Annex B

CQC Local System Reviews

Local System Overview

Information Request

Introduction

Following the budget announcement of additional funding for adult social care, CQC has been requested by the Secretary of State for Health to undertake a programme of targeted reviews in local authority areas. These reviews will be focused on the interface of health and social care.

The reviews will look specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The review will not include Mental Health Services or specialist commissioning but, through case tracking, will look at the experiences of people living with dementia as they move through the system.

The purpose of the reviews is to provide a bespoke response to support those areas facing the greatest challenges to secure improvement.

Our intention is that these reviews will provide a useful reflection for each of the local areas highlighting what is working well and where there are opportunities for improving how the system works for people using services.

Once we have completed all of the reviews, we will also be producing a national report of our findings, which will identify key themes and recommendations.

As outlined in a letter to York on 31st July 2017, your area has been selected for a local system review, commencing on 30 October 2017.

Local System Overview Information Request

In preparation for your review we are asking for a representative in your area to complete this Local System Overview Information Request. It contains 15 questions and provides an opportunity for you to introduce your area to us, and tell us in your own words how York works as a system for older people moving between health and social care.

The aim is to help us understand:

- How health and social care is organised across your local authority area
- What you are trying to achieve as an integrated system and the impact this is having for people who use services
- The challenges and constraints you face

Accompanying the information request is a ‘System Contact Form’ document (see question 1 for details). This will need to be completed and returned ahead of the main document.

How the information will be used

The Local System Overview Information Request is a vital part of the review process. The information you provide will help the review team understand your local system, inform the planning and delivery of review activities, and help the team develop the findings of the review.

The Local System Overview Information Request will also be shared with the analytical team and will be used to inform the national report of our key findings and recommendations, which will be published after all of the reviews are completed.

The information you provide in response to this request will be treated in accordance with CQC's information governance policy. As a public body we are obliged to consider requests for disclosure of information under the Freedom for Information Act 2000. In the event of a request for any information you have provided we will consult with you before deciding whether to release or withhold the information.

Who should complete the Local System Overview Information Request?

We expect an individual to hold the responsibility for completing the Local System Overview Information Request on behalf of your area. It is up to each area to decide who takes on responsibility for this, but we recommend that it is a person with strong contacts across health and social care, as the questions will need to be answered from a whole-system perspective. You may wish to use your Health and Wellbeing Board as a forum for completing and/or signing off the document, however this is not mandatory.

How to compete the Local System Overview Information Request

We have a very limited timeframe to review submitted information before we visit your area. We want to ensure that we are able to make the best use of all the information you provide. To help us do this we ask that you follow these guiding principles when answering the questions:

- **Answer concisely** and within the question word limit. Prioritise the reporting of exceptions- what is going particularly well/ less well. We welcome the use of diagrams and charts where appropriate.
- **Answer candidly**; reflecting openly on the challenges you face as a system, as well as your successes. The review is intended to provide a useful reflection for your area highlighting what is working well, and where there are opportunities for improvement and this can only happen if your responses are accurate, honest and transparent.

- **Answer specifically**; directly address each question and avoid copying large chunks of more general text from existing documents. If you refer to supporting documents or data in your answer, include a page or tab reference and attach the document/file. We can only review attached documents/files where it is clearly explained how they address the question and where there is a page/tab reference.
- Be mindful of the scope of the local system review programme, described at the beginning of this introduction.

Deadline for completion

The Local System Overview Information Request is vital to our planning for your review. We therefore ask that you please send your completed document to health&socialcarereviews@cqc.org.uk no later than 20th October 2017

Please note that the accompanying 'System Contacts Form' document should be completed and returned ahead of the main document by Friday 29th September 2017. See question 1 for more detail.

Further information

If you have any questions about completing the Local System Overview Information Request or would like further information about the local system reviews programme, please email health&socialcarereviews@cqc.org.uk and a member of the team will get back to you.

