nhs.uk/wp/wp-content/uploads/2016/11/stp.pdf*)

Mental Health and Wellbeing	Starting and Growing Well	Living and Working Well	Aging Well
Get better at spotting the early signs of mental ill health and intervening early	Support for the first 1001 days, especially for vulnerable communities	Promote workplace health and remove barriers to employment	Reduce loneliness and isolation for older people
Focus on recovery and rehabilitation Improve services for young mothers, children and young people Improve the services for those with learning disabilities Ensure that York becomes a Suicide Safer city Ensure that York is both a mental health and dementia friendly environment	Reduce inequalities in outcomes for particular groups of children Ensure children and young people are free from all forms of neglect and abuse Improve services for students Improve services for vulnerable mothers Ensure that York becomes a breastfeeding-friendly city Make sustained progress towards a smoke-free generation in York	Reduce inequalities for those living in the poorer wards and for vulnerable groups Help residents make good choices Support people to maintain a healthy weight Help people to help themselves including management of long-term conditions Work with the Safer York Partnership to implement the city's new alcohol strategy	Continue work on delayed discharges from hospital Celebrate the role that older people play and use their talents Enable people to recover faster Support the vital contribution of York's carers Increase the use of social prescribing Enable people to die well in their place of choice

Table 1: Four Themes for Health & Wellbeing in York 2017- 2022 (JHWS)

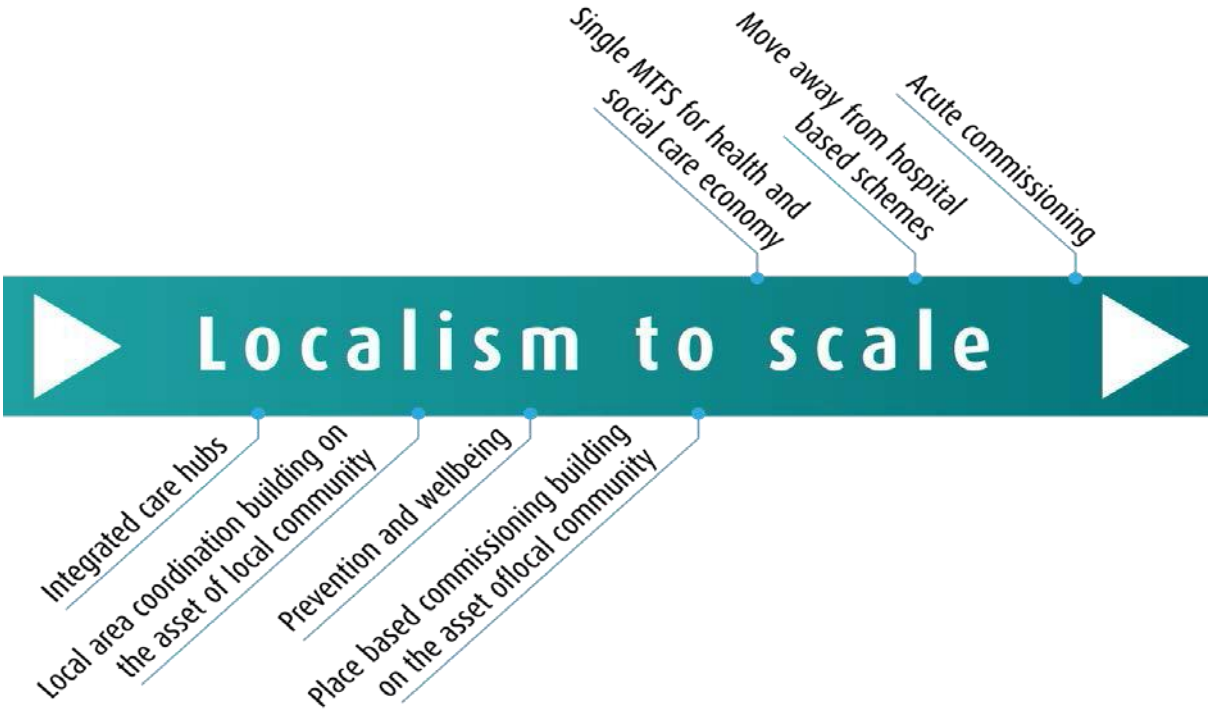
How our local vision will be achieved

System first, organisation second

The Better Care Fund continues to influence how we join-up health and social care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. However, we cannot rely on the BCF in isolation to resolve some of the complex pressures facing our joint health and care system to deliver our local vision for 2020. The most fundamental change facing the current system requires partners to work together to shift away from statutory agencies meeting needs through the provision of services and medical interventions, towards working with individuals and communities to support self-help and self-care. This will require all agencies to shift the focus of commissioning activity upstream towards early intervention and prevention.

Combining the benefits of scale and localism

We want to use the resources available to us in the most effective manner possible. This means that we will use our assets at scale or locally, depending upon the outcomes we are trying to achieve. Graphic 1 sets out the approach we will take across this continuum for different aspects of health and social care.



Graphic 1: Localism to Scale –JHWS Vision

Integrated service delivery

We will continue to develop and deliver integrated models of service to improve the experience and outcomes of people who we support. This is based on the consistent messages from local people about only wishing 'to tell their story once' and the challenges of navigating the 'system'. Local providers are committed to working together to improve the efficiency and effectiveness of their services.

Prevention through self-care and self -management

Empowering people with the confidence and information to look after themselves when they can, and access statutory services when they need to gives people greater control of their own health and encourages behaviours that help prevent ill health in the long-term.

More cost-effective use of statutory services allows money to be spent in local priority areas to focus on improved health and care outcomes. Furthermore, increased personal responsibility around healthcare helps improve people's health and wellbeing and better manages long-term conditions when they do develop. There is a significant opportunity for us to more closely connect the support available through community assets and third sector provision in the York HWB.

Background and local context

York's population is now estimated to be just over 200,000 people. By 2025, it is estimated that:

- the 65+ population in York will have increased by 16%
- the 85+ population in York will have increased by 32%
- the 0-19 population will have risen by about 9%

York's population is, on the whole, healthy (in a recent survey, 83.9% stated that they are in very good or good health compared to 80% regionally and 81.2% nationally). But this is not true of all communities and groups.

The city has become more culturally and religiously diverse with a Black and Minority Ethnic (BME) population of 9.8% (non-White British) compared to 4.9% in 2001.
If we look at 'York in a nutshell' (see Graphic 2) we can illustrate what the composition of York would be like if it was a village of 100 people based on available data. (October 2016).

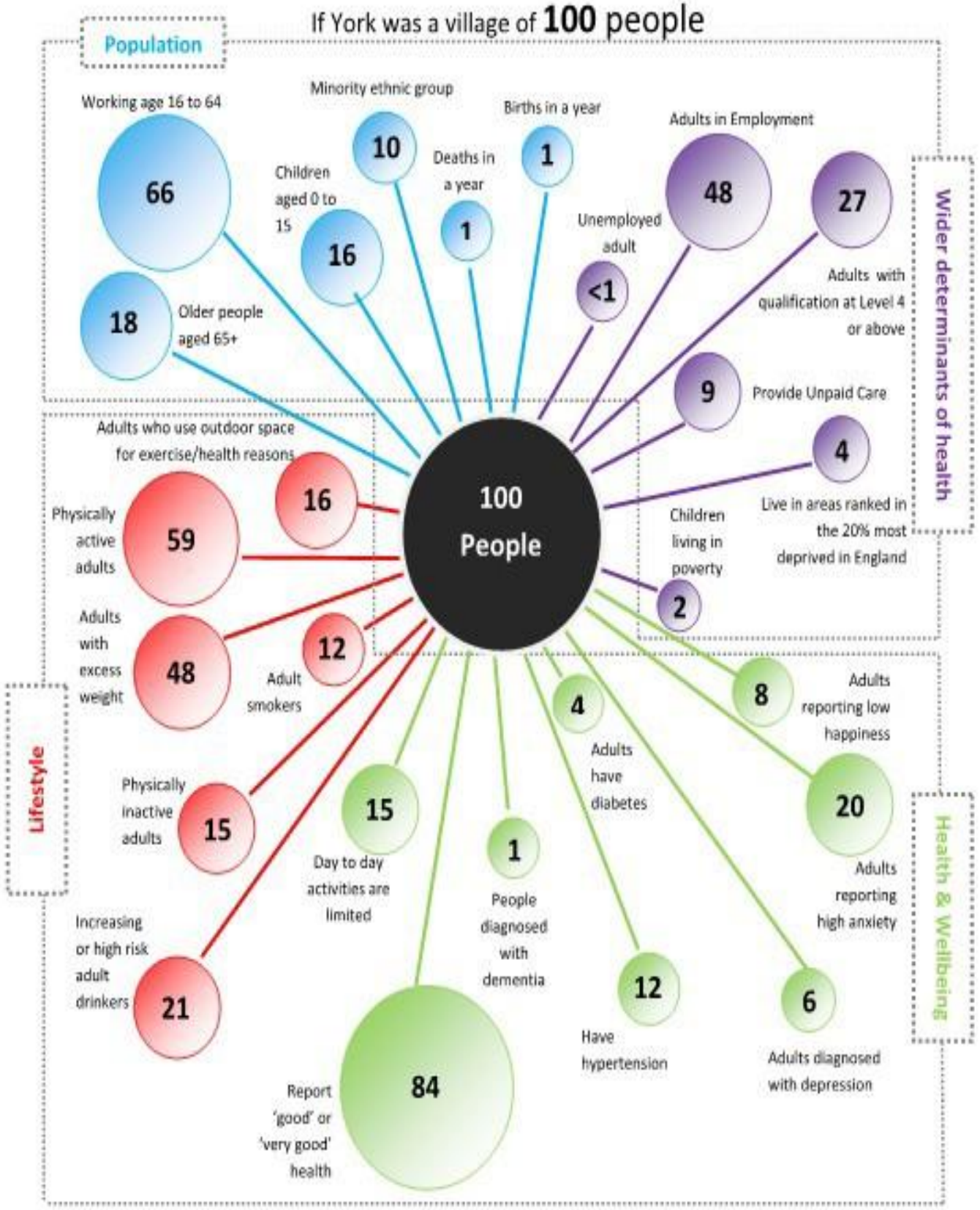
This shows that the York HWB population is generally well with a high proportion of people reporting 'good' or 'very good' health and wellbeing; a good number of people being physically active and using outdoor space; very low unemployment levels and a high number of the population working between the ages of 16 and 64 years.

Despite this picture the following challenges remain:

a) **Health inequalities exist** and there are communities for whom health and wellbeing fall short of those enjoyed by the majority. The difference in life expectancy between the most and least deprived is 7.7 years for women and 5 years for men.

b) **People who experience mental ill health are still not consistently getting the services they need.** A new mental health/dementia strategy is in draft stage to steer the development of services that meet people's needs going forward. This strategy will recognize the need for physical and mental health services to be more closely aligned than they are currently.

c) **A high level of reliance on hospital based services by the public.** A recent Utilisation Management review commissioned by the CCG found the system to be 'hospital centric'. In part, the review found this was due to limited community-based alternatives. However, the CCG MTFS shows that the Vale of York CCG spends 9% less on acute care per head than the STP average. The 26 GP practices that deliver primary care in the locality have been assessed as 'good' and localities are progressing integrated care solutions wrapped around primary care models of delivery.



The graphic above illustrates what the composition of York would be like if it was a village of 100 people based on available data. Produced November 2016.

Graphic 2 'York in a nutshell'

d) An **acute trust provider that has historically delivered good performance but is facing significant financial challenge and deteriorating performance**. The development of place based commissioning through the locality delivery model is demonstrable progress towards system wide solutions to try to reduce demand on hospital services.

e) **Significant financial challenges faced by both the CCG and the council**. The focus on early intervention and prevention is a helpful driver for aligning CCG and CYC financial plans. The role of public health is pivotal in this regard, alongside the opportunity gained from developing existing forums within the third and voluntary sector.

York Teaching Hospital NHS Foundation Trust (YTHFT) is the acute trust and community service provider for the local population, with the main hospital being sited within walking distance of the city centre. The trust also provides services to the neighbouring population of Scarborough and Ryedale CCG and has an acute and community base in these localities. An over-reliance on acute care has necessitated a jointly owned and managed strategic plan to move the public's mind-set to more self-care and personal resilience to reduce the demand for public services.

Mental health services are provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) who were awarded the contract in October 2015. A significant focus over the last two years has been the development of the capital estate across services and transitioning systems and processes to support new ways of working in both acute and community mental health services. Following a public consultation in 2016, plans are on track to deliver a new mental health hospital by December 2019.

Workforce pressures are of significant concern in the York locality with full employment in the local area; this is kept constant as a result of the competitive opportunities in the tourist and retail industry which is strong in the historic city centre. A multi-agency Workforce Development Group has been established to identify and address areas for improvement.

There is also a large student population which, although transient, has physical and mental health needs that are unique to this segment of the population.

The general population is relatively affluent, with high levels of employment. The care home market is buoyant with a large customer base of self-funders. The uptake of personal health budgets in the community remains low.

The context of the broader health and social care economy is, therefore, one of significant financial pressure with a local population that has a history of high dependency on hospital services and residential care provision.

Although challenging, this context provides a significant opportunity for agencies to benefit from the assets that exist with the local population and wider community. York has a demonstrable history of community benevolence with over 1000 voluntary sector agencies operating across the population.

Moving towards fuller integration by 2020

A priority for the York BCF footprint is to deliver improved outcomes for the local population within the context of the demographic, cost and demand pressures faced by the health and social care system. There is recognition that these pressures, together with the financial context of the statutory agencies, requires a whole system approach to transformation and the development of a single medium term financial strategy (MTFS) for the system.

There has been a significant commitment in system leadership in York over the last 18 months and the 2017/19 Better Care Fund (BCF) Plan has been developed by a multi-agency group based on a common understanding of the issues that must be addressed to deliver high quality, co-ordinated care in the locality.

There is a shared commitment to place based commissioning and a high level of consensus about the characteristics of an integrated health and social care system for York. This has allowed organisations to work through challenges and gain a greater understanding of each other's drivers and perspectives. There is still work to do to make sure delivery follows through from plans but there are mechanisms in place to support this.

From within the system discussions and debate, a locality approach has now become the established model for delivery. This is reflected in the health footprint and across social care in the form of Local Area Co-ordination. Geographically, the Vale of York CCG has a population that spans the York HWB footprint whilst also falling within the even wider geography of the STP. To support the locality delivery model across the CCG's full population three locality delivery groups have been established in the North, Central and South geographies of the CCG.

The Central Locality Delivery Group is co-terminus with the York HWB population. This group is multi-agency in nature and has representatives from the Clinical Commissioning Group (CCG), City of York Council (CYC), GP practices, Community Voluntary Service (CVS), York Teaching Hospital Foundation Trust (YTHFT) and Tees, Esk & Wear Valleys Foundation Trust (TEWV).

As part of its financial recovery plan, the CCG has developed an Unplanned Care Programme with system partners. The programme provides an overarching approach across each of the CCG localities to improve the independence and resilience of local people, reducing the need to access secondary care. Each Locality Delivery Group is using the programme as a framework to identify local priorities for action.

The partner organisations represented in the Central Locality Delivery Group have agreed that their immediate focus is on the following three workstreams:

- ✓ **Urgent/same day access in primary care** to provide alternatives to secondary care and to free up GP time to deliver different models of care

- ✓ The development of **more integration across services at a team level** to manage frail/elderly people in a different way in care homes and their own

homes

- ✓ Support to **help people self-care/manage their health and social care needs** to maintain independence and make best use of the community assets available to the local population. The methodology we propose to adopt is:
  1. Review existing models which are working well in other areas such as the Manchester Choose Well campaign *(http://www.choosewellmanchester.org.uk/)* and the joined up approach being taken by Windsor, Ascot and Maidenhead: (*http://www.windsorascotmaidenheadccg.nhs.uk/wp-content/uploads/2015/05/talkbeforeyouwalkwamfinalweb.pdf).*
  2. Contact the local authorities who are doing this well to understand three things; how embedded the model is locally, what difference has been made and how that's known.
  3. Undertake local research to find examples of 'self-care' activities, and explore how they are working in York with health and care providers, and present findings to the Central Locality Delivery Group.
  4. Set up a cross sector steering group to develop and deliver an action plan to test this.
  5. Develop a simple model for York, agree testing conditions and basic metrics to measure outputs and outcomes.
  6. Use agreed metrics to review outputs, outcomes and overall effectiveness.

These three programmes of work are not stand alone but have been agreed as the initial areas that partners wish to focus on collectively to support system change. They are augmented by other workstreams that are critical to changing the way services are currently delivered.

Progress to date

Integrated commissioning

Partners have found the Better Care Fund to be a useful construct driving integrated working and joining services together to achieve better outcomes. We have used the process to further identify opportunities for integration as evidenced by progress made through the development of a Joint Commissioning Strategy and the appointment of a jointly funded Head of Joint Commissioning.

A Joint Commissioning Strategy was approved by the York HWB in January 2017. This is a high level strategy which sets out why and how we will work together in the period to 2020 to commission health and social care services for children, young people and adults. It is designed to provide a framework within which specific strands of joint commissioning work will take place, including the schemes linked to the BCF.
(http://democracy.york.gov.uk/documents/s112190/Annex%20A-yesitb%20joint%20commissioning%20strategy%20final%20draft.pdf)

Our local definition of joint commissioning refers to the ways in which the organisations which form part of the system of health care, social care and public health work together and with the local community to make the best use of the resources available to them in designing and delivering services and improving outcomes for local people of all ages.

Commissioners will work together to specify and agree an integrated approach to needs assessment, service specifications, funding and financial management, governance, contracting, performance management, community engagement and risk management.

The first annual joint commissioning plan, currently in development to align with the usual business planning cycle, will set out priorities for joint commissioning work, with specific plans for the actions to be taken to deliver the plan as part of the broader integration agenda.

Joint commissioning outcomes include:

- The integration of community based health and care services and delivery through local care hubs including mental health care support
- The development of integrated assessments and care plans for vulnerable adults
- A single pathway and pooled budget for reablement and intermediate care
- Integrated personal budgets for health and social care, to promote choice and personalisation
- Development of a single integrated pathway for Continuing Health Care
- Creation of a pooled budget and joint commissioning arrangements for mental

health and learning disabilities

- Agreement on, and implementation of, an approach to incrementally shift funding towards early intervention and prevention

Identifying key actions, agreeing individual lead organisation responsibilities, engaging with providers and the community and setting timescales for action in relation to these strands of work is an immediate focus for partners.

Governance and leadership arrangements in place to support the development of joint commissioning can be found in Appendix 1 of the Joint Commissioning Strategy.(http://democracy.york.gov.uk/documents/s112190/Annex%20A-yesitb%20joint%20commissioning%20strategy%20final%20draft.pdf)

Integrated delivery

It is important to recognize that the BCF plan/funding is one slice of the wider health and social care system and, as such, a direct correlation between individual schemes and a particular impact is difficult to evidence. However, the effect of various strands of work across system partnerships can be evidenced in the following ways:

- Archways Intermediate Care Unit – In 2016, system partners worked together to reprovide a 22-bedded Intermediate Care Unit through a home based model. Through our 'One Team' project we have brought together intermediate tier services (health provided intermediate care, local authority provided reablement and voluntary sector provided 'home from hospital'). These teams are now co-located in the Archways building together with the Hospital Social Work team and Community Discharge Liaison Service.

- Prevention Partnership – Although early days, a forum to bring third sector providers together has been established which will allow commissioners and providers to develop ways to further increase partnerships, look at new ways of working across partners and identifying further opportunities to develop the community assets available in York

- Integrated teams – the York Integrated Team, funded from the BCF initially as a pilot across one GP practice population, has now been rolled out to cover the full population registered with GP practices within the City. This service works directly with practices and A & E to support case management of those at high risk of readmission in order to reduce non-elective admissions and speed up discharge.

The appetite for whole system transformation has been steadily gaining momentum over the last 18 months and there is a clear recognition within the CCG, the Council and the York HWB wider membership that the BCF provides a platform on which to build sound strategic transformation that will deliver better outcomes, better value for money and person–centered coordinated care in the context of the financial risks and service pressures across the system.

Partnership arrangements

System leaders are resolved to work through the financial, operational and political challenges jointly and collectively with HWB partners to manage these pressures and to identify further opportunities to transform services that can be delivered sustainably.

During 2017/19 the BCF plan figures prominently in the wider integration agenda underpinned by robust governance arrangements to support delivery. A high level review of current governance arrangements across the system has been undertaken, which has resulted in a clear understanding of the partnership arrangements that are in place to support the different levels of system change required. This is a shared strategic intent and is being progressed at pace through mechanisms including the:

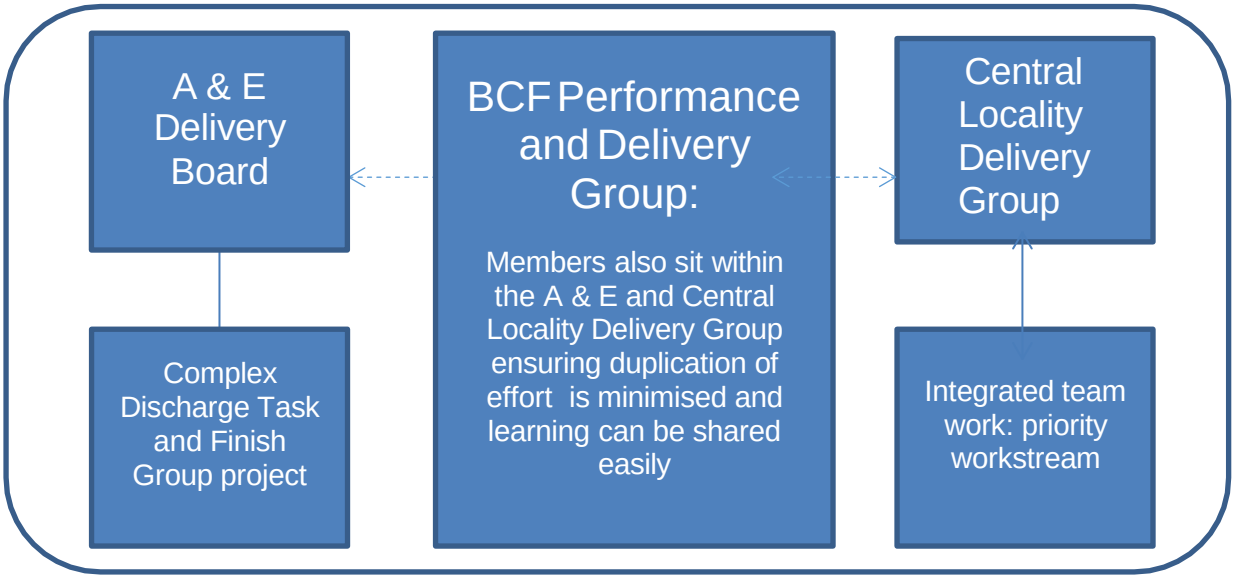
- Central Locality Delivery Group
  One of the three locality groups that sits within the Accountable Care Partnership Board arrangements. This group focuses on systematic change at a locality level and is working on three priorities (see 'Moving towards fuller integration by 2020' for more information).The partnership is co-terminus with the York HWB footprint.

- Complex Discharge Programme Task and Finish Group
  This forum is a sub-group of the A & E Delivery Board arrangements and has a work programme to reduce the number of stranded patients in acute hospital beds, improve the quality of assessments of long term care needs and reduce duplication and variation in decision making through the integration of teams. There is a clear connection in the work of this group to the Delayed Transfers of Care (DTOC) targets set within the BCF (see 'Managing Delayed Transfers of Care') . The membership of this group is based on the local acute hospital footprint and therefore has a wider system focus.

- Better Care Fund Performance and Delivery Group
  This programme of work connects into individual health and social care arrangements as well as drawing on the above groups to deliver the requirements of the BCF plan. The BCF Performance and Delivery Group forms part of the governance arrangements linked to the York HWB and was established in 2016.
  Commissioners are clear that national conditions for the BCF require oversight and sign off by HWB. HWBs have a duty to promote greater integration and partnership working, including joint commissioning, integrated provision and pooled budgets.

We use matrix working to co-ordinate governance between the complex systems but the BCF Performance and Delivery Group brings the systems together working closely with the Central Locality Delivery Group and the Complex Discharge Programme Task & Finish Group to deliver the BCF plan.

The BCF partnership recognizes the complex system that is already in place with governance arrangements connecting to formal arrangements such as the A & E Delivery Board and the Central Locality Delivery Group. Individual relationships and a commitment to improve services for people allow progress to be made despite this complexity. An example of this is given as a 'case study' in Graphic 3.



Graphic 3: Case Study on work relating to Care Homes

Regular reports on progress in relation to metrics and performance have been provided to the HWB over the last year with agreement by the Board in May 2017 to extend the performance dashboard to include greater detail on the impact of schemes within the wider system for 2017/19.

2016/17 Performance

An end of year position was reported to the HWB in September 2017 as set out in Table 2. Some measures have not delivered the anticipated target but there is evidence of success within non-elective admissions (NEA) and Delayed Transfers of Care (DTOCs) and Reablement as described below:

NEA - Using national activity data, NEA measure fails the BCF target by 1,858 admissions (which is 8.9% above plan). However, the introduction of the YTHFT Ambulatory Care unit accounts for around 250 spells per month, which are recorded as NEA activity in the national return.

This new model of service delivery which centres around providing expert advice, avoiding admissions to acute wards, and sending patients home safely, usually on the same day. When taking this local context into account, NEA performance is very positive at just above target by 0.7%, which equates to 130 admissions above plan, which was originally based on 1% growth. We recognise that managing to a level of 1.7% growth in acute admissions would place the system within the Vanguard performance nationally compared to a national level of around 3% growth as referenced in the 'Next Steps 'document.

This is a significant achievement given the system challenges described in the earlier sections of the BCF plan.

DTOC - Although the year end position is above the plan for 2016/17, Q4 shows a significant improvement. In-year monitoring shows a continued improving trajectory for acute DTOCs which has been considered in setting the plan going forward. Another factor that needs to be considered when assessing performance is the change in reporting of mental health DTOCs in July 2016 which was not considered when the 2016/17 plan was set. Although this change in process created some challenges for partners, the resulting governance and revised systems and process has created a transparent, more robust set of arrangements between partners.

Reablement – The Q4 position shows a positive improvement against the target set at the start of the year showing more people were still at home 91 days after discharge from hospital into these services. This type of support has been further invested in for 2017/19 as set out in the 2017/19 Plan section.

Metric type	Metric description	Target	Q1 position	Q2 position	Q3 position	Q4 position	Year End Position
National:	Reduction in non-elective admissions (General & Acute)	20,781	5,530	5,639	5,739	5,731	22,639
*Local metric (outwith routine reporting framework)	Reduction in non-elective admissions (General & Acute) *National data adjusted for Ambulatory Care Recording issues	20,781	5,063	5,220	5,317	5,319	20,919
National:	Delayed Transfers of Care: Number of bed days per 100, 000 of population	9,837	2,497	2,889	3,117	2,032	10,535
National:	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	657.8	189	184	143	153.6	669.6
National:	Number of permanent admissions to residential & nursing care homes for older people (65+)	238	70	68	53	57	248
National:	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	0.758	NO DATA	NO DATA	NO DATA	0.793	NO DATA
Local:	Injuries due to falls in people aged 65 and over per 100,000 population	2,454.7	591	641.6	588.4	665.6	2,486.6
Local:	Injuries due to falls in people aged 65 and over (actuals)	922	222	241	221	250	934
Local:	Overall satisfaction of people who use services with their care and support	0.664	NO DATA	NO DATA	NO DATA	0.62	NO DATA

Table 2: Summary of 2016/17 BCF Performance Metrics

Evidence base and local priorities

The changes in demographics in the York HWB footprint (see Background and local context section for more detail) means that the Council has to take a pro-active approach and has already started a process to re-design their operating model focusing on prevention, reducing and delaying the need to access statutory care and support provision. The Council is focused on meeting locally identified need by listening to the voice of local people and providing the means by which local groups can develop and flourish.

Demographics show that there are 2,700 older people in York with dementia, this is set to grow to around 3,500 in the next 10 years, across York 14,000 live alone, this is set to grow to 16,000 by 2027 and there are an estimated 2,500 people over 65 providing 20 hours or more unpaid care each week. By 2025, it is estimated that that this level of care provided by older people will increase by 16%. These are just some of the challenges that the social care market faces in York.

The Council is currently revising their Market Position Statement but there are a number of key messages emerging;

- There is an ongoing and continued pressure on providers to recruit and retain paid carers in a "full employment city"

- The Council's commitment to maximising independence to prevent, reduce and delay access to care services

- That information and advice provision needs to be well developed to meet the cities aspirations of promoting independence, choice and control

- That we need with partners to greater understand the needs of self-funders which present a challenge to the City in terms of numbers and service requirements

- That York has a strong established process for monitoring the quality of service provision and supporting providers that may be struggling *(https://www.york.gov.uk/downloads/file/3740/shaping_care_for_york_%E2%80%93_market_position_statementpdfn)*

From a health and wellbeing perspective we know that:

- York has a higher rate of emergency hospital admissions for intentional self-harm than the national average. Additional psychiatric liaison resource in A & E has been put in place (funded through national monies) which will provide increased support for people. Other improvements in crisis care services and the introduction of a 'Safe Haven' initiative in 2017 are part of the wider system solutions to address this challenge.

- 3.8% of York's population live in areas that are among the most deprived in the country. Childhood obesity affects more children in our most deprived wards. There are also poorer health and wellbeing outcomes for certain vulnerable groups, e.g. the gypsy and Roma community and the lesbian, gay, bisexual and

transgender (LGBT) population.The Primary Care Home (west) initiative has identified childhood obesity as a priority and is taking forward a range of projects to try to improve these wider health determinants.
(***https://www.york.gov.uk/downloads/file/12806/joint_health_and_wellbeing_strategy_2017_to_2022***)

Evidence from a health perspective shows that there are a number of opportunities to ensure people are getting access to care at the optimum time.Service reviews across primary and secondary care are underway as part of a planned joint programme of work with York Teaching Hospital NHS Foundation Trust. Work is well underway on a revised musculo-skeletal pathway with respiratory and cancer pathways also in hand. To support these priorities, engagement work with partners and the public has been taking place during the last12 months.
https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-vale-of-york-jan17.pdf

Improving access to mental health services across all ages is a key priority for the next 12 months. This work is on-going and runs in parallel to the plans for a new mental health hospital by December 2019.

Sustainable, evidence-based, integrated solutions for care that supports our local vision are referenced throughout this plan. As a system we have recognised the financial pressure that faces individual organisations which, in turn, impacts us collectively. For 2017/19 we believe we have developed a set of investments that maintain existing services as well as looking to new opportunities that contribute to shared strategic plans.

Evaluation of 2016/17 schemes

The Better Care Fund Plan is critical to delivering the wider strategic vision for health and social care for York. Schemes within the plan are part of a larger pattern of service redesign and development. Our design principles provide a framework for deciding our priorities and planning for change.

The Joint Strategic Needs Assessment informs commissioning intentions and underpins the Joint Commissioning Strategy. Better Care Fund schemes also draw on evidence of effectiveness, learning and best practice from elsewhere, and translate these for local circumstances.

2016/17 schemes were evaluated using agreed metrics and key performance indicators against their individual aims that reflect the focus on reduction of non-elective admissions in accordance with the Better Care Fund requirements for the period.

A summary of the key elements of existing schemes that are continuing is given below:

Disabled Facilities Grant – This is a mandatory grant which helps disabled people to allow them to remain living in their own homes, safely and independently. Adaptations can include improving access to and around their home, bathing adaptations, adapting lighting and in some cases building extensions to meet very complex needs. Customers are means tested for grants. The maximum amount is £30k although the Council has discretion to add to this total. These customers would need on-going formal care if their home wasn't adapted which is much more expensive longer term than these one off grants. 160 grants were awarded in 2016/17 and a recent review of the DFG process resulted in the feedback that 100% of customers who responded felt safer remaining in their homes following the work. We are also running a pilot in the Clifton Ward called the Quick Fix Scheme. The service is targeting residents in that ward as a recent housing survey classed the houses in that area as being of a design and age where falls are more likely to occur. The intention is to reduce the admissions to hospital and subsequent treatment needed by making adjustments to prevent the falls occurring.

Community Support Packages (Protection of Adult Social Care) - We will deliver a 40% increase in community support packages to address demographic growth.

This funding is being used to support people to remain as independent as possible, preventing placement in residential and nursing care and allowing customers to be discharged from hospital and moved through reablement. The scheme allows for the purchase of approximately 3,400 hours of home care per week plus a contribution to social care staffing budgets to enable the assessment and review of customers. Key performance measures include numbers of people seen, outcomes, and reduction in the numbers of DTOCs and a reduction in numbers of residential and nursing care placements. In the past year there has been a reduction in York acute DTOCs from 2016 to 2017 alongside a reduction in the numbers of people entering Residential Care.

Carers support - This funding enables carers to lead their own lives whilst they look after a cared for person and maintain a caring role. Support includes respite for carers, direct payments and grants, improving what the Carer's Centre offer to support carers and other contracts to support Carers groups. The service will be re-commissioned during 2017 with an enhanced specification placing increased emphasis on identifying and supporting carers across the City. The scheme allows for significant investment in carers services to avoid preventable carer breakdown and associated unplanned admissions to hospital and residential/nursing care. It also reduces and delays the need for health and social care, improves outcomes and quality of life for carers and enables people to be supported at home following discharge from hospital. Key performance measures include numbers of carers supported, reduction in residential and nursing care placements, reduction in readmissions after 91 days, reduction in hospital admissions due to carer breakdown and improved outcomes identified through the Carers Satisfaction Survey. Outcomes this year include:

- A 10% growth in the number of new registrations with York Carers Centre
- Targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016
- 1,119 customer contacts have been provided during extended opening hours (Friday / evening cover)
- The target for Carers Assessments of Need has been exceeded by 17% (88 completed assessments against a target of 75)
- Carers now have to wait for a maximum of 4 weeks for a carers assessment, compared to an average wait of over 8 weeks in May 2016
- Case studies evidence that a complete breakdown of the care giving role has been avoided for at least 207 households in the 11 month period May 2016 to March 2017

Care Act Implementation - Supports activities and services resulting from statutory duties imposed on local authorities by the Care Act 2014. Key services provided through this scheme include Care Act Advocacy Services, financial assessment/personal accounts and information/advice services, statutory safeguarding adults board, and increased support to Carers services. The outcomes we are expecting include services which intervene at an earlier stage, improvement in the wellbeing of the population, provision of information and advice, advocacy support, increased numbers of carers assessments and customers being reviewed in an appropriate and timely manner. Some of the outcomes achieved were a 10% growth in the number of new registrations with York Carers Centre, targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016. (1,095 new referrals have been received against a target of 980) and the waiting list for Carers Assessments in the city has reduced from 90 to 21 since May 2016.