Thank you for your support in completing the Local System Overview – we look forward to working with you and colleagues in your area over the coming weeks.

Lead contact details

Please provide the contact details of the lead person completing the Local System Overview Information Return.

Name: Name: *Pippa Corner*

Role: *Head of Joint Commissioning Programme*

Organisation: *City of York Council (CYC) and NHS Vale of York Clinical Commissioning Group (VOYCCG)*

Email: *pippa.corner@york.gov.uk*

Telephone: *01904 551076* ***or*** *07500 973 261*

Section 1: Background to your local system

1. **In the accompanying document (System Contacts Form) please identify the key organisations and the system leaders within them that drive the commissioning, planning and delivery of services for older people at the interfaces of health and social care.**

   Please note the System Contacts Form needs to be completed and returned ahead of this main document, by 29th September 2017

2. **How are health and social care services organised to serve the population within your local authority area, in particular for people aged 65 and over? [max 500 words]**

[Tip: This is an opportunity to articulate what the health and social care system(s) looks like in your local authority area. We recognise that there may be more than one system operating across your local authority boundary]

[Tip: You may wish to use a diagram or chart here to illustrate how your health and social care system(s) are organised]

A pattern, not a puzzle

Our view of the system in York starts with the person.

Working across sectors, we are building a truly person-centred, place-based pattern of support. Tackling loneliness and isolation is the top priority, preventing, reducing, delaying and managing need at the least intensive level possible.

The voluntary and community sector **is a formidable resource in York. We are building capacity and resilience in communities, for example our** Ways To Wellbeing Service(2.1) **uses social prescribing to tackle loneliness and isolation among older people.**

In Primary Care**, Vale of York Clinical Commissioning Group is leading the development of** integrated care hubs(2.2)**, and partnership working with the GP federations.**

The Council is leading on a new 'community operating model'. With partner organisations in NHS, community and voluntary services, through our strong partnership with York CVS, we are reviewing the volunteering strategy for the city, which will focus more on the growth of social action and impact volunteering – 'People Helping People'. Our Local Area Coordination(2.3) **programme and** Community Facilitation **is central to this approach.**

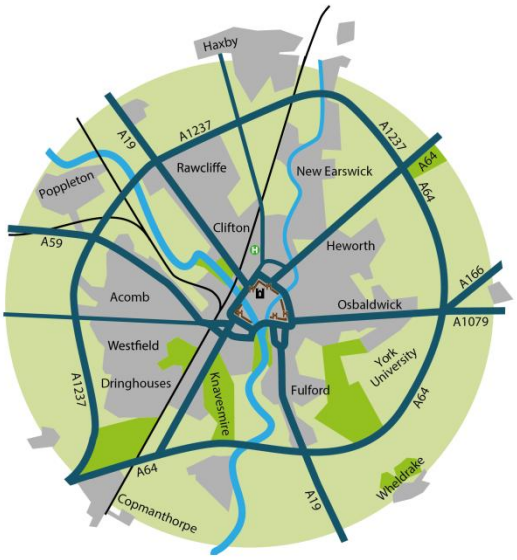
Future Focus(2.4) **– our assessment and care management redesign programme – starts with a strength based approach, reaching people quickly with information, advice and guidance, skilled in helping people stay well and resilient, maintaining their independence for as long as possible.**

We have united our Intermediate Care and Reablement teams (which support people through a crisis or returning home from hospital) as 'One Team'(2.5)**.**

Our aim is for people who need care and support to receive it at home or as close to home as possible, reducing our dependence on acute and in-patient

services.

This review centres on the City of York Health and Wellbeing Board footprint.



Our system geography is highly complex.