Reablement (Human Support Group contract) - **In 2017/19 we will deliver a 50% increase in reablement capacity.**

One of the key actions during 2017-19 will be to build on the successful approach adopted for reablement and improve performance both against the "customers remaining at home after 91 days" indicator and outcomes in relation to reduced support following a period of reablement. The service has been recently re-commissioned and a revised specification developed. This will include a pathway for people to be assessed at home following a stay in hospital facilitating discharge and supporting the reduction of delayed transfers of care. The service currently provides around 400 hours of direct care to customers, this will increase to a maximum of 612 hours during the next two years which will enhance capacity and will be achieved through the development of an integrated approach via the "One Team" and a revised, challenging specification.

The service currently reduces support levels by approximately 53% with around 25% of customers receiving no service following their period of reablement. This, however, needs to be seen in the context that the service in York has high numbers of people with intensive packages of support in comparison to similar services. The new specification challenges the provider to achieve targets of 40% of all completed cases have no on-going care by 2019 and 90% of all completed cases to have a reduced care package by 2019, alongside developing collaborative working, onward referrals, outcomes measures such as the customer experiencing flexibility, choice and control and a requirement that 80% of all Rapid Response referrals, which are 20% of all referrals, are commenced within one day of receipt. These will support both the increase and effectiveness of our Reablement approach and ensure customers remain independent; facilitates discharge from hospital and supports a reduction in delayed transfers of care.

Community Facilitators - As the community hubs develop and extend across the whole HWB population these roles are seen as being fundamental to community development and resilience promoting self-care, self-management and proactive care.

Investment supports two members of staff within adult social care who connect customers with activities and support within their communities (for example dementia cafes) allowing them to remain independent and contribute to their communities. Their role includes supporting customers in feeling less isolated in their communities, increasing the wellbeing of customers, providing respite options for carers and supporting carers to maintain employment. Linked to this is a pilot social prescribing scheme which is a new initiative for 2017/108.

Step up/Step down Care Beds - Investment will support the provision of up to 12 residential beds with social care staff support to help prevent people from going into hospital, facilitate recovery when discharged from hospital and thus allow them to live in their own homes and communities. The key indicators are occupancy of SUSD beds (99.5% occupancy), people supported after hospital discharge (138 in previous year), length of stay in hospital, on-going packages of care following SUSD against likely cost of care if beds were not available and an analysis of SUSD. Key performance indicators include the length of stay of these people, their onward destination and their satisfaction with the service provided.

Telecare and Community Equipment - Investment supports the use of Telecare and equipment to assist people to remain independent and in their own homes; they can then continue to contribute to their communities and lead fulfilling lives. Provided by "Be Independent" and complimenting the warden call and response services the Council commissions, the service supports reductions in non-elective admissions to acute care, delays admission to long term residential/nursing care, reduces the number and size of domiciliary care packages and supports informal carers to carry the caring role for longer. The provision also improves people's health and wellbeing and reduces the number of, and negative consequences of, falls**.** The key indicators include the number of items of equipment issued, the number of responses to alarms, hospital conveyances prevented, a reduction in A&E attendances, reduced home care packages and reductions in referrals due to carer breakdown. Approximately 19,000 equipment deliveries in 2016/17 with 98.5% delivered within 5 working days.

Home Adaptations - This scheme supports the prevention of early and/or unnecessary admissions of residents to hospital, nursing care and/or residential care by providing minor adaptations to their homes to prevent falls and allow continued access and use of their homes. Provided by Be Independent and complementing the Telecare, Warden Call and response service the Council commissions. The scheme helps towards reducing social care admissions, enhances the quality of life for people with care and support needs, improves carers reported quality of life, delays and reduces the need for care and support, reduces the need for readmission to hospital and supports people to recover from episodes of ill health. Key performance measures include numbers of adaptations issued, reduction in number of falls at home, number of people remaining at home 91 days after discharge from hospital, an increase in people's satisfaction with the service and reduced A&E admissions.

York Integrated Care Team (YICT) - The YICT is 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. The 2016/17 plan established this model in each of the CCG's HWB footprints and learning from each of the delivery models has informed the development of the teams for 2017/19.

The aim of the scheme is to support high risk and frequent/high usage patients, and those discharged from ED or wards via a daily MDT. Each MDT reviews the patients seen/discharged recently, updates their plan, assesses any support requirements and provides appropriate short or longer term support.

The decision to continue this scheme is based on analysis of the YICT which is positive and shows that NEAs are down by 2.1%, admissions are holding static and, when patients are admitted, their excess bed days have decreased by 25% when compared to 2015/16 figures.

Urgent Care Practitioners (UCP) - The UCP model implemented is a see and treat/hear and treat/see and refer onwards from the ambulance service to a variety of local health and social care teams. This in turn not only ensures the patient is given the right care in the right place but reduces A&E attendances and subsequent acute admissions. The decision to continue this scheme is based on 16/17 performance

data which shows that of 4,981 urgent care practitioner attendances an ambulance conveyance was avoided in 2,876 cases (57.7%).

Hospice at Home (Extended Hours) - The aim of this scheme is to reduce non elective admissions and A&E attendances for End of Life patients; increase the numbers of patients able to die in their preferred place of choice; improve the quality of patient and carer experience and increase the clinical and support time with patients and their carers.

During 2016/17 the service supported 495 people to be cared for in their own homes, of these, 150 (30%) were cared for during the extended hours of the service. For the duration of the extended service to date (Jan 15 – Mar 17), 281 crisis intervention cases were identified (over 56% of the 495 patients seen during that period). It is assumed that these crisis intervention referrals avoided a call out of other services such as ambulance and Out of Hours GPs.

Street Triage – this service is provided by TEWV to work alongside the North Yorkshire Police and support them in incidents involving people with Mental Health concerns. The aim of the service is to try and support officers in managing individuals with mental health with the least restrictive approach to their needs and this includes looking at alternatives to the police powers under S136 to detain an individual and offers up to 3 follow-up interventions to individuals not already linked into Secondary Care services to help prevent further crises and contact with the police. This scheme supports the local police and ensures an appropriate intervention for the individual. In 16/17 Street Triage team attended 81% of S136 detentions which have occurred in the York area and out of these 81% a further 71% have had an enhancement to their care package.

Out of hospital services (commissioned by CCG) – includes: specialist nursing, integrated community teams, community therapies, and community equipment and wheelchair services.

Specialist nursing services including: Specialist cardiac nursing and tissue viability play a crucial role in the primary health care team working alongside GPs and other health care professionals. They visit housebound people in their own homes or in residential care homes, assessing the health care needs of patients, providing high quality holistic nursing care to patients who have a nursing need. Community nurses have an important role in keeping hospital admissions and readmissions to a minimum and ensuring that patients can return to their own homes as soon as possible. As well as providing direct patient care, community nurses also have a teaching role, working with patients, their families and carers to promote self-management and independence. *Specialist Respiratory Practitioner* – practitioners give specialist advice and treatment options to improve the quality of life for patients and their families/cares living with chronic obstructive pulmonary disease (COPD) and other respiratory conditions to promote self-management and assist in preventing unnecessary admissions to hospital.

Integrated community teams/therapies including: *Specialist Continence Advisory Service* – is a multi-disciplinary team who are specialists in the treatment and management of bladder and bowel conditions. The service is provided for adults with

accessible clinics in local areas and home visits are provided when required. The aim is to treat and manage bladder and bowel dysfunction where possible maintaining individuals' comfort and dignity; *Community Response Teams* – this service was developed by bringing together the existing Fast Response and Intermediate Care Teams. These teams (made up of nurses, physiotherapists, occupational therapists and generic support workers) are able to support people to achieve short term goals to maximize their independence. This can be to help prevent an admission to hospital or to support an earlier return home following a hospital stay. The teams all work from 8am to 8pm, seven days a week – including bank holidays.

The 2017/19 Plan

A number of schemes have been maintained going forward for 2017/19 alongside a commitment to invest in new schemes. An agreed methodology was used to build up the investment schedule as follows:

Step 1 – Existing schemes maintained (following high level review)
Step 2 – Full year effect (FYE)/recurrent commitment costs applied
Step 3 – Risk share costs absorbed
Step 4 – Inflation/growth applied if applicable
Step 5 – Recurrent investment in non-recurrent pilot schemes/ Additional new schemes agreed and added

This methodology supports the following investment profile (note figures are rounded to the nearest £1K when compared to the BCF planning return template

Investment Profile	17/18 Proposed £m	18/19 Proposed £m
1. 2016/17 schemes maintained	12.203	15.196
2. FYE/Recurrent commitments	0.723	0.658
3. Risk share costs absorbed	1.227	0
4. Inflation/growth applied	0.104	0.126
5. Proposed commitments	1.091	0.571
Total pooled fund (£M)	**15.348**	**16.551**

Table 3: 2017/19 Investment Profile

The full amount of the DFG allocation has been utilised within the BCF for 2017/19.

The use of the iBCF is in line with both the Grant Conditions and the Intention of the Grant providing both stability to existing services and additional capacity.

- It is being used to "support existing adult social are services, as well as investment in new services" as required in Paragraph 46 of the Integration and BCF planning requirement for 2017-19
- It is being used "to enable the local authority to quickly provide stability and extra capacity in local care systems" as required in pages 17 and 18 of the 2017-19 Integration and Better Care Fund policy framework.

A summary of the services funded in 2016/17 and proposed for 2017/19 is given in Table 3. To provide further detail this full list of investments has been broken down into 'scheme types' to allow for classification of the investment going forward as described in Table 4. This analysis reflects the summary of BCF expenditure as set out in the Planning Return Template**.**

Summary of BCF Expenditure	2017/18 Expenditure	2018/19 Expenditure
Acute	732,243	732,769
Mental Health	150,150	150,150
Community Health	5,939,418	5,941,122
Primary Care	750,000	757,500
Social Care	7,624,259	8,397,523
Other	151,918	571,568
Total (£M)	**15,347,988**	**16,550,632**

Table 4: Summary of BCF expenditure by scheme type

Within each of these classifications, there is a mix of existing, system wide and additional new schemes as defined by the investment profile set out in Table 3.

- We can confirm the iBCF monies are not being used to fund carers' breaks and reablement services. These services are funded out of the core BCF in the amount identified for protection of social care.
- Furthermore, we can confirm that the iBCF does not replace and is not being used to offset against the NHS minimum contribution.
- We have developed iBCF and BCF as a two year investment plan, in 17/18 largely focusing on stabilizing the local system, and in 18/19 either enhancing or developing additional services to promote better flow through the system and reduced dependency on the acute sector and other statutory services.

Each scheme links to one or more of the BCF grant determination criteria of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting people to be discharged from hospital when they are ready
- Ensuring the local social care market is supported

Schemes that are new to the Better Care Fund for 17/19 are detailed below.

Arc Light (A Bed Ahead) - this scheme provides support for homeless clients who present at A & E in the form of a link worker, and also takes referrals from inpatient wards to assist with discharge arrangements. The scheme also prevents delayed discharge by offering a bed at the Arc Light Centre.

Age UK – Escorted Transport - the Age UK York Escorted Discharge Service provides personal transport home from hospital where indicated by clinical need and when patients are unable to make their own arrangements. The driver also completes a referral form that identifies other needs that the person may have such as such as needing assistance with washing and dressing. This information is subsequently shared with social services if their input is required. The scheme potentially reduces re-admissions to hospital by identifying potential crisis situations.

Rapid Assessment & Treatment Service (RATS) - this scheme provides additional support for the hospital Rapid Assessment Team to extend the service to cover

evenings and weekends. This requires additional occupational therapy, physiotherapy and social care support. The aim of this scheme is to increase the number hospital admissions avoided by assessing and treating patients that require short term support to return home 7 days a week (8.30am-8pm) including Bank Holidays. Funds pay for social care support required to provide the RATS extended hours scheme.

Priority Outreach - the aim of this scheme is to capture all referrals from the Rapid Assessment Therapy Service (RATS) providing a response within 2 hours to a RATS referral for patient support in the home avoiding admission and possible

readmission. Also includes additional ICT support enabling early supported discharge while awaiting packages of care to commence. This scheme also aims to avoid admissions and enable early discharge.

Step Up/Step Down Beds & Occupational Therapy (OT) - this scheme provides a flexible resource for patients who can be discharged with a requirement for intensive short term therapy. It also takes step-up referrals from GPs and UCPs so may prevent some admissions. This scheme also provides OT support for the therapy required in the nursing home, working as a link between RATS discharges and nursing home requirements. The intensive therapy supports prevents delayed transfers of care as well as preventing admission for those with minor rehabilitation/reablement needs.

Increased Reablement Capacity - building on the existing Reablement Service, this investment will enable the service to increase capacity and facilitate earlier discharges from hospital. Customers will be able to move on following their episode(s) of reablement so freeing up capacity to enable customers to be discharged from hospital and home with a reablement service and into a setting where they can be appropriately assessed.

Self-support Champions - will be based within the Council's assessment and care management teams and will provide dedicated staff resources to visit customers within 48 hours (where possible) of referral and enable staff to have a "different conversation" with customers and look to signpost people away from formal services to community resources. This will reduce delays for customers being seen that can result in deterioration and will further create capacity within reablement to focus on those most in need. A pilot has resulted in 38% of customers been signposted away to community resources.

'Ways to Wellbeing' - is York's social prescribing service, delivered by York Community Voluntary Service (CVS) in partnership with the local voluntary and community sector. It connects people to local community support to make them feel better. Nationally, 20-25% of patients consult their GPs for social problems, e.g. loneliness. The Service will reduce the use of GP appointments for social issues, helping people stay safe and well at home for longer.

Expanded handypersons service – investment in increasing the capacity and outcomes of the existing Handypersons Service, a new specification will include increased access for GP's, Out of Hospital support, low level prevention services and a Gardening service. Outcomes will include fewer deaths/injuries from falls, reduced social care admissions, delaying and reducing need for support, reducing need for readmission to hospital and reduction in A&E admissions and attendances.

Information & Advice – curate information and advice on community support and self-care across public health, adult social care, Health, Children's services and other local authority services. Linking to development of a cross system wellbeing portal, e-marketplace and re-design of Connect to Support web platform, the aim is to maximise an asset based approach across the voluntary and community sector. Provision of advice and guidance will support people to improve their health and wellbeing and demand on health and social care services will be reduced as people

are encouraged and supported to remain independent and as healthy as possible. The approach will see reduction in GP and A&E attendance, reduced hospital admissions and a reduction in health and social care contacts.

Alcohol Prevention – investment to drive a promotional campaign and the delivery of training programmes to support an early intervention and preventative approach. Low level drinking of alcohol has a wide body of evidence which demonstrates it is attributable to many different health conditions. These behaviours can result in a range of health conditions and social problems and the aim of the campaign will be to drive improvements in many areas including long term health conditions, social problems and alcohol dependence.

7 day working: multi-agency – to develop and facilitate discharge from hospital 7 days a week. This will improve customer experience ensuring that they do not spend unnecessary time in hospital with risks of deconditioning and hospital acquired infections. The system benefit will be reduced length of stays in hospital and the potential to reinvest resources from acute to community support. This project will connect into the work that is already in hand through the Complex Discharge Task and Finish Group.

ANNEX A

Summary list of schemes	2016/17 Current £000	2017/18 Plan £000	2018/19 plan £000
Existing schemes continuing from 2016/17			
Disabled Facilities Grant	1,003	1,101	1,199
Community support packages	2,174	3,115	3,208
Contribution to social work post	137	138	139
Carers support	655	655	655
Care Act implementation	454	454	454
Community facilitators	40	40	40
Reablement services (Human Support Group contract)	1,099	1,099	1,099
Step up/step down beds	300	303	312
Telecare and Falls lifting	192	192	192
Community equipment	180	180	180
Home adaptations	75	75	75
York Integrated Care Hub	625	750	758
Urgent Care Practitioners	569	526	526
Hospice at Home	170	173	176
Street Triage	150	150	150
Out of hospital services (commissioned by CCG)	4,380	5,262	5,408
Additional new schemes			
Arc Light – A Bed Ahead	0	81	83
Age UK – Escorted Transport	0	91	93
Step up/step down beds & OT support (6 months funding pending review)	0	152	0
Rapid Assessment & Treatment Service (RATS) extended hours and social worker	0	207	208
Priory Outreach	0	180	182
Increased reablement capacity (7 months in 17/18)	0	97	168
Self-support champions (4 months in 17/18)	0	33	98
Social prescribing/ways to wellbeing (8 months in 17/18)	0	101	152
Expanded handypersons service (4 months in 17/18)	0	10	30
Information and advice (4 months in 17/18)	0	16	49
Alcohol prevention (5 months in 17/18)	0	15	47
7 day working: multi-agency project	0	0	300
Contingency funds	**0**	**152**	**571**
Total (£M)	**12,203**	**15,348**	**16,551**

Table 5: Summary of 2017/19 BCF schemes

Funding Contributions

An assessment of the investments in 2016/17 has been used to inform the funding plan and detailed list of schemes for 2017/19. The 2017/19 BCF plan has been jointly agreed by partners, including the level of maintenance for social care, funding for reablement and carers breaks as set out in summary in Table 5.

The full amount of the DFG allocation has been used within the BCF for 2017/19 as agreed by the City of York Council is the single local authority covering the York HWB population.

The iBCF monies have been used to stabilise existing system wide commitments across health and social care as well as support new investments with a priority on supporting delayed transfers of care across seven working days.

A summary of the services funded in 2016/17 and proposed for 2017/19 is given in Table 6.

Funding Contribution	15/16 Actual £m	16/17 Actual £m	17/18 Proposed £m	18/19 Proposed £m
LA Minimum (DFG)	0.951	1.003	1.101	1.199
LA Additional (iBCF and iBCF supplementary funding)	0.000	0.000	2.847	3.735
CCG Minimum	11.176	11.200	11.400	11.617
Total pooled fund	**12.127**	**12.203**	**15.348**	**16.551**

Table 6: 2017/19 Funding Plan

On completing the Planning Return Template, we note that this highlights the inflationary uplift impact on the fund for 20171/19 when compared to contributions in 2016/17. However, Table 7 demonstrates that we are spending more than the required inflationary uplift for social care protection expenditure within the pooled budget over the next two years. The table models three scenarios:

1. **Planning requirement** assumptions, applying the 1.79% and 1.90% uplift to the funding from CCG based on RNF, which has a total cumulative inflation of £0.188m

2. Our **Actual** spend on social care protection from within the template compared to the 2016/17 funding from CCG based on RNF, which has a total cumulative inflation of £0.315m

3. The **Planning template** requirement assumptions, applying the 1.79% and 1.90% uplift to the 2016/17 social care protection spend, which has a total cumulative inflation of £0.293m

Scenario		2016/17 £M	2017/18 £M	2018/19 £M	Total £M
1. Planning requirement	Funding from CCG based on RNF	3.412	3.473	3.539	**10.424**
	Inflationary uplift from 16/17		0.061	0.127	**0.188**
2. Actual	Funding from CCG based on RNF	3.412	3.676	3.463	**10.551**
	Inflationary uplift from 16/17		0.264	0.051	**0.315**
3. Planning template	Planned Social Care expenditure from the CCG minimum	5.306	5.401	5.504	**16.211**
	Inflationary uplift from 16/17		0.095	0.198	**0.293**

Table 7: Inflationary uplift for social care protection

Managing delayed transfers of care (DTOCs)

A partnership approach to managing DTOCs is in place through the Complex Discharge Programme.

This programme is overseen by a multi-agency Task and Finish Group on behalf of the A & E Delivery Board as set out in Graphic 4**.** The programme lead is a member of the BCF Performance and Delivery Group as this is a key element of the BCF plan. The Task and Finish Group is developing a performance report which includes length of stay for older patients, delayed transfers of care and stranded patients, weekend discharge rates and occupied bed days. The Task and Finish Group will also be tackling DTOCs from mental health settings.

There are five key work streams that fall within this programme:

1. Integrated Complex Discharge Planning Project

This project aims to improve the discharge planning process for patients with complex needs, based on best practice from NICE. It has four key workstreams; workforce (an integrated discharge liaison team), training and development, policies and procedures and communication (between acute and community teams and with patients and their carers).

2. Community Bed Review

Following an audit across all community inpatient beds and a range of stakeholder workshops, this project aims to take a home first approach to ensure that intermediate services (home and bed-based) meet the needs of patients. It will work with local people and clinicians to develop a co-produced model for the future.

3. Integrated Intermediate Care and Reablement

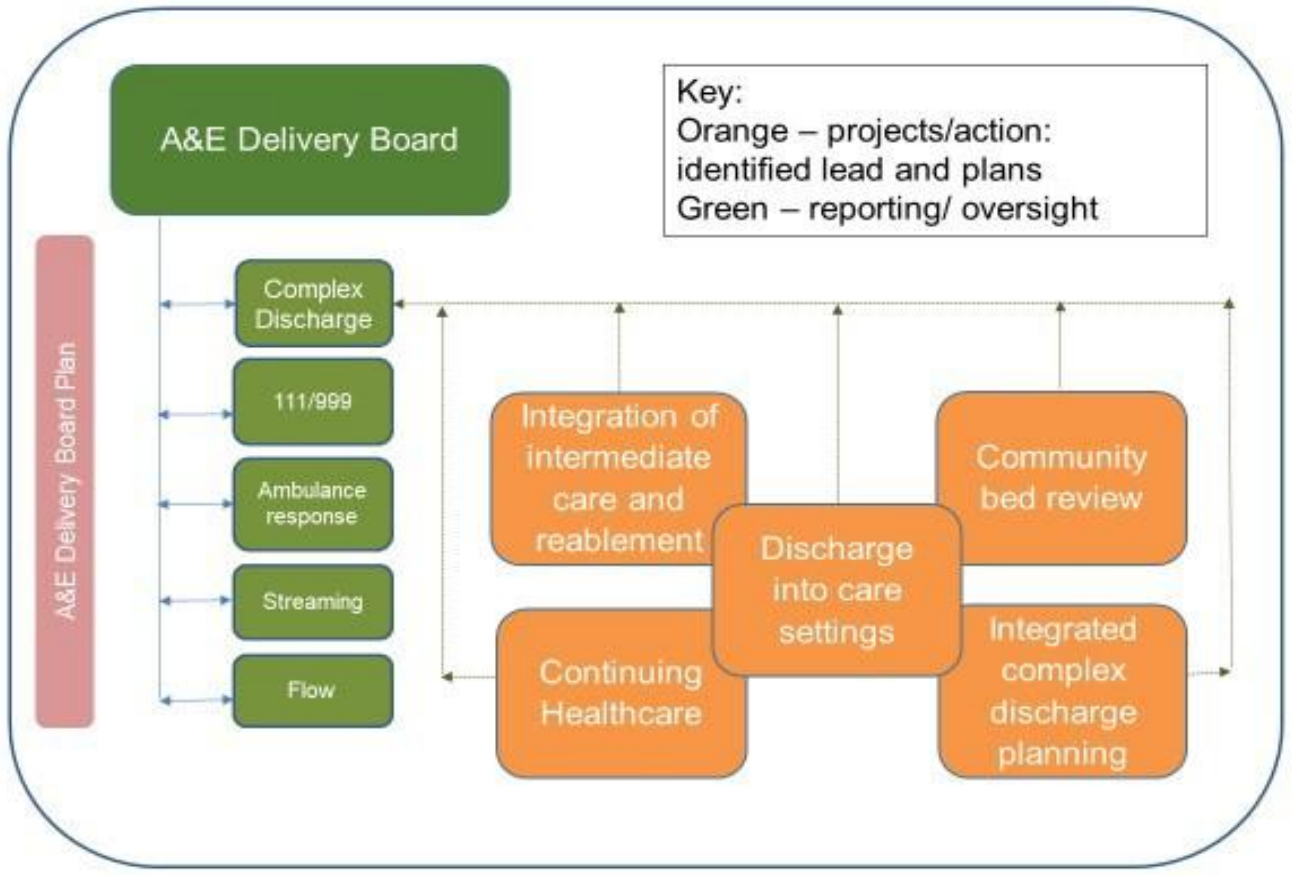
In each locality covered by the A & E Delivery Board, projects are underway (at different stages) to develop an integrated intermediate tier of services. These will bring together health intermediate care (Community Response Teams) with local authority reablement services and voluntary sector wellbeing support in order to simplify referral pathways (for both step up and step down referrals), ensure people receive the right service first time and maximise capacity within available resources.

4. Ensuring 85% of Continuing Health Care (CHC) Assessments take place outside Acute Settings

This project sits within a wider context of redesign of CHC (as set out in Gateway letter 07091) and aims to deliver the national requirement for assessments of continuing health care which needs to take place outside of acute settings, ensuring patients have reached their optimum independence before making decisions about long-term care needs. We recognise that, for those who are eligible for CHC, improved timelines for decision making are crucial.

5. Improving Discharge into Care Settings

This project sits within wider developments to improve the support provided to care home residents and staff. It aims to improve the communication between hospital teams and care home staff, minimising the time that residents need to spend in hospital.



Graphic 4: Complex Discharge Group arrangements

High Impact Change (HIC) Model

A system wide self-assessment has been undertaken by the Complex Discharge Programme Task and Finish Group (see Appendix 1). The results of the self-assessment are being used to review the projects underway within the programme. To support this, a multi-agency 'Stranded Patient Review' was conducted at York Hospital to understand the reasons why patients faced extended stays in hospital. The findings from the review and the self-assessment process are being triangulated to identify the priority areas for action.

There is a plan in place for implementing actions from the self-assessment as set out in Table 8 which shows how the High Impact Changes map across to the projects within the Complex Discharge Programme. The projects described are being delivered within a partnership approach with actions in place to support improvement against each HIC.

High Impact Change	Project Links
Early discharge planning	This is a key focus for the Integrated Complex Discharge Planning (ICDP) project and is also supported by the 'Flow' sub-group of the A&E Delivery Board which is implementing SAFER in acute settings. The Project Initiation Document for the ICDP project is included as Appendix 2.
Systems to monitor patient flow	The actions relating to this change predominantly sit with the Flow work stream, however the system has also approach the national Home from Hospital team to request support with system wide capacity and demand modeling.
Multi-disciplinary, multi-agency discharge teams	This is a key focus for the Integrated Complex Discharge Planning project shown in Appendix 2. The project to ensure that 85% of Continuing Health Care assessments take place away from acute settings is also key to delivering this change.
Home First / Discharge to assess	A 'Home First' approach runs throughout the Complex Programme and a project has already been completed to introduce the discharge to assess approach across all wards at York Hospital. The Integration of Intermediate Care and Reablement 'One Team' project (see Appendix 3 for more details) seeks to create additional capacity in intermediate tier services support the delivery of home based assessment of long terms needs.
Seven day services	This is covered for discharge planning teams as part of the Integrated Complex Discharge Planning project. The BCF plan includes a project to review seven day services in 2018/19.
Trusted assessors	This is included as part of the Integration of Intermediate Care and Reablement project and the Task and Finish Group are undertaking a self-assessment based on the recently released national guidance regarding opportunities to develop Trusted Assessment models. This could also be developed as part of the discharge into care settings project.
Focus on choice	A Joint Protocol is already in place but the review of this is included within the Integrated Complex Discharge Planning Project.
Enhancing health in care homes	The CCG are leading a project to improve support to care homes which includes admission and discharge processes (linking through the Complex Discharge Programme) and prevention of admission (through the Central Locality Delivery Group).

Table 8: Complex Discharge Group arrangements

NATIONAL CONDITIONS

7 day services

Developments early in 2017/18 include the extension of psychiatric liaison services across 7 days operating from within the local acute trust (YFT) as part of the A & E team which supports admission avoidance into an in-patient bed for those in crises. The service is not yet fully established in terms of staffing which is a priority going forward. Once a full complement of staff is in place it is expected that service pathways will be redefined to reduce hand-offs and unnecessary delays for people. An external evaluation will be undertaken to assess the impact of the scheme early in 2018. This information will be used to support financial modelling to ensure continuity of the scheme once the current national monies expire. A multi-agency project is in development as part of the BCF plan for 2018/19.

Joint approach to assessment and care planning

Continuing Health Care is one of the strategic programmes of work being addressed by the CCG. Current systems and processes are being reviewed following the appointment of a Director of Transformation and Delivery in July 2017. The CCG recognises that there are opportunities to manage this activity in a more integrated way with partners leading to improvement in pathways for people across health and social care systems.

Data Sharing

An overarching information sharing protocol is in place, and system partners are beginning to sign up to data sharing agreements that sit underneath this as needed. The CCG continues to promote the use of the NHS number as the common identifier across health and care services, and is confident that for health services, uptake is extremely good. More work is needed, however, to understand the current position, and any opportunities around social care use of the NHS Number.

In terms of service delivery, integrated working across services is developing well, with a number of multi-disciplinary team (MDT) based approaches to coordinating care for complex and frail patients. Explicit consent is obtained from patients to enable the sharing of information across agencies who are involved in their care. Currently, integrated access to clinical systems is limited (no EMIS/SystemOne interoperability) so MDTs are using multiple PCs to log into Provider systems to access and cross-reference information to help with care coordination.

Progress with Local Digital Roadmaps has been slow, with a view that the LDR footprint should ideally match the STP footprint, and conversations have taken place to understand whether governance arrangements could support this. Commissioning support (through Embed) is working with CCGs to develop Universal Capability Delivery Plans to support digital transformation.

Risk Management

In 2016/17 a set of risk management principles were developed and adopted within the Section 75 agreement as set out below:

Risk Share Principles

- Lead Partners should look to share gains as well as losses to incentivise good performance.

- All efficiencies/underspends generated from activities within the scope of the programme are attributed to the programme until the programme is in financial balance.

- When the programme is in balance, ideally any over achievement should be used to fund additional transformation activities and adding to the size of the BCF.

- As the Partnership Board reporting to the Health & Wellbeing Board, the Integration and Transformation Board should support recommendations on where to invest financial gains relating to the BCF plan.

- Lead Partners should spread risks and gains around the system to recognise the responsibilities/contributions of different partners.

- Providers should bear their share of risk and it is the responsibility of the commissioners, lead or joint, to agree a risk management plan with the provider.

- Where services are commissioned then the costs of failure should be recovered through the contract from the provider.

- Lead Partners should make a decision on financial risk share on a scheme by scheme basis.

- When services are jointly commissioned then losses and gains will be split 50/50 between commissioners.

- In a situation where there is a lead commissioner then losses and gains will be managed through discussion between CYC and CCG.

The key risks to delivery for this plan have been considered by the BCF Performance and Delivery Group and are regularly reviewed as at Appendix 4. The HWB updates include risk log reporting.

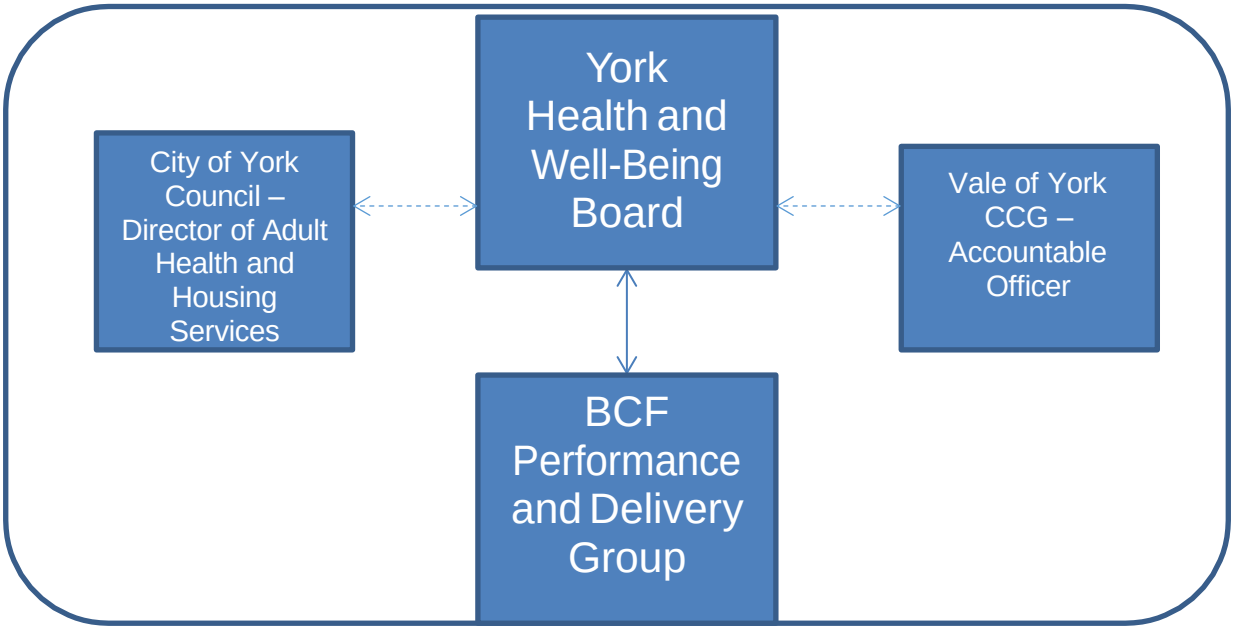
Programme Governance

The York BCF is based on shared system outcomes overseen by the York Health & Wellbeing Board (HWB) within the wider context of the Vale of York population from a CCG perspective.