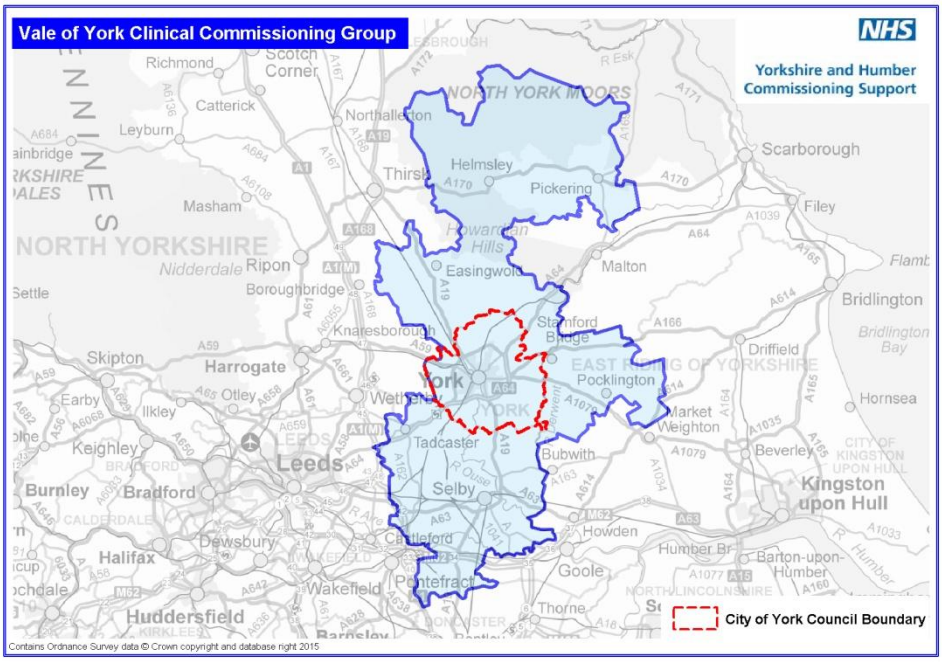
York CVS **– bringing together the voluntary and community sector, with a network of 1,000 organisations and groups.**

www.yorkcvs.org.uk

VOYCCG **– commissioning in partnership with CYC, NYCC and ERYC, across North South and Central (York) Localities. There are two GP federations under**

the VOYCCG umbrella, as well as unaligned practices.

www.valeofyorkccg.nhs.uk



YTHFT**- providing acute and community healthcare to the populations of York and Scarborough (and surrounding areas). YTHFT operates York district general hospital, two community rehabilitation units and community teams working from several locations. The** Healthcare of Older People **directorate (acute) has led the development of improved services for frail patients arriving at hospital. The** Out of Hospital Care **directorate brings together adult community services and allied health professionals (acute and community).**

www.york.nhs.uk

TEWV **– delivering mental health and learning disability services to the CCG registered population, as part of a much wider Trust footprint. TEWV has disaggregated Adult Mental Health and Mental Health Services for Older People into specialities, aligned to Royal College guidelines.**