The York HWB is a statutory committee of CYC and is chaired by the elected member with a responsibility for health and social care. The Board meets bi-monthly and, along with its wider health and wellbeing duties and exists to consider and make recommendations to the Council's Executive and the CCG on the use of BCF funding based upon jointly agreed plans. The Board covers the City of York Council population boundary and has a membership covering a broad range of partners as set out in Table 9.

HWB Partner Agencies	
City of York Council	York Council for Voluntary Services
NHS Vale of York CCG	Healthwatch York
York Teaching Hospital NHS Foundation Trust	Independent Care Group
Tees, Est & Wear Valleys NHS Foundation Trust	North Yorkshire Police
NHS England	

Table 9: HWB Partners



Graphic 5 shows the programme governance in relation to the BCF arrangements

Approval and sign off

The York HWB has received regular updates on the BCF Plan throughout 2016/17 and, at the May meeting agreed to delegate authority to the Chair and Vice Chair of the Board to act as signatories to the plan should the submission timetable fall out with the Board meeting cycle.
(http://democracy.york.gov.uk/ieListDocuments.aspx?CId=763&MId=9352&Ver=4)

The 2017/19 BCF plan has been prepared with the involvement of partners represented in the BCF Performance and Delivery Group as well as through informal discussions held within other partnership forums.

A final draft version of the BCF narrative was considered and approved by the HWB on 6 September 2017 in advance of the final submission by 11 September 2017. The Board delegated authority for approval of the final plan to the Chair of the HWB, following consultation with the Chair of VOY CCG. Signatories to the plan include the Chair of the HWB, Chair of the CCG (who is also Vice-Chair of the HWB) and the Acountable Officers for the Council and CCG as set out in Table 10.

Members of the Board are aware of the extremely challenging financial difficulties facing health and social care commissioners and are cognisant of the financial constraint within the wider system.

The HWB recognize the efforts made over the last year in developing a shift towards greater collaboration across partners to achieve a balanced, agreed plan which is underpinned by the revised Joint Health and Wellbeing Strategy 2017/2022.

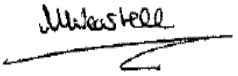
Role	Name	Signature	Date
Chair York Health & Wellbeing Board	Carol Runciman		11/09/17
Chair NHS Vale of York Clinical Commissioning Group	Keith Ramsay		11/09/17
Accountable Officer NHS Vale of York Clinical Commissioning Group	Phil Mettam		11/09/17
Chief Executive City of York Council	Mary Weastall		11/09/17

Table 10: BCF Plan Signatories

National Metrics

Delivery against the 2016/17 plan has been reviewed to inform the individual metric plans as set out in this section (Tables 11-14) reflect information in the planning return template (PRT).

- **Reduction in non-elective admissions**
  The NEA metric demonstrates a 3% reduction in 2017/18 over 2016/17, and a 13% reduction in 2018/19 over 2017/18. The CCG non-elective plan that was submitted includes reductions aligned to QIPP plans for 2017/18 and 2018/19. The ambitious trajectory for 2018/19 relies primarily on RightCare, the roll out of the integrated care teams, and the out of hospital care model, to account for the significant reductions planned.

  Local partners, including York Teaching Hospital NHS FT, are committed to working with the CCG to deliver this very ambitious improvement. Partners recognise the level of challenge in this trajectory and note that, based on national experience and previous local performance, there are significant risks to achieving this level of reduction in NEAs.

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
Non-Elective Admission Plan	5,439	5,429	5,579	5,435	4,720	4,711	4,841	4,716	21,882	18,989

Table 11: Non-elective admission metric

- **Admissions to residential care homes**
  Reduced admissions to care homes as set out in Table 12 will be achieved through the protection of domiciliary care, alongside an enhanced and better integrated reablement offer. These schemes are closely linked to the development of more extra care housing as an alternative to residential care and the transformation of assessment and care management services to ensure people are able to access this.

		15/16 Actual	16/17 Actual	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	683.1	660.3	638.4	616.4
	Numerator	253	248	243	238
	Denominator	37,037	37,561	38,067	38,611

Table 12: Residential care homes metric

- **Reablement metric**
  A revised specification has been produced to support a reprocurement of this service - see on the 2017/19 Plan for further detail.

		15/16 Actual	16/17 Actual	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Annual %	75.7%	79.2%	86.0%	86.0%
	Numerator	106	42	41	43
	Denominator	140	53	50	50

Table 13: Reablement metric

Delayed transfers of care (DTOCs)

The BCF PRT Version v14 6b shows the trajectory for delayed days attributable to the NHS as zero. This is recognised locally to be incorrect and has been flagged to NHS England locally and the Better Care Fund Support Team nationally. We note the data given in the file: *BCF DTOC 15 August checkpoint supporting analysis received 8 September 2017* which sets out the level of NHS attributable daily delays as 'zero'. Following receipt of the initial pre-populated BCF planning return template on 13 July 2017, this issue was flagged, by email to the national Better Care Fund Support Team on 18 July 2017 requesting a telephone call to understand the rationale behind this data. A call was held on 19 July 2017 with input from CCG, CYC and the local Better Care Fund Support Team Manager. The advice given in this call was limited in terms of explanation as to where the 'zero' figure had originated from with a commitment to provide a follow-up to the call to provide further detail. An email was received by the CCG analyst on 20 July 2017 which stated the following:

It appears that the expectation for the NHS attribution is indeed '0'.

Note: "There is normal flexibility to propose a different distribution if more appropriate. It is recognized that some of the target reductions look very challenging, e.g.Sheffield, Nene, Oxfordshire. These may need to be discussed with respective regional teams."

Further discussion has taken place locally during August, including the reasons for the HWB not resubmitting the locally proposed trajectory. No further formal explanation has been provided until 11 September 2017 when discussion with the Lead Analyst, Data Science Hub confirmed that the pre-populated BCF template has pulled data through from an A&E Delivery Board submission in June 2017. Discussion with the Lead Analyst identified the following:

1. Potential under-reporting of all acute DTOC activity relating to the Vale of York CCG footprint that then informed the proportional NHS attributable delays for each of the CCG's HWB footprints. We understand this may be the case in other areas across the North.

2. Incorrect interpretation across the Vale of York system as to how the June A & E Delivery Board DTOC template showing the level of NHS planned reductions should be completed. On receipt of the submitted templates national analytical teams aligned the NHS data to LA data. On applying the reductions for LA DTOCs to the NHS trajectory, a negative number was created and then moved to 'zero' in recognition that a negative figure is not possible.

In the absence of a clear steer from NHS England about whether the "zero" can be corrected, and because we cannot replicate the derivation of the NHSE indicative plans, we have undertaken an exercise to estimate what the plan to reflect the York HWB footprint should be. We have included not just the NHS component, but also the adult social care component given the baseline date of February 2017. This month showed a particularly low count of delayed days – even after adjusting for days in the month. Also, from a CYC perspective, 99.9% of the DTOCs counted against CYC (NHS, ASC and Joint) are for Vale of York CCG patients.

The revised CYC plan is based on broadly two principles: firstly, that the number of delayed days for NHS:ASC:Joint are split 52:45:3. Secondly, the target level replicates the best performance seen over the past 9 months. The average monthly delayed days attributed to the NHS between November 2017 and March 2018 is 307; this is 29% lower than the 433 days per month for the CCG's patients in CYC measured over Q4 2016-17, but needs to be looked at in the context of time as DTOCs vary greatly from month to month and recognising seasonal pressures that need to be considered planning.

When agreeing proposed targets we have also needed to recognise the difficulties in setting the HWB footprint trajectory and plan in the context of the requirement to deliver the A&E delivery board footprint reductions of 3.5%. The ownership of these solutions by partners will be a critical factor in success. To this end we are in agreement that the proposed trajectory is realistic given the causes of delay and the work that needs to be done to move culture, systems and processes forward. Despite the challenges outlined above we are committed to work at pace and deliver sustained improvement.

		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1454.4	1682.7	1815.5	1173.6	1094.4	1211.1	1095.0	991.8	991.8	991.8	991.8	986.4
	Numerator (total)	2,497	2,889	3,117	2,032	1,895	2,097	1,896	1,729	1,729	1,729	1,729	1,729
	Denominator	171,684	171,684	171,684	173,149	173,149	173,149	173,149	174,327	174,327	174,327	174,327	175,281

Table 14: Delayed transfers of care metric

Following the escalation process the information below is now the agreed approach:

The revised DTOC Metric plan demonstrates our agreement and ambition to deliver the required 3.5% DTOC target.

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Quarterly rate	1454.4	1682.7	1815.5	1173.6	1094.4	1062.7	873.8	835.8	845.0	854.1	854.1	831.2
Numerator (total)	2,497	2,889	3,117	2,032	1,895	1,840	1,513	1,457	1,473	1,489	1,489	1,457
Denominator	171,684	171,684	171,684	173,149	173,149	173,149	173,149	174,327	174,327	174,327	174,327	175,281

Appendix 1 – High Impact Change Model Self-Assessment

Impact Change	Where are you now	Comments
1) Early Discharge Planning	Elective: a) **Plans not established**: *Early discharge planning in the community for elective admissions is not yet in place*. Emergency/ unscheduled: b) ***Plans in place****: Plans in place to develop discharge planning in A&E for emergency admissions*	• Pre assessment focus is on the anaesthetic risk assessment of patients having surgery (POPs Model for elderly). There is no proactive management of potential complex discharge management, there is a strong drive at pre assessment to ensure no day case patients are admitted for social reasons and the onus is on the patients to identify support. Pre assessment can occur on the day of or day before surgery and not all patients are pre-assessed. Patients being referred in should have this discussion with the primary care. • SAFER , bundle includes EDD set within 48 hours - RATS identify/assess patients on admission to ED and aim to turn get them home from ED. York have a social worker attached and have links to York ICT team to support discharge. EDD not set in ED - AAU /AMU/B –EDD set for todays and tomorrows discharges
2) Systems to monitor patient flow	*a)* **Not yet established:** *No relationship between demand and capacity* *b)* **Not yet established:** *Capacity available not related to current demand* c) **Plans in place:** *Analysis of causes of bottlenecks underway and practice changes being designed* d) **Plans in place:** *Analysis of admissions variation on going with capacity increase plans being developed* e) **Plans in place**: Staff training in place to ensure understanding of the need to increase senior clinical capacity	• Discharge levelling and golden patient work implemented across both Acute sites • Capacity and demand work required for community teams • Support has been requested from NHSI for demand analysis across the system. • Stranded patient reviews planned 17 August to identify delays /escalation • SAFER/ Stranded patient escalation
3) Multi-disciplinary, multi-agency discharge teams including voluntary and community sector	a) **Plans in place:** *Discussion on going to create integrated health and ASC teams* *b)* **Plans in place**: *No daily multidisciplinary team meeting in place* c) **Not yet Established:** Continuing Healthcare assessments carried out in hospital and taking "too" long	• Integrated Complex Discharge planning project and the one team • Board rounds SAFER in acute and community units ASC team and community DLT attend the weekly Community MDTs. Integrated complex discharge planning model • Pathway 3 yet to be established for discharge to assess
4) Home First Discharge to Assess	*a)* **Plans in place:** *Nursing Capacity in community being created to do complex assessments in the community.*	• Expansion of Scarborough CRT has increased capacity in Scarborough for pathway 1, Pathway 1 has been supported by CRT however the One

	b) **Established :** People usually only enter a care/nursing home when their needs cannot be met through care at c) **Not yet Established:** People wait in hospital to be assessed by care homes	team in York through integration should develop pathway 1 to be supported by intermediate care and reablement. Complex discharge to identify pathway capacity. • CYC numbers show that there is a reduction in the number of people entering care/nursing homes • There is currently no evidence to support the current time to assess, local audit would need to be developed
5) Seven day services	*a)* **Not yet Established:** *Discharge and social care teams assess and organise care during office hours five days a week* *b)* **Not yet Established:** *OOH'S emergency teams provide non office hours and weekend support* c) **Not yet Established:** Care Services only assess and start new care Monday-Friday **Plans in place:** *Hospital Departments have plans in Place to open in the evening and weekends*	• CRT and RATS 7 day service 8-8pm. SW attached to RATS does not cover the full hours • Care Services will restart existing care but not new POC. Wards can request the restart of existing POC within 2 weeks of admission. • Pharmacy, diagnostic and transport available evenings and weekends Age UK home form hospital operate 7 days a week and into the evening. New patient transport contract due to commence April 2018
6) Trusted Assessors	a) **Not yet Established:** Assessments done separately by health and social care *b)* **Not yet Established:** Multiple assessments requested from different professionals c) **Not yet Established:** Care providers insist on assessing for the service or home	• One Team does have plans to develop trusted assessment but these are not yet in place. This forms the 2nd phase priority for the team who will be analysing and developing the internal referral processes between the teams and the training of the workforce. • Care home providers still come into assess although there some occasions when assessment is accepted for example fast track patients. CYC SW assessments accepted by care provider. Work to be developed through care home project.
7) Focus on choice	a) **Plans in place:** Draft pre-admission leaflet and information being prepared b) **Plans in place:** Choice protocol being written or updated to reduce seven days *c)* **Not yet Established:** *No Voluntary sector provision in place to support self funders*	• Admission and discharge leaflet "Planning your Discharge from Hospital" available, no reliable process to ensure every patient receives. Plans in place with DLO to build a sustainable process add to the complex discharge project Workstream 3 • Joint Protocol to be reviewed as part of the Complex discharge project Workstream 3 • No plans in place to involve voluntary sector we have an example where CYC social work team provide this support for self funders. •

8) Enhancing health in care homes	a) **Plans in place:** CCG and ASC commissioners working with care home providers to identify need. b) **Plans in place:** Specific high referring care homes identified and plans in place to address c) **Established:** Quality and safeguarding plans in place to support care homes	• Care Home project- Lead nurse for quality and safety appointed to work with care homes. • Care Home project: High referring homes known and plans in place with the care home project to work with these areas • The CQC inspections- the data shows that we do not currently have any inadequate homes in our area and we are actually above the national average for ratings. • Local authority homes have improvement plans in place.

Glossary

POPs – Proactive Care of Elderly People Undergoing Surgery

SAFER care bundle – Senior review, All patients to have an expected discharge date, Flow of patients to commence by 10am from assessment units, Early discharge, Review weekly for patients with extended length of stay

EDD – Expected discharge date

ED – Emergency Department

RATS – Rapid Assessment & Triage Service

AAU – Acute Admissions Unit

AMU – Acute Medical Unit

NHSI- NHS Improvement

ASC- Adult social care

DLT – Discharge Liaison Team

MDT – Multi-disciplinary Team

CRT – Community Response Team

CYC – City of York Council

OOH- Out of Hours

SW - Social worker

POC- Package of care

DLO – Discharge Liaison Officer

Appendix 2:

York Teaching Hospital NHS
NHS Foundation Trust

Integrated Complex Discharge Planning Project

Project Initiation Document

June 2017

ANNEX A

Contents **Page**

1. Introduction

1.1 Purpose of this document

The purpose of this document is to define and describe the Integrated Complex Discharge Planning Project. This project is one of a number of projects under the Complex Discharge Task and Finish programme and should be read in conjunction with the overarching programme.

1.2 Background and Context

This section outlines the context that has driven the need to develop this project.

National

The National Institute for Clinical Excellence (NICE) has issued a clinical guideline on the transition between inpatient and community (or care home) settings[2]. The guidance particularly emphasises two overarching principles; the importance of personalised care planning for this cohort of patients and communication and information sharing between teams (and with patients, their families and carers).

There are 6 key areas. These are:

1. Before admission;
2. Admission to hospital;
3. During hospital stay;
4. Discharge from hospital;
5. Supporting infrastructure;
6. Training and development.

The guidance highlights the role of a discharge co-ordinator, as part of a multi-disciplinary team, liaising with community teams to plan discharge and arrange follow-up support. It re-iterates that discharge planning must start from the point of admission to hospital and utilise existing care plans where these have been developed in the community. Redesign of discharge processes should be based on the recommendations in the NICE guideline.

[2] NICE (2015) Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)

An initial (partial) assessment coordinated by the Clinical Effectiveness Team in June 2016 demonstrated that the Trust was not fully compliant with the guideline. A more recent Quality Standard issued by NICE, 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs (December 2016[3])', identifies five quality standards.

A recent scoping exercise against these standards demonstrated that the Trust does not comply fully against these standards. Appendix 1 provides a table summarising the findings. The five standards are:

1. Information sharing on admission;
2. Comprehensive geriatric assessment;
3. Co-ordinated discharge;
4. Discharge plans;
5. Involving carers in discharge planning.

Whilst these principles and key standards are the responsibility of all staff involved in the care of the individual whilst in hospital, it is essential that we adopt a system wide approach in the evaluation and design of the supporting processes to ensure better patient experience and improved compliance.

Local

In February 2017, the North West Utilisation Management Unit (at the Greater Manchester Academic Health Science Network) was commissioned by NHS Scarborough and Ryedale CCG on behalf of the NHS Vale of York CCG, NHS Scarborough and Ryedale CCG, NHS East Riding of Yorkshire CCG and NHS Hambleton, Richmondshire and Whitby CCG, to identify causes of the reduced Emergency Department performance at York Teaching Hospital NHS Foundation Trust. The report is based on national and local data analysis together with site based observations and it identifies key recommendations to improve whole system performance.

In February 2017, a paper was commissioned by the Deputy Director of Out of Hospital Care to explore the potential to develop an integrated discharge team approach. The report highlighted the current level of resource available across the teams and outlined four potential model options.

Option 1

[3] NICE (2016) Transition between inpatient hospital settings and community or care home settings for adults with social care needs – Quality Standard

No change to current organisational or line management arrangements but focus on service improvement strategies to improve communication and the development of pathways, with clearer processes for monitoring patients' progress and a review of roles and responsibilities along the pathway. Ensure not only focus for discharge from the acute bed base but also facilitating timely discharge from the community bed base.

Option 2

Merge the acute and community discharge liaison teams under the out of hospital care directorate management team and establish a co-located base. Re-structure the teams in order to establish a clear operational reporting structure. Develop and implement clear pathways for admission avoidance, discharge to assess, step down to community units and discharge from hospital wards/assessment units.

Option 3

Merge the acute and community discharge liaison teams as above with appropriate re-structure and accountability arrangements. Co-locate social care colleagues within same operational base in order to facilitate timely patient focussed pathways and inter professional problem solving. Have both social care and health colleagues line managed by one team leader working to joint goals.

Option 4

Fully integrate health and social care teams to come under single operational management reporting system which facilitates appropriate governance, accountability arrangements and budgets.

A decision has been taken recently to implement option 2 and integrate the acute and community discharge liaison teams and review the current structures and processes in place to manage complex discharge patients.

Currently the acute discharge liaison team have bases within York, Bridlington and Scarborough Hospital and the community discharge liaison team are based geographically at White Cross Court, St Helens and Malton. The City of York Council hospital social work team have a small office based within York Hospital and team base at Archways. The Operational Manager – Integrated Discharge Liaison Team and Community Discharge Team Leader are based at Archways.

The discharge liaison team, discharge liaison officers and social care team are central to the achievement of a large proportion of the NICE standards and are pivotal in coordinating complex discharges across the organisation.

2. Project Definition

2.1 Aims and Outcomes

This section describes the overall aims of the project and the measureable outcomes that will be achieved. The following section will then describe the changes that will be made to deliver these outcomes.

Aim:

1. To ensure patients have no unnecessary waits in hospital;
2. Patients receive a safe coordinated discharge;
3. Increasing the number of patients being discharged to their normal place of residency.

Outcomes

- Reduced number of Delayed Transfers of Care (DToC);
- Reduced number of stranded patients;
- Improved patient experience of the discharge process;
- Reduced length of stay;
- Reduce the number of occupied bed days.

2.2 Deliverables

This section outlines the key deliverable changes to be achieved these are:

- Ensure existing care plans are shared with admitting team;
- Review operational model of the discharge liaison team and develop standard operating procedures;
- Specify the role of the discharge co-ordinator;
- Use of technology to support identification of potential complex discharges and discharge planning;
- Review the Joint Protocol for Transfer of Care;

- Ensure discharge planning from point of admission;
- Development of training programme for discharge planning;
- Develop discharge care plans;
- Develop a post-discharge follow up calls process.

2.3 Authority for the Project

This project has been authorised by the Complex Discharge Task and Finish group reporting to the A & E Delivery Board. The Complex Discharge Task and Finish group is a multi-agency group that represents the key partners across health and social care (including commissioners).

2.4 Scope, Exclusions, Assumptions and Interfaces

This section attempts to define the scope of the project and the assumptions at the time of development.

Scope

The scope of the integrated complex discharge planning project is to address the discharge planning process for complex patients discharged from hospital and intermediate care (bed based and home based). Patients who are in hospital and intermediate care with complex needs will require referral for assessment by a range of members of the multi-disciplinary team, or the involvement of another agency or care provider.

Definition Complex Discharge:

Patients who have complex discharge needs are defined as:

- Patients that would be discharged home or to a carer's home or to intermediate care or to a residential or nursing care home (that is not their normal place of residency).

And

- Who have complex on-going health and social care needs which require detailed assessment, planning and delivery by the multi-disciplinary team and multi-agency working.

Exclusions

Simple discharges where patients do not require additional support from social services or health services at home to maintain independence.

Definition Simple Discharge Planning:

The action needed in the discharge planning for these cases does not usually require the involvement of a full multi-disciplinary team or require the involvement of another agency.

Patients with simple discharge needs are defined as those[4]:

- Being discharged to their own home or usual place of residency; and
- Having simple on-going care needs that do not require complex planning or delivery.

Assumptions

It has been assumed that, before the project undertakes the process change that has been described, we will know:
The work programme for the:

- Care homes project;
- Continuing health care review;
- Frailty comprehensive geriatric assessment project;

Interfaces

The other projects and pieces of work that interface with this project are:

- Interface with the ward based DLO and how they will work as part of this model; (led by Tracey Wright);
- Interface with the Safer Bundle, particularly clinical management plans and EDD; (led by Donald Richardson);
- Interface with stranded patient work (led by Donald Richardson)
- Interface with flow work (led by Mark Hindmarsh);
- Interface with frailty work (led by Jamie Todd);
- Interface with primary care coordinators (York Integrated Care Team and CAVA);
- Interface with Primary Care Home and York Care Collaborative;

[4] Department of Health (2010) Ready to go?
Planning the discharge and the transfer of patients from hospital and intermediate care

- Interface with Continuing Health Care review (VOYCCG Becky Case);
- Interface with Care Home project (VOY CCG Jenny Carter);
- Interface with Primary Care Frailty (S&R CCG);
- Interface with Future Focus - adult social care remodelling (CYC Mike Richardson).

2.5 Constraints

This section highlights the factors that will be critical to the success of the project and so, as a result, have the potential to significantly impact on delivery (and timescales). In deciding to proceed, consideration must be given to the potential risks arising from this and partners should be clear on the actions that will be collectively required to minimise these.

The following constraints have been identified:

- Staff time to attend meetings due to on-going operational commitments and existing commitments to other project work streams;
- The interdependencies of projects. There are a number of overlaps within this project and with other projects, consideration needs to be given to identify the priorities and interdependencies between each.

3. Project Approach

3.1 Governance

This section describes the structures and reporting mechanisms that will govern the project.

Executive Project Sponsor

The Executive Sponsor for this project is Wendy Scott

Project Board

The Project Board is the Complex Task and Finish Group

Project Lead/Owner

The Project Lead/Owner is Melanie Liley

Project Manager

The Project Manager is Gillian Younger

Project Team (Steering Group)

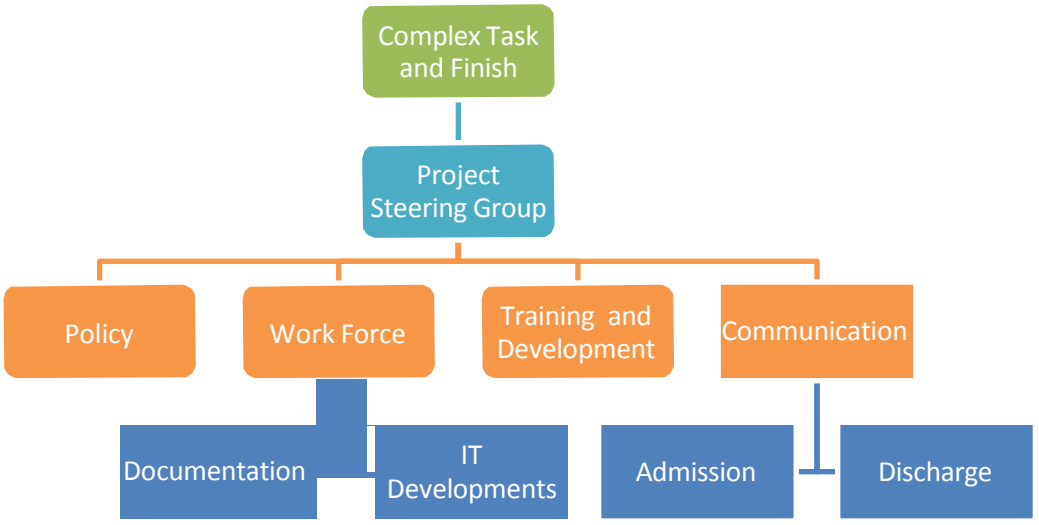
Name	Division/Organisation
Deputy Director Out of Hospital Care (Chair)	YHFT
Out of Hospital Community Service Manager *(Deputy Chair)*	YHFT
Senor Hospital Flow Manager	YHFT
Community Therapies Operational Manager	YHFT
Operational Manager Integrated Discharge Liaison	YHFT
Corporate Nursing Representative	YHFT
Discharge Liaison Team Lead/Manager	YHFT
Service Manager Hospital S/W Team	City of York
Service Manager Scarborough, Selby	North Yorkshire
Service Manager	East Riding
Project Manager	YHFT

Operational Leads

In order to achieve the aims and objectives of the project there will be a number of focused work streams, each work stream will have a nominated operational lead and work stream membership will consist of identified stakeholders. The work streams are as follows:

Work stream	Operational Lead
Workforce- Integrated Discharge Liaison Team	Bev Proctor
Training and Development	Sara Kelly
Policy	Tracey Wright
Communication Admission & Discharge Processes	Corporate Nursing

3.2 Project Organisation



Each work stream will report monthly into the project steering group. The steering group will report progress monthly to the Complex Discharge Task and Finish Group (Project Board).

Each work stream will be expected to complete a written update (plan on a page) on a monthly basis. The Steering Group will produce an executive summary for the Complex Discharge Task and Finish Group.

3.3 Stakeholders

Each work stream will undertake a stakeholder mapping and analysis exercise. Once stakeholders have been identified, they will be analysed to estimate their levels of interest and influence on the successful delivery of the aims and objectives of the work stream.

3.4 Communication

A communication plan will be developed by the steering group to identify the methods to be used to communicate the work and any changes made.

4. Project Plan

The three sections that follow describe the next steps for the project. It also sets out the approach that will be taken to identifying and managing risks associated with the programme.

4.1 Milestones and Timescales

A full project plan will be developed but the following table highlights the key milestones identified for the project and the timescales for these to be delivered. The draft project plan can be found in appendix 1.

Milestone	Timetable
Approve Project Scope	May 2017
Present draft Programme Initiation Document to multi-agency stakeholders	June 2017
Approve Programme Initiation Document	June 2017
Set up work streams and contract with work stream leads	June 2017
Undertake stakeholder mapping and analysis and develop communication plan	June 2017
Identify prioritisation and overlaps	July 2017
Write detailed project plan	July 2017

Implementation	August-December 2017

4.2 Deliverables

The full list of deliverables will emerge with the completion of the project plan, however the following table highlights some of the key early deliverables.

Deliverable	Timetable
Approve Project Scope document	May 2017
Draft Project Initiation Document	June 2017
Establish Integrated Complex Discharge Planning Project Group	June 2017
Communication Plan	June 2017
Risk Register	June 2017
Project Plan	July 2017

4.3 Risks

In order to support the management and mitigation of risk associated with the project; a comprehensive risk register will be established and held by the steering group.

5. APPENDICES

5.1 Appendix 1: NICE Quality Standards scoping exercise summary

The recent Quality Standard issued by NICE, 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs (December 2016[5])', identifies five quality standards. A recent scoping exercise against these standards demonstrates that the Trust does not comply fully against these standards. Table 1 provides an overview of this scoping exercise and identifies some of the actions required to improve compliance.

Table 1: Quality Standards and Initial Assessment

Quality Standard	Assessment	Assessment Evidence
QS1: Information Sharing on Admission Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.	Non-compliant	Discussions with the SNS team have started about identifying patients who have previously been discharged with a Section 5 (NOD) or who are known to be complex patients on the District Nursing/community teams' case load who have existing care plans. More understanding is required around the opportunities within primary care and social care processes for patients with existing care plans.
QS2: Comprehensive Geriatric Assessment Older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.	Partial Compliance	Comprehensive Geriatric Assessment (CGA) is currently completed but is not in a single coordinated assessment. The information is collected during the admission process at various points by multiple professionals. Timeliness and comprehension needs to be improved. There are plans to pilot a single combined CGA document from the point of admission across both sites and the pilot will commence firstly in Scarborough.
QS3: Coordinated Discharge Adults with social care needs who are in hospital have a named discharge coordinator.	Non-compliant	Acute Discharge Liaison nurses and DLO have allocated ward responsibilities and manage complex discharge. DLO's (Managed by the patient flow team) are allocated to each ward manage all discharges. SW team act as the coordinator for social care. Need to define the role and agree the key responsibilities against the standard to provide greater assurance. Determine the role of the wider MDT in co-ordination.
QS4: Discharge Plans Adults with social care needs are given a copy of their agreed discharge plan before leaving hospital.	Partial Compliance	Electronic Discharge Notification gives very limited information; some chronic conditions have self- management plans? Need to better understand the documentation given to patients / family from social care Design a discharge care plan for consistency
QS5: Involving Carers in discharge planning Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.	Partial Compliance	Family/Carers attend Acute MDT Meeting (case Conference) Family/Cares involved in initial assessments Discharge to assess family /carer involved and present at the point of discharge; model to be rolled out Complaints trends indicate that we do not communicate or involve patients Proactive evaluation of discharge experience of patients and family's

NICE (2016) Transition between inpatient hospital settings and community or care home settings for adults with social care needs – Quality Standard

ANNEX A

Appendix 3:

York Teaching Hospital NHS
NHS Foundation Trust

Project Brief- Refresh Phase 2

Project Title: Integration of Intermediate & Reablement care 'One Team

1) Executive Sponsors	
Melanie Liley	Michael Melvin
YHFT	CYC

2) Operational Project Lead		
Rachael Smye	Dr Lesley Godfrey	Belinda Jones
YHFT/ CRT	Primary Care/ ICT	CYC/Adult Social care

3) Project Manager if applicable	
YHFT- Gillian Younger	CYC - Chris Weeks

Date of Project Brief Agreement	August 2016

Project Start Date	August 2016	**Project End Date**	1 April 2018

4) Background to the Project
In August 2016 through Provider Alliance project approval was given to commence an integration project for intermediate care and reablement within the City of York. **Aim:** The aim of the project is to design a patient centred intermediate rehabilitation and

reablement service across the City of York. The service aims to be responsive and well-coordinated to enable patients to be safely cared for/supported to remain in their own home and maximise independence

Project Scope:

Service included:

- Community Response Team
- Reablement Service (commissioned by CYC)
- York Integrated Care Team
- CYC Adult Social Care Teams
- Voluntary Sector

Requirements

1. Single Specification / Outcomes framework
2. Single point of access/triage
3. Co-location of teams
4. Shared Documentation/Assessments
5. Trusted Assessor model
6. Workforce Development
7. Co production model for design

The project has now been running for 1 year and entering phase two.

Phase 1: (August 2016 – August 2017) **Progress to date**

- Testing joint triage with core teams
- Space for co-location at Archways provided for up to 20 members of the 'One Team' to be co-located. Teams included are CRT, ISS, Hospital SW (own space), Reablement, Community Discharge Liaison Team.
- Co production model with service users and regular public reference forums in place. Public Reference Group, include customers and carers from the focus groups who expressed an interest, Healthwatch York, Older Citizens Advocacy York (OCAY), York Older People's Assembly (YOPA).
- Rehab social work team working with CRT directly has reduced the time from initial referral and reduced duplication and improved communication.
- The team have agreed a set of joint metrics/outcomes both quantitative and qualitative.

Phase 2: (September 2017– January 2018)

- **Embed the joint triage process** – This will start to see movement between teams and reduce the hand offs back to wards

- **Assess the feasibility of a single point of referral** for health and social care referrals into the one team (step down)- This will provide the wards with a simple referral pathway (joint referral documentation) and reduce the hand offs back to wards and further develop pathway 1 of supported discharge (Trusted Assessment) and more patients being assessed at home.

- **Standardisation of assessments between Hospital /community adult social care teams –** This will enable reablement to have a single assessment process, reduce time for Hospital social work teams

- **Workforce –** Begin to develop an in depth understanding of the role and competencies with each team and identify opportunities for share training and development. Explore the governance arrangement that would be required for joint care of patients

Phase 3: (January 2018– April 2018)

- Assessment of Progress

5) Key Objectives with Quality and Success Criteria

The outcomes and key functions of the service has remained unchanged these were:

Outcomes :

- People who use the service and their carers have a positive experience of care and support
- People and their carers are supported effectively to enable them to keep living in their own home or normal place of residence
- People are supported to recover from episodes of ill health or following injury

This project will include four of the key functions identified;

1. **Access and co-ordination** – the 'one team' will be expected to provide daily co-ordination of individuals in transition between care settings; regular meetings to support care planning for high risk individuals; an interface between the team and other services (including acute care) and co-ordination within the team.
2. **Rapid response** – the 'one team' will be expected to provide a timely response (within hours) to those with an urgent need, wrapping additional support around existing services to ensure an individual can remain at home in a crisis.
3. **Facilitated and supported discharge** – the 'one team' will be expected to actively pull individuals from acute settings, wrapping additional support around existing

services to ensure an individual can return home. This will include providing assessments of long term care and support needs where required.