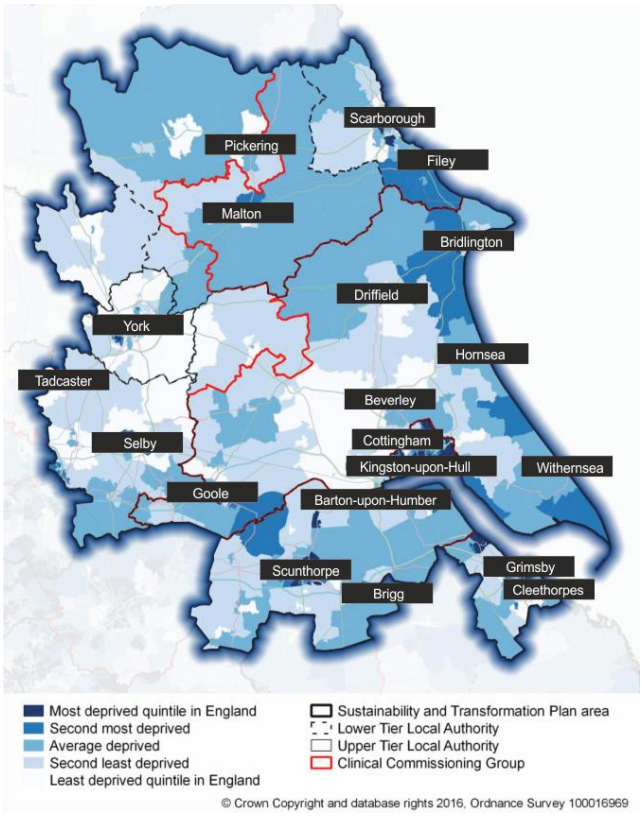
www.tewv.nhs.uk

YAS - **providing the region's emergency, urgent care and non-emergency patient transport services, serving a population of over five million people across Yorkshire and the Humber. The catchment area for our NHS 111 service extends to North Lincolnshire, North East Lincolnshire and Bassetlaw in Nottinghamshire.**

www.yas.nhs.uk

Humber, Coast and Vale STP

www.humbercoastandvale.org.uk



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3. What key partnership, commissioning and governance arrangements are in place across the system(s) to support the planning and delivery of joined up care for older people at the interfaces of health and social care? [max 500 words]

[For example, Better Care Fund plan; Local A&E Delivery Board; integrated care programme work streams; joint or aligned commissioning and provider arrangements]

York – part of the wider system

Under the Humber, Coast and Vale Sustainability and Transformation Partnership**, the** Accountable Care Systems Partnership Board **covers the Vale of York and Scarborough and Ryedale CCG catchment populations.**

An Unplanned Care Programme **has been approved by the Board. This is overseen by a Steering Group with delivery through three** Locality Delivery Groups**, aligned to local authority boundaries.**

The A&E Delivery Board**, covering the York Teaching Hospital NHS FT footprint, reports to NHS Improvement North and NHSE, and is responsible for developing and managing urgent and emergency care across the system. Amongst other things, the Board has introduced a** Complex Discharge Programme(3.1)**, which is overseen by the** Complex Discharge Task and Finish Group(3.2) **(comprising senior managers from across the partner agencies), focussing on operational actions to improve discharge pathways, implementing the High Impact Changes and reducing delayed transfers of care.**

Partnership arrangements in York

The Health and Wellbeing Board **oversees the direction of health and social care in** York**.**

During 2017 The HWBB reviewed and streamlined the formal reporting structure beneath it. A single Steering Group **now reports to the board.**

The Board published York's Joint Health and Wellbeing Strategy 2017-2022(3.3) **in March 2017.**

All partners are signed up to the Health and Wellbeing Strategy which sets out our aspirations for the way we will promote and sustain the health and wellbeing of the whole community, and particularly including those people who need care and support.

The strategy is underpinned by the JSNA(3.4), **(which is a continual**

programme of work, compiling evidence and shaping priorities), and the Annual Public Health Report(3.5) **– which sets out the state of health for the area over a yearly cycle.**

In January 2017 the HWBB approved the Joint Commissioning Strategy(3.6)**. This formalises the commitment of CYC and VOYCCG to align and pool budgets where appropriate and to form a joint commissioning unit in preparation for integration by 2020.**

The developing partnerships for Mental Health, Learning Disability and Autism will be informed by the findings of this review.

The Better Care Fund Plan(3.7) **has accelerated our journey towards greater integration of service delivery. The** BCF Performance & Delivery Group(3.8) **is a multi agency task and finish group where our joint plans are developed in partnership and schemes are monitored and evaluated to ensure value for money from the fund. This group works closely with the** VOYCCG Central Locality Delivery Group**, which covers York.**

System leaders have regularly reviewed the effectiveness of our partnership groups and networks in the context of the changing external environment for VOYCCG. Some groups such as the Integration and Transformation Board have had a relatively short life but have been critical in establishing trust and consensus, and adopting shared values and behaviours to drive system change.

Partnership arrangements in primary care between Primary Care Home and York Care Collaborative are developing.

In addition, there are regular contract management boards between VOYCCG and TEWV and VOYCCG and YTHFT.

4. What is the history of NHS and local government collaboration in your local authority area? [max 500 words]

[Tip: To what extent is there a track record of partners working together at the system level in your area? What are your successes and where have you historically faced difficulties in collaborating?]

Recent history:

We have invested in system leadership, addressing together the combined

challenges facing our system (Q6).

Our shared appreciation of the changes needed is shaping our approach to integration and service transformation.

- **Co-location: e.g. West Offices, Archways, 30 Clarence Street**
- **Collaboration: e.g. BCF, Joint Commissioning Programme, Quality initiatives**
- **Communication: e.g. Co-production principles, DTOC protocol, Choice Protocol**

Changes in step – looking back

York has benefited from formal and informal partnership arrangements for many years, including some long standing working relationships.

However, there have been many changes along the way, in key leadership roles and in organisational structures. This has required individuals and agencies to rebuild relationships frequently, investing personal energy in partnerships and open communication.

Joint Commissioning

Changes in the configuration of NHS commissioning (PCTs, CCGs, CSU, PCU) and changes in personnel across the system in recent years have interrupted working arrangements and disrupted relationships at times.

In 2013-14, the inception of the BCF fostered openness and transparency in joint finances - we recognise that this has been a long journey. Each year's process has deepened our integration. There remains a sense that some schemes are CCG and some council. Joint commissioning will overcome this within the lifetime of the current plan.

Over the past year the Council and CCG have worked together, jointly commissioning a Community Service for Older People and an Advocacy Hub - consolidating all aspects of advocacy support under one single specification and provider. The Council acted as lead commissioner on behalf of the partnership.

We are now in the process of jointly re-commissioning our carers service.

Integrated provision

Providers here have a tradition of working together to pool resources,

supported by the commissioners as a vehicle for whole system working.

The impact of Transforming Community Services (TCS in 2011) and changes in provider contracts have now settled. The past two years have seen a period of greater stability. Since that time a number of planned and unplanned changes to beds have been required. This has been undertaken in a collaborative manner to meet patient needs.

The York Dementia Action Alliance(4.1) **comprises over 60 groups and agencies working to make York a dementia friendly city.**

In 2016, we established our Provider Alliance Board bringing together primary care leads, mental health trust, local authorities, foundation trust and voluntary sector leads. The Board has developed relationships and trust between provider organisations to support integrated service delivery.

The System Resilience Group previously led the winter planning and escalation processes. Its leadership role incentivised integrated approaches to service delivery by allocating one-off winter monies. The group evolved into the A&E Delivery Board, established in September 2016. It leads the provision of urgent and emergency care.

We have a history of collaboration between the council and foundation trust to improve discharge pathways. Our joint work to introduce a 'discharge to assess(4.2)' approach during 2016 has been followed by a project to integrate intermediate rehabilitation and Reablement services under the banner of "One Team" with a new single specification(4.3). (Q12)

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5. How effective are local relationships in delivering integrated health and social care for people in your area*? [max 500 words]

[Tip: Please add any comments that would give further information to how different parts of the system work together to deliver health and social care to older people in your geographical area, focussing on quality of relationships in the system.]

<u>A step change</u>

We can demonstrate progress against key local and national targets as evidence of our step change in delivery.

There is now a common purpose across the partnership to prevent, reduce, delay and manage people's need for care and support. We are developing as a team and are emphatically optimistic about our direction of travel.

The past two years show renewed stability in the leadership teams across the health and social care system. Regular meetings – formal and informal - between system leaders are adding value to working relationships, resulting in opportunities for joint posts, sharing assets and resources, such as estates.

Our BCF plan opens:

"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 are proud of the changes we are making to join up services around the people who need them and improving flow through the system. (Examples detailed in Q12).