4. **Maximising independence** – the 'one team' will work with individuals, taking a coaching approach, to promote prevention, self-care and the use of community support to maximise independence.

6) Key Stakeholders both Internal and External, including Finance and CET Leads (including contact details)

Project Team

Rachel Smye (YHFT)

Lesley Godfrey /Liz Allen (Primary Care)

Rachel Daniels (YHFT)

Sam Watts (previously Cathy Holman) (CYC)

Liz Conheeney (CYC)

Nicky Openshaw (Age Uk)

Emma Brough (YHFT)

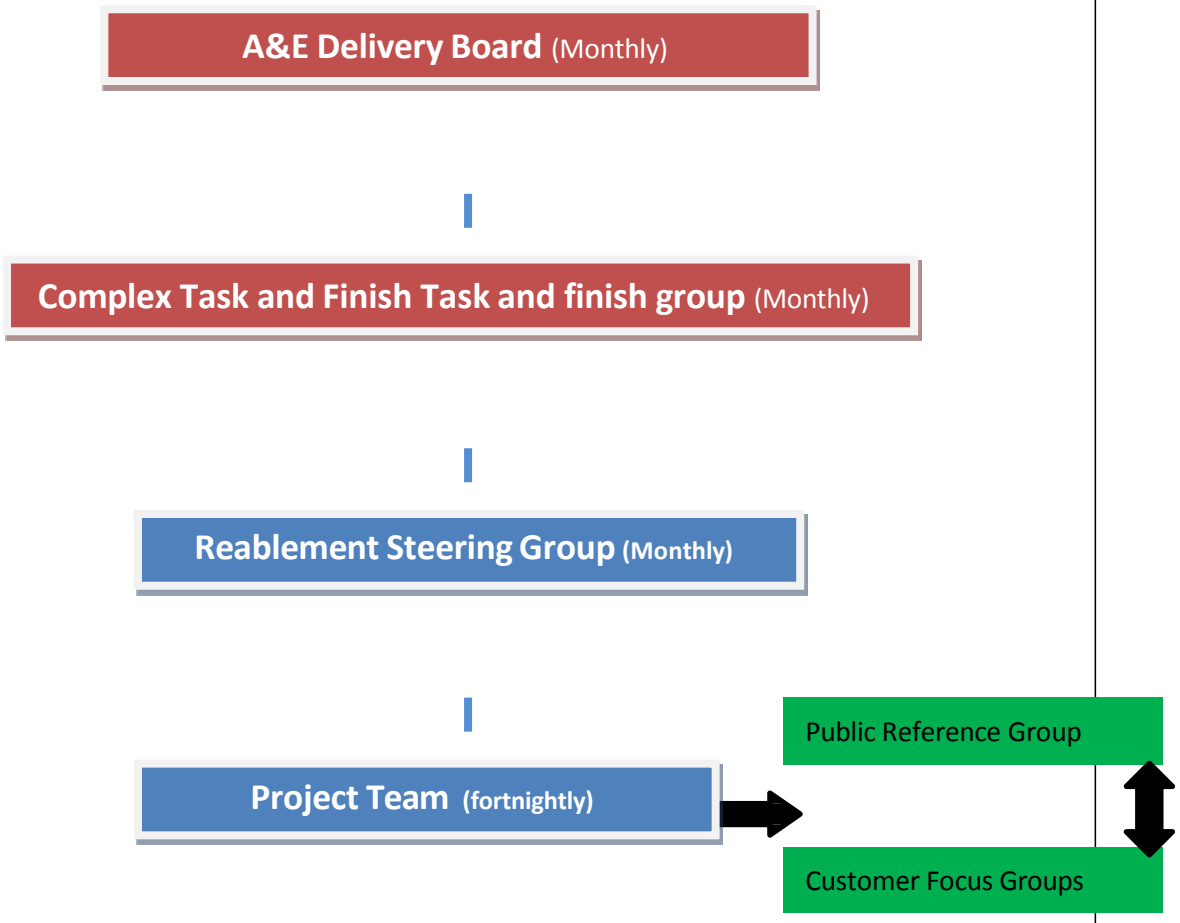
Community Discharge Liaison (YHFT)

Other stakeholders will be co-opted a plans and focus changes

7) Governance, Reporting and Monitoring including Communications Plan (including Frequency and Format)

Governance & Reporting and Monitoring

The Project Team will provide a monthly written update to the reablement steering group and the complex discharge task and finish group and report by exception an any other time.



8) Risk and Issues, and Constraints

There have been a number of constraints. In summary these include:

- The service scope for York CRT has changed significantly over the last 7 months team now cover north Ryedale and City North and has required the operational team to focus on the delivery of core business whilst balancing the demands of an integration agenda.
- CRT referral activity has increased by over 50 % and capacity is now at full

escalation.

- The reablement tender process ran from January – April and contract mobilisation commencing August 2017, have both delayed any direct engagement until the tender was awarded. However the specification was very clear about the one team model.

- IT delays in the installation of additional network capacity and equipment

9) Assumptions

- No further changes will be made to York CRT
- Mobilisation of the reablement contract continues as planned

10) Measures for Success

The team have agreed a set of joint metrics/outcomes both quantitative and qualitative. Outcomes include

- **Number of referrals** – The project aim is increase the number of referrals managed from the baseline of August 2016
- **Number of patients who remain in their own residency 91 days after discharge** – The project aim is to increase the number of patients remaining in their own residency.
- **The number of permanent admissions to residential care**. The project aim is reduce the number of patients admitted to residential care
- **Outcome from service -** The project aim is reduce the size of care package at start and service vs at end of service
- **Functional outcome from services** The project aim is increase the functional ability from the start of service vs end
- **Overall patient satisfaction with the service -** The project aim is increase patient satisfaction
- **Overall staff satisfaction with communication between services-** The project aim is increase staff satisfaction.

11) Resourcing Arrangements

Continued to be funded by existing resources

Approval Date: ……../……/……

Appendix 4: BCF Risk Log as of 26th July 2017

Risk Description	Consequences	Impact/Likelihood	Controls/mitigating actions
Inaccurate assumptions underpinning financial modelling and target setting within the plan.	• Financial consequences for whole system. • Knock on effect for future years. • Reduction in confidence in system leaders. • Reputational damage with national programme directors	High impact/low likelihood.	1. Monthly performance monitoring at BCF PD Task Group 2. Further work to develop a joint performance management framework. 3. Recovery plans whenever underperformance.
Failure to take up joint commissioning opportunities.	• Inefficient use of resources and duplication of activity. • Fragmented delivery, care and support. • Reduced opportunity to achieve a sustainable health and care system. • Difficulties in bringing about integration of health and social care by 2020.	High impact/low likelihood.	1. Joint commissioning strategy agreed 2. Risk management principles in place 3. Challenge at partnership boards. 4. Joint commissioning programme Manager appointed
Failure to achieve KPIs at individual scheme level.	• Performance impacted. • Assurance level of CCG impacted. • Potential financial impact (dependant on KPI measure)	High impact/moderate likelihood.	1. Monitoring of BCF delivery PD Group and HWB. 2. Organisational monitoring of individual schemes in line with lead commissioner.

Risk Description	Consequences	Impact/Likelihood	Controls/mitigating actions
Failure to achieve national targets (especially NEA)	• Performance impacted. • Assurance level of CCG impacted. • Potential financial impact (dependant on KPI measure)	High impact/moderate likelihood.	1. Monitoring of BCF delivery. 2. Organisational monitoring of individual schemes in line with lead commissioner. 3. Application of risk management principles. 4. Signed S75 agreed and in place. 5. Seeking reconciliation of ambulatory care reporting issues (NEA)
Workforce pressures affect delivery of schemes	• Reduced capacity and/or capability. • Negative impact on KPIs, financial and national metrics. • Wider system pressure.	High impact/moderate likelihood.	1. Joint workforce strategy in place. 2. Wider system focus via HWB partnership. 3. On-going discussions with strategic partners. 4. Monitoring of individual systems by lead commissioner to flag any issues at an early stage.
STP and Capped Expenditure Programme creates pressures on delivery of the BCF plan.	• Financial pressures. • Reputational damage. • Workforce disruption. • Negative impact on KPIs, performance.	High impact/high likelihood.	1. Involvement of senior leaders in STP planning arrangements. 2. Reporting via organisational systems. 3. Monitoring of BCF delivery via HWB. 4. Regular informal briefing sessions delivered by CCG to partners
External Inspection by CQC of BCF Programme	• Reputational damage • Limited power of CQC to take action	Low impact/High Likelihood	1. Capacity pressures with other reviews and inspections (CQC, SEND) 2. iBCF compliance with National Conditions

ANNEX B

NHS England
Skipton House
80 London Road
London
SE1 6LH

20 December 2017

To: *(by email)*

Cllr Carol Runciman	Chair, City of York Health and Wellbeing Board
Mary Weastell	Chief Executive, City of York Council
Phil Mettam	Accountable Officer, Vale of York Clinical Commissioning Group

Dear Colleagues

BETTER CARE FUND 2017-19

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. The Better Care Fund is the only mandatory policy to facilitate integration of health and social care and the continuation of the BCF itself. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. For the first time, this policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically.

Your plan has been assessed in accordance with the process set out in the *Better Care Fund 2017-19: Guide to Assurance of Plans.*

In determining and exercising further powers in connection with your application, NHS England has had regard to the extent to which there is a need for the provision of health services; health-related services (within the meaning given in section 14Z1 of the NHS Act 2006); and social care services.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. In summary, the assurance team recognises your plan has been agreed by all parties (local authority(s), Clinical Commissioning Group(s) (CCGs), and your Health and Wellbeing Board), and the plan submitted meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, and the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

Amounts payable to the CCG in respect of the BCF are subject to the following conditions under section 223GA of the NHS Act 2006:

1. That the CCG will meet the performance objectives specified in its BCF plan; and
2. That the CCG will meet any additional performance objectives specified by NHS England from time to time.

If the CCG fails to meet those objectives, NHS England may withhold the funds (in so far as they have not already been paid to the CCG) or recover payments already made; and may direct the CCG as to the use of the amounts payable in respect of the BCF.

In addition to the BCF funding, the Spring Budget 2017 increased funding via the Improved Better Care Fund (IBCF) for adult social care in 2017-19. This has been pooled into the local BCF. The new IBCF grant (and as previously the Disabled Facilities Grant) will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government has attached a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local better care manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours faithfully,

Simon Weldon
Director of NHS Operations and Delivery and SRO for the Better Care Fund
NHS England

Copy (by email) to:

Martin Farran	Director of Adult Social Services, City of York Council
Paul Howatson	Head of Joint Programmes, NHS Vale of York CCG
Jo Farrar	Director General, Department for Communities & Local Government
Jonathan Marron	Director General, Department of Health
Sarah Pickup	Deputy Chief Executive, Local Government Association
NHS England North	
Richard Barker	Regional Director
Moira Dumma	Director of Commissioning Operation
Julie Warren	Locality Director
Helen Dowdy	Associate Director of Strategy, Yorkshire and Humber
Tim Barton	Senior Manager, Intervention and Support
Jenny Sleight	Better Care Manager
Better Care Support team	
Keziah Halliday	Programme Director, Better Care Fund
Rosie Seymour	Deputy Director, Better Care Fund

This page is intentionally left blank

Health and Wellbeing Board **24 January 2018**
Report of the Director of Health Housing and Adults Services and the Accountable Officer, NHS Vale of York Clinical Commissioning Group

CQC Local System Review of York - update

Summary

1. The Care Quality Commission (CQC) has been commissioned to review twenty local systems during 2017 -18, focusing on how local services work together to support older people at the interface of health and social care.
2. The local system is defined by the Health and Wellbeing Board area, and therefore the council area. A performance dashboard of six key indicators was used to identify the initial programme of reviews. York was among the first twelve areas to undergo a review in this new methodology.
3. The CQC Local System Review concluded with the publication of their report on 22nd December 2017. The full report is available at: https://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems
4. York is required to submit an action plan to CQC by the end of January 2018.
5. The Accountable Care Systems Partnership Board met on 19th December 2017 and received a briefing on the outcome of the review and the requirement for a system wide response through the action plan. Partners discussed the advantages of establishing a Place Based Improvement Board for the York system to oversee the development and implementation of the action plan. Such a board would naturally also provide the locality arrangements for York under the Accountable Care System Partnership Board, which covers the Vale of York and Scarborough & Ryedale footprint.
6. In view of the council's role as the lead body for Place, there was support for the City of York Council to co-ordinate the

development of the action plan and proposals for the Place Based Improvement Board.

7. The HWBB is requested to consider the future governance arrangements for the delivery of the CQC action plan, including the potential advantages of establishing a Place Based Improvement Board for this purpose.

Background

8. The Better Care Fund (BCF) was established to support improvement in outcomes for people using services and local communities by promoting integration and transformation of health and social care. It focuses on out of hospital care to prevent admissions to and reduce the impact of delayed transfers of care.

9. In the budget 2017 the government announced an additional £2 billion nationally, paid directly to councils – the improved Better Care Fund (iBCF). The aims of the fund are:

- Meet adult social care needs
- Reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensure that the local social care provider market is supported

10. Following the Spring Budget announcement of additional funding for adult social care, the Department of Health and Department for Communities and Local Government commissioned the Care Quality Commission (CQC) to undertake a programme of targeted reviews of local authority areas. The purpose of the reviews is to ascertain how people move through the health and social care system with a focus on the interfaces, with particular reference to Delayed Transfers of Care (DTOC).

11. The Local System Reviews are taking place first in areas that have been identified as challenged according to 6 key metrics in relation to *"user access and flow (including high numbers of delayed transfers of care)".*

12. The York Local System Review was initiated at the end of September, and included seven days on site in York in October and early November. A multi-agency working group oversaw the

preparation for the review, providing evidence and responding to information requests.

13. Our narrative set out the history of partnership and integration in the area, the renewed commitment to working together and recent improvements in performance, highlighting the direction of travel.

Main/Key Issues to be Considered

14. The review culminated in the Local Summit to receive the CQC findings and begin the development of an action plan to address their recommendations. This event was facilitated by the Social care Institute for Excellence (SCIE) which will also support the action planning process.

15. The final report was published on 22nd December 2017. There has been limited attention to it in local media, presumably due to the proximity to Christmas. The national interim report was published the same week, summarising the findings from the first six reviews. York was the seventh review and is not covered by the interim report.

16. CQC highlighted a wide range is issues grouped under the established five domains of their inspection Key Lines Of Enquiry (Safe, Effective, Caring, Responsive and Well-Led). These issues include:

- The need to continue improvements in partnerships and collaborative working at all levels – strategic and operational / frontline

- The lack of a single vision and strategic plan for the York system, and the need to raise the voice of York in the wider STP arrangements

- The need to communicate the York vision more clearly to the population, to staff and to people needing services

- The lack of progress on implementing the eight High Impact Changes to improve individual outcomes and patient flow – this includes issues such as access to reablement, seven day working, weekend discharges, person centred approaches in CHC, discharge to assess

- Information sharing, in terms of performance data as well as shared care records is a significant problem, arising from the lack of IT integration

- Workforce and market capacity are a significant challenge now and in the future

- Pace of improvement in all the areas above is a concern

17. The report makes thirteen recommendations arising from these issues. The HWBB is required to submit and action plan in response to the report. It should be returned to CQC by the end of January 2018. A firm deadline of 31st January 2018 has now been set for this by CQC.

18. An initial high level action plan has been drafted, based on the specific recommendations made by CQC. This is attached at Annex 1.

19. This high level plan will need to be accompanied by a more detailed action plan. York is receiving regular support from our SCIE advisor on the preparation of the plan. All partners involved in the Local System Review are contributing to the development of the plan and are asked for their support in ensuring that it is received and recognised within the governance arrangements of individual organisations to ensure whole system commitment.

20. CQC found the HWBB to have made positive strides to streamline the governance arrangements for York in 2017. However, the review identified weaknesses in the sharing of performance information across the system, with limited evidence of shared and agreed performance metrics to inform or support system performance.

21. Partners present at the Accountable Care Systems Partnership Board on 19th December (covering the Vale of York and Scarborough &Ryedale footprint) have agreed in principle to explore the advantages of establishing a Place Based Improvement Board for York to take forward CQC's recommendations and address the issues raised in the report. An Improvement Board would be accountable to the HWBB for delivering the action plan.

22. Such a board could also address wider system improvement, beyond the scope of the review which focused narrowly on people

over 65 years of age, and excluded their mental health and wellbeing, other than services for people with dementia. Proposals for the potential governance arrangements are set out in an early draft, attached at Annex 2.

23. In re-launching the Accountable Care Systems Partnership Board, the question arises of how the other localities, beyond York, might fulfil the requirement for locality arrangements. The York HWBB is responsible for ensuring effective governance arrangements for its area. The York approach may inform and influence other areas as it is making faster progress on this. Partners will be engaged in these developments.

24. Due to the timing of the meeting in relation to the deadline for the submission of the action plan, the HWBB is asked to delegate the responsibility for finalising and approving the final version of the plan and the further development of the governance arrangements to the Chief Executives of the council and Foundation Trusts, and the Accountable Officer of the CCG.