- **Ways to Wellbeing – showing 30% reduction in people needing to see their GP.**

- **YICT has reduced excess bed days for their admitted patients by 33% in 2016-17, identifying those at risk and pulling people out of acute care to be looked after closer to home.**

- **The One Team has enabled a 14% increase in the number of patients able to access intermediate care (home and bed based) and increased the proportion delivered at home from 33% to 50%.**

- **The Complex Discharge Task and Finish Group High Impact Changes self-assessment(5.1), highlighting progress and the work still required.**

- **Discharge to Assess: we have worked collaboratively to deliver a project testing three D2A pathways during 2016/17.**

- **We are exploring the use of step down and short breaks services in our**

Independent Living Communities.

- **The Ambulatory Care Unit opened in 2016, enables 90% of its patients to be discharged with some treatment and to stay in their local communities.**
- **The Emergency Department front door streaming commenced in July 2016 triages 'walk –in' patients to the right place, such as a medical ward, a GP, community pharmacy or social care.**
- **TEWV and YTHFT host weekly DTOC meetings involving CCG and council to reduce delays in Older Peoples' wards with a clear focus on delivering the best possible discharge outcomes for individuals.**
- **TEWV has a dedicated Care Home and Dementia Team who specifically work with the care homes across the Vale of York.**
- **HCVSTP recently completed a NHS 111 direct booking (in hours / out of hours) PID for the Urgent and Emergency Care Network.**

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* Please note we will ask system contacts (question 1) to complete a short anonymised survey that will form part of an audit on system relationships.

6. What significant pressures and challenges are you currently facing as a system(s) that impact on the delivery of joined up care for older people? [max 500 words]

[For example, financial; health and care workforce; provider market. Please provide any data or financial detail in support of your answer.]

[Tip: Are there any contextual factors that are specific to your area e.g. geography]

The pressures and challenges facing York are unique within the region.

pressures and challenges	**impact on delivery**
The **funding formula** has not reflected York's financial and demographic pressures over a considerable period. The affluent image of York makes it harder to attract new funding – (4% of the population lives in the 20% most deprived areas in England). The capped expenditure regime and NHSE legal directions imposed on the CCG reflect £50m deficit in annual budget across NHS organisations.	York has an allocation 11% lower than HCVSTP benchmark(6.1). The Capped Expenditure Programme impedes invest to save opportunities. National BCF assurance process delays funding reaching our voluntary sector schemes.
Workforce pressures across health and social care are deepened by the unequal prosperity, high cost of housing and full employment environment whereby social care is less attractive than other industries. Low paid workers cannot afford to live in the city. Qualified staff (all levels) in high demand. Nursing and medical workforce is significant challenge for YTHFT and TEWV, as well as the specialist independent sector care beds. EU referendum is a factor.	Difficulty in retaining the staff in home care and care home sector. High cost of agency staff in YTHFT(6.1/2) causes significant budget pressure and vacancies impact on safe service and efficiency. Pressure on placements and care packages – risk for the future and current cause of DTOC.
The wider system is **highly complex**. Geography of strategic and operational systems is often mismatched. HCV STP footprint is not necessarily a natural affiliation for York. CCG footprint includes CYC, NYCC, ERYC. YTHFT footprint: York, Easingwold, Malton, Selby, Scarborough,	Public gravitates to convenient and familiar services - not necessarily best placed to meet their need (such as emergency department). Two GP federations and some unaligned practices impedes CCG's ability to lead York as one system. Competing regulatory frameworks. Resources are stretched in partnership arenas.

Bridlington. For YAS and TEWV York is a small but pressured part of their business.	A&E delivery board doesn't disaggregate for the York population.
Demographic demand: 9,500 older people in York – rising to 10,000 by 2020. 2,700 older people with dementia – rising to 3,500 in next 10 years.	Reliance on bed based services, including in mental health. Workforce pressures (see below) will be compounded by rising need. The council in-house care homes closure programme.
Population expectations are high in York. Relatively affluent and educated people make higher use of elective services. General health is better overall, but the most deprived do not always seek the support they need early enough.	The number of (lower need) self funders buying care impacts on the flexibility and capacity in the wider system.
Information sharing is impeded by legacy of multiple IT systems and low investment in mobile devices.	No single shared case record. People have to tell their story more than once. Poor history of shared data / business intelligence
7 day services not yet fully embedded.	Impact on weekend discharge. Potential impact on individuals unable to obtain right care, right time, right place.