Consultation

25. Discussion has taken place at the Accountable Care System Partnership Board which covers the Vale of York, Scarborough and Ryedale. Informal consultation on the contents of the action plan has taken place with partners.

Options

26. Not applicable

Analysis

27. Not applicable

Strategic/Operational Plans

28. CQC acknowledged the overarching vision for the system as York's health and Wellbeing Strategy 2017-22. The action plan will incorporate other relevant plans already in place.

Implications

29. **Financial** – full implementation of the CQC recommendations will require investment or redirection of resources. Failure to achieve the required improvement in performance on the 6 domains of the

NHS and Social care dashboard may result in a review of iBCF, and conditions being attached to its deployment in York.

30. **Human Resources (HR) –** no implications at this time.

31. **Equalities** - the implementation of CQC recommendations will support inclusion for older people.

32. **Legal –** no implications at this time.

33. **Crime and Disorder –** no implications at this time.

34. **Information Technology (IT) –** CQC made a specific recommendation relating to IT integration and interoperability: “A review of IT interconnectivity should be completed to ensure appropriate data sharing and a more joined up approach across health and social care services”.

35. **Property -** no implications at this time.

36. **Other** - no other implications at this time.

Risk Management

37. Failure to submit a compliant action plan to CQC and the Department of Health on time may result in sanctions being imposed on York HWBB and its constituent organisations.

Recommendations

38. The Health and Wellbeing Board are asked to consider:

    i. Delegating the oversight of developing and submitting the CQC action plan to the Director of Health Housing and Adults Services, acting alongside system leaders.

    Reason: to ensure that the work is completed in line with the requirements of the Department of health and CQC.

    ii. Delegating the task of further developing future governance arrangements for the CQC action plan and wider system improvement to the Chief Executive of the council, acting alongside system leaders.

    Reason: to enable proposals to be developed and consulted on informally prior to further recommendations being brought to the HWBB at a future meeting.

Contact Details

Author:

Pippa Corner
Head of Joint Commissioning Programme
Adults Commissioning
CYC / NHS VOYCCG
Tel No.551076

Chief Officer Responsible for the report:
Martin Farran
Executive Director of Health Housing and Adults Services
CYC

Report Approved ✓ **Date** *16.01.2018*
Phil Mettam
Accountable Officer
NHS VOY CCG

Report Approved ✓ **Date** *16.01.2018*

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

All relevant background papers must be listed here*.*
CQC Local System Review Interim National Report
CQC City of York Local System Review
Available at:
https://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems

Annexes

Annex 1 – high level action plan
Annex 2 – draft proposals for governance arrangements

This page is intentionally left blank

Annex 2

DRAFT: TERMS OF REFERENCE FOR YORK PLACE BASED IMPROVEMENT BOARD (11-1-18)

York Place Based Improvement Board

DRAFT Terms of Reference

January 2018

For The Attention of HWBB:

These DRAFT Terms of Reference have been compiled as a starting point to stimulate discussion and enable partners to consider some of the likely features of the Improvement Board. They are not intended to predetermine the eventual form of the Board.

1 Vision and Purpose of the York Improvement Board (YIB)

1.1 The overarching strategic vision is set out in York's Joint Health and Wellbeing Strategy 2017 – 2022.

1.2 YIB will translate this strategic vision into a single plan for York, and to lead rapid progress in its achievement, while recognising the leadership role of YorOK on Children and Young People.

1.3 YIB will bring together all partners, focusing on the delivery of specific actions within the single plan.

1.4 YIB will work to achieve transformational change across the York system, building a shared approach to system leadership and collaborative working relationships at all levels.

2 Responsibilities of the York Improvement Board (YIB)

2.1 The Board is accountable to the Health & Wellbeing Board for delivering certain Health & Wellbeing Strategy priorities and objectives. The Board has several specific responsibilities as follows:

2.2 To lead the development of integration in health and social care in York on behalf of the whole system.

2.3 To oversee the development and implementation of the CQC action plan, following the CQC Local System Review (December 2017).

2.4 To drive improvement in outcomes, including improved performance against the NHS and Social Care Dashboard.

2.5 To establish a whole system approach to performance management and evaluation.

2.6 To provide assurance to the Health and Wellbeing Board on the Better Care Fund, and receive reports from the BCF Performance and Delivery Group for this purpose.

2.7 To lead the development and delivery of joint commissioning. This includes a joint assessment of need in order to agree common priorities across the partnership. The YIB will explore the potential for pooled and aligned budgets.

2.8 To be an inclusive partnership, fostering collaboration and recognising the range of contributions from across the system, not limited to financial commitments.

2.9 To produce an annual report on its activities for the Health and Wellbeing Board.

2.10 **Membership:**

CYC, NHS VOY CCG, YTHFT, TEWV, York CVS

Others, including any service user or carer engagement to be considered.

2.11 Lead Officer – the Lead Officer will assist the Chair and Vice Chair in determining the forward plan, prioritising, scheduling and coordinating agenda items, is responsible for ensuring that appropriate reports, presentations and attendees are available for items tabled and acts as a contact point for enquiries.

2.12 Secretariat - Board meetings will be serviced by a secretariat. The secretariat is responsible for planning and coordinating meetings and

venues, maintaining an up to date register of Board members and their contact details, disseminating agendas and papers to Board members, taking minutes of Board meetings and acting as a contact point for enquiries.

2.13 Other support for the Board - The council and VOYCCG will ensure that the Board receives the necessary support to enable the Board to discharge its responsibilities effectively. This will include financial and legal advice and specific support to monitor and review performance.

2.14 Making decisions - The Board will not exceed its powers and will comply with any relevant obligations imposed by its members. Members will seek to achieve consensus through discussion. Any vote will be by a simple majority of members in attendance with the exception of proposals to alter or amend the Constitution. The Chair has a casting vote if needed.

2.15 Interests of Board members - Board members must declare any personal or organisational interest in connection with the work of the Board. Where there is a potential conflict of interest for individual Board members, this should be openly and explicitly declared. At the Chair's discretion the Board member may be excluded from the discussion and / or decision making related to that particular agenda item.

2.16 Leaving the Board - A person shall cease to be a member of the Board if s/he resigns or the relevant partner agency notifies the Board of the removal or change of representative.

2.17 Meetings - The Board will normally meet on a monthly basis i.e. 12 meetings per annum. The Board will be quorate when at least five members, including at least one representative from City of York Council, one representative from the Clinical Commissioning Group and one other partner are present. If the meeting is not quorate it may proceed at the discretion of the Chair but may not take any decisions that would require a vote.

3 Involving people in the work of the York Improvement Board

3.1 The Board expects that the views and involvement of local people will influence the work of the Board and its sub groups at all stages. It will ensure their views inform planning, commissioning, design and delivery of service provision.

3.2 YIB will begin by using the opportunity provided by the CQC action plan to set out improvements to our communication and engagement arrangements, and to seek further means for involving people in developments. Reports to the board will be required to describe the way local people have been engaged in their preparation, and the Board will adopt the co-production principles accepted by the Health and Wellbeing Board in 2017.

4 What the Board doesn't do

4.1 The Board is not directly responsible for managing and running services but it does consider the quality and impact of service delivery across partner organisations. It does not have direct responsibility for budgets, except where these have been delegated to it.

5 Accountability and reporting

5.1 YIB is formally accountable to the Health and Wellbeing Board for York.

5.2 The Chair of the YIB will be confirmed upon the formal establishment of the Board.

5.3 YIB may establish subgroups, or "task and finish" groups as appropriate to deliver its agenda and priorities. These subgroups will be accountable to the Board and will report at least annually to the Board.

5.4 Initially, the following groups will report directly to YIB:

- Better Care Fund Performance and Delivery Group
- IT integration working group
- CQC action plan working group

5.5 The Board will receive reports from any partnership forum where commissioning activity is undertaken. The Board will receive reports on the financial position of any pooled budget at meetings of the Board.

6 Expert advice and support for the Board

6.1 Financial and legal advice will be available to the Board from within the Local Authority and the NHS Vale of York Clinical Commissioning Group to ensure that decisions taken are both permissible and in accordance with proper accounting procedures.

6.2 Specialist performance and management information support and advice will be provided by the Local Authority and the NHS Vale of York Clinical Commissioning Group to enable the Board to fulfil its performance and outcome monitoring role.

7 Culture and values: how the Board exercises its responsibilities and functions

7.1 The Board will take into account the following behaviours and values in exercising its functions.

Board Members will:

Participate on the basis of mutual trust and openness, respecting and maintaining confidentiality as appropriate;

Work collaboratively, ensuring clear lines of accountability and communication;

Share expertise and intelligence and use this synergy to provide creative solutions to complex issues;

Take account of any particular challenges, policies and guidance faced by individual partners;

Have regard to the policies and guidance which apply to each of the individual partners;

Adhere to and develop their work based on the vision statement approved by the Board;

Where decisions of the Board require ratification by other bodies the relevant Board Member shall seek such ratification in advance of any meeting of the Board or promptly following Boards recommendations;

The Board shall exercise its functions so as to secure the effective cooperation of partners and the provision of high quality integrated services.

7.2 Board members will adhere to the Nolan principles for the conduct of public life.

1. Selflessness
2. Integrity
3. Objectivity
4. Accountability
5. Openness
6. Honesty
7. Leadership

More information is available at:

www.gov.uk/government/publications/the-7-principles-of-public-life

8 Public participation

The YIB is not a public forum. However, the work of the Board will be reported to the HWBB .

Relevant documents:

- Health and Wellbeing Strategy
- Joint Strategic Needs Assessment
- CQC Local System Review of York
- CQC Action Plan

Health and Wellbeing Board **24 January 2018**
Report of the Chair of the Health and Wellbeing Board Steering Group

Update on the work of the Health and Wellbeing Board Steering Group

Summary

1. This report provides the board with an update on the work that has been undertaken by the Health and Wellbeing Board (HWBB) Steering Group. The board are asked to note the update.

Background

2. The HWBB Steering Group has met twice since it last reported to the Health and Wellbeing Board. There is a commitment from the group to meet at least once every two months. There is still work to do around ensuring partner representation and engagement with the group.

3. The paragraphs below provide an update on some of the recent work of the HWBB Steering Group.

Main/Key Issues to be Considered

HWBB Work Programme

4. As part of their remit HWBB Steering Group manage the business on the HWBB's work programme. This should ensure the board receives and considers the most appropriate material at its meetings. The Steering Group consider this at most of their meetings but in a rapidly changing health and social care system the work programme needs to be flexible enough to accommodate a wide variety of items, sometimes at short notice.

5. Recently the Steering Group agreed to add the following items to the Health and Wellbeing Board's work programme:

- Older People's Survey Report (January 2018)

- Report from North Yorkshire Fire and Rescue Service around their offer in relation to early intervention and prevention (date to be confirmed).

6. The group also propose to defer the item on the learning disabilities strategy scheduled for the March 2018 until there is a draft strategy to consider. However, they have been assured that work is ongoing to produce this and that this involves working with the learning disabilities community.

7. Ongoing attention is needed to manage the volume of business scheduled into the work programme so that individual meeting agendas are manageable and where possible themed. The Steering Group will continue to look at this.

Pharmaceutical Needs Assessment (PNA)

8. At their meeting in November 2017 the Steering Group considered the draft PNA for York for the period 2018-2021. This has now been formally consulted on and the final PNA is being prepared for consideration at the March 2018 meeting of the Health and Wellbeing Board.

9. The Steering Group looked at some of the key things that had changed since the last PNA was produced highlighting population changes (there has been an increase in the older population since the last PNA was published); general population increase; changes in the way some services are commissioned and the growing population of students in York and their access to pharmacies.

10. It is standard practice to consult with neighbouring areas in relation to PNAs and the Steering Group have been asked to comment on North Yorkshire Health and Wellbeing Board's PNA. A response will be prepared prior to the formal consultation finishing in February 2018. The Steering Group are not expecting to find anything that negatively impacts on York as a working group with partners from both areas has worked to develop both PNAs.

11. The final version of the PNA will be presented to the HWBB in March 2018 for sign off.

Communications and Engagement

12. The Winter HWBB newsletter was published in December 2017 and covered some of the highlights of the Ageing Well and Mental Health themed meetings of the Health and Wellbeing Board.

13. The JSNA Road Shows continue and encompass a number of showcasing events to raise awareness and enable partners to get the best from the JSNA. Unfortunately there has not been a good turn out to many of these but those that are planned will still go ahead.

14. A strategy mapping event is scheduled for 1st February at Priory Street and this is being led by CVS; the event is a drop in style event and the purpose is to map and understand what is happening across the city and our communities in relation to delivering the joint health and wellbeing strategy.

15. Finally, work is underway to plan for Health and Wellbeing Board, in collaboration with One Planet York to take part in this year's York Festival of Ideas. The theme for this year's festival is 'Imagining the Impossible'. As part of this wider city conversation it is proposed that HWBB and One Planet York focus on healthy city and place and the and the working title for the day is: Paradise Found: How Can One Place Work for Everyone. The provisional date for this event is 12th June 2018.External speakers are currently being sought and a number of focused workshops will also take place.

16. A small working group has been set up to lead this work and has already sought input from the Health and Wellbeing Board Steering Group.

Consultation

17. Consultation and engagement around specific projects and topics is ongoing. The current HWBB Steering Group is a multi-agency group with the ability to co-produce, engage and consult on specific areas of work.

Options

18. The Board are asked to note the contents of this report.

Analysis

19. This report is for information only.

Strategic/Operational Plans

20. The Health and Wellbeing Board have a statutory duty to produce a Joint Strategic Needs Assessment; a Joint Health and Wellbeing Strategy and a Pharmaceutical Needs Assessment.

Implications

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

Risk Management

22. The production of a JSNA, a Joint Health and Wellbeing Strategy and a PNA are statutory responsibilities for the HWBB. Delivering against these is resource intensive and needs to be managed to ensure they are fit for purpose and subsequently delivered.

Recommendations

23. The Health and Wellbeing Board are asked to note this update.

Reason: To update the Board in relation to the work of the HWBB Steering Group.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Tracy Wallis Health and Wellbeing Partnerships Co-ordinator City of York Council/NHS Vale of York Clinical Commissioning Group	Sharon Stoltz Director of Public Health City of York

Report Approved ✓ **Date** 16.01.2018

Tel: 01904 551714

Specialist Implications Officer(s) None

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Glossary
HWBB – Health and Wellbeing Board

This page is intentionally left blank

Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 24th January 2018 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Governance			
Appointments to the Health and Wellbeing Board	City of York Council Tracy Wallis Angela Bielby		• To appoint a new representative for NHS England
Theme: Living & Working Well (lead HWBB Member: Sharon Stoltz)			
Progress against the Living & Working Well theme of the Joint Health and Wellbeing Strategy (including performance management)	City of York Council Sharon Stoltz		• To receive a progress update on the Living & Working Well theme of the Joint Health and Wellbeing Strategy • To include a performance and monitoring update in relation to the Living & Working Well theme of the Joint Health and Wellbeing Strategy
Theme: Mental Health (lead HWBB Members: Martin Farran and Phil Mettam)			
Mental Health Strategy for York	City of York Council Martin Farran NHS Vale of York Clinical Commissioning Group Phil Mettam		• to receive the final draft of the all age mental health strategy for York for final comment
Mental Health Housing and Support	City of York Council Martin Farran NHS Vale of York	City of York Council Chris Weeks	• For noting and cross-agency support

Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 24th January 2018 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
	Clinical Commissioning Group Phil Mettam		
Other Business			
Older People's Survey	City of York Council Fiona Phillips		• To note the results of the York Older People's Survey and respond to the recommendations in the report. •
Better Care Fund	NHS Vale of York Clinical Commissioning Group/city of York Council Pippa Corner		• To receive an update on the Better Care Fund and the iBCF
CQC Whole System Review	NHS Vale of York Clinical Commissioning Group/city of York Council Pippa Corner		• To receive the final report arising from the CQC Whole System Review
Update from the HWBB Steering Group	City of York Council Sharon Stoltz		• Update from the HWBB Steering Group

Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 7 March 2018 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Theme: All themes: Wider Determinants of Health (lead HWBB Member: Sharon Stoltz)			
			•
TBC: Reducing Health Inequalities through Cultural Commissioning	Tbc	Tbc	• Tbc
Other Business			
Update from the HWBB Steering Group	City of York Council Sharon Stoltz		• Update from the HWBB Steering Group
Pharmaceutical Needs Assessment (PNA)	City of York Council Sharon Stoltz		• To receive a new PNA for the city covering the period 2018-21
Healthwatch York's Report on Dental Services	Healthwatch York Siân Balsom		• To receive a Healthwatch York report on dental services
			•

Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 9 May 2018 - West Offices			
Item/Topic	**Lead Organisation & Officer**	**Other Contributing Organisations & Participants**	**Scope**
Theme: Wrap up Meeting – content of agenda to be confirmed			
Performance Management	TBC		• To receive a performance and monitoring update in relation to the Joint Health and Wellbeing Strategy
Other Business			
Update from the HWBB Steering Group	City of York Council Sharon Stoltz		• Update from the HWBB Steering Group
TBC: Learning Disabilities Strategy for York	Tbc	Tbc	• To receive a progress update on the development of a Learning Disabilities Strategy