Word count 500 / 500

7. How have you managed changes to your system spend for older people and/or changes in demand for services since 2010/11[max 500 words]

[Tip: Describe how your system spend for older people has changed since 2010/11. This information may be collected by your STP or you may wish to draw on your Better Care Fund detail. Please provide data or financial detail in support of your answer.]

Spending less, achieving more together – "the glass half full"

Our social care story of spend describes three key cultural changes:

- Prevention
- Redesign
- Cost effectiveness

Our focus on tackling loneliness and isolation through social prescribing is preventing **the need for traditional care services, shifting towards personalised support, drawing on the strengths and assets of individuals, families and communities.**

Make choices and plans which keep me independent, **preventing** the need for services in the long term

Find support if I'm at risk of losing independence, **reducing** my need for services

Access help to get me back to an independent situation if something happens to be **delaying** the need for more acute services

Plan and **manage** my own support wherever I can to address the things which matter most to me

We are redesigning **services to manage demand differently.** Future Focus **is expected to achieve recurrent savings by changing the culture.**

The JSNA informs our planning and commissioning**. For example the Older People's Accommodation Strategy(7.1) promotes independent living – providing 900 new units by 2020.**

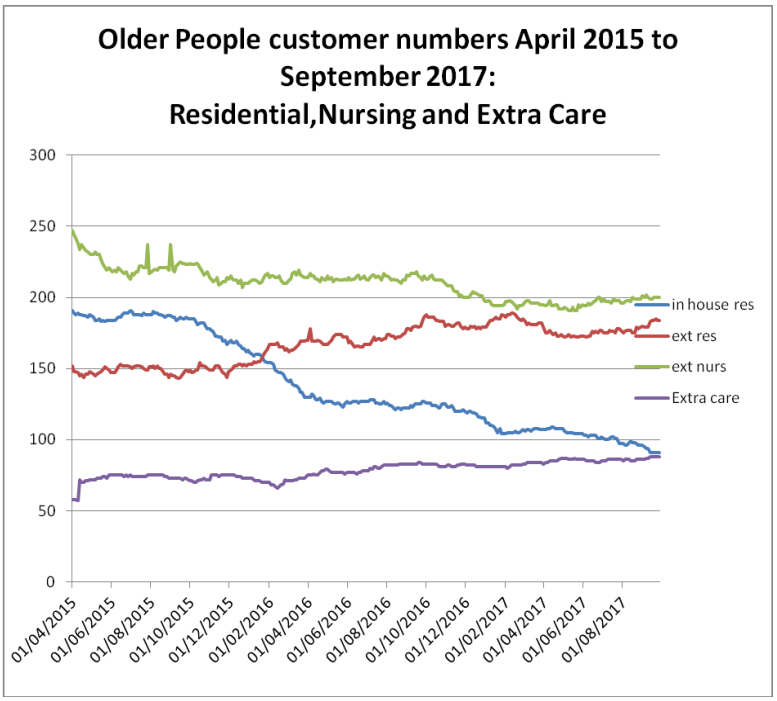
We are becoming more efficient **while improving outcomes through our joint commissioning programme. For example, the Sensory Hub and the Older Person's Community Service, the Community Wellbeing Service and services for carers.**

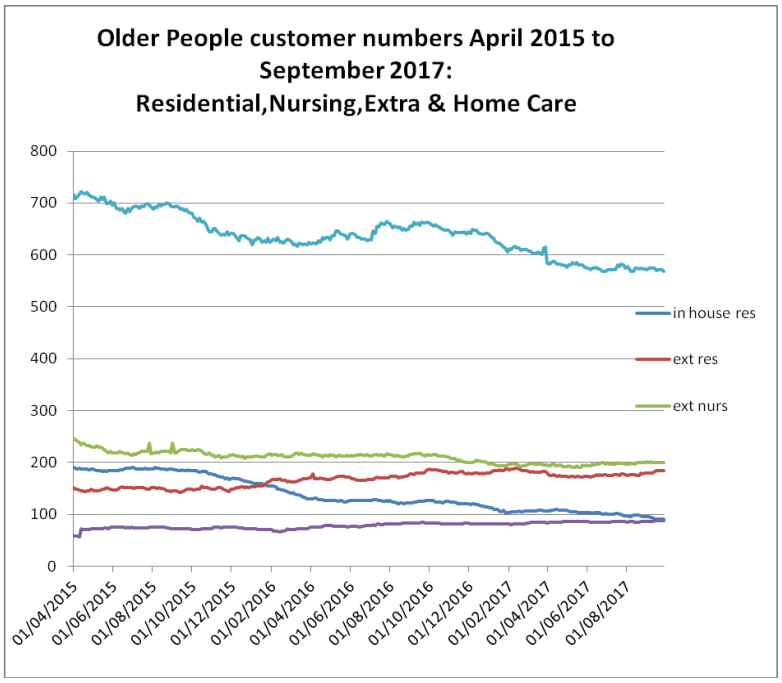
CYC/HHAS Older People spend has reduced by £2m since 2010/11 and achieved a balanced budget since 2015.

Total customer numbers are reducing; admissions to Residential Care are reducing.

The council's standard rates have increased by 30% over the last six years having worked with providers on two Actual Cost of Care exercises. Demand for residential care has dropped over the last two years (See graph).

We have implemented full cost recovery in council run homes for those who can afford to pay.





Home care customer numbers are also reducing but complexity is rising.

The hourly home care rate has increased significantly over the last six years. Demand has declined in terms of numbers of people supported (see graph) but the complexity has risen. The total number of hours of home care purchased has stabilised over the 30 months.

Our BCF Plan(see 3.7) sets out our financial commitments for 2017-19.

The Council raised the Social Care precept by 3% in 2017-18. This has been used to fund the price increases for external provision.

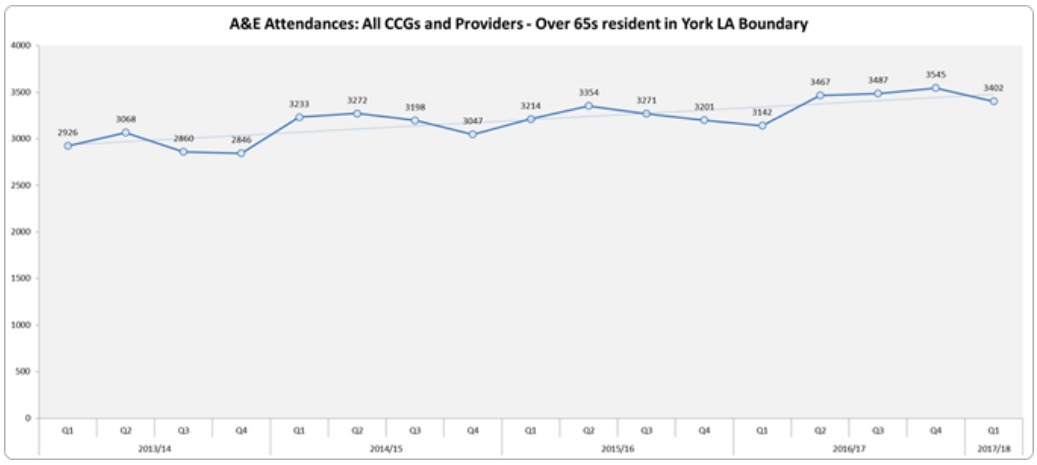
The CCG opened 1st April 2013 and does not have financial "legacy information". The CCG footprint differs from the legacy PCT.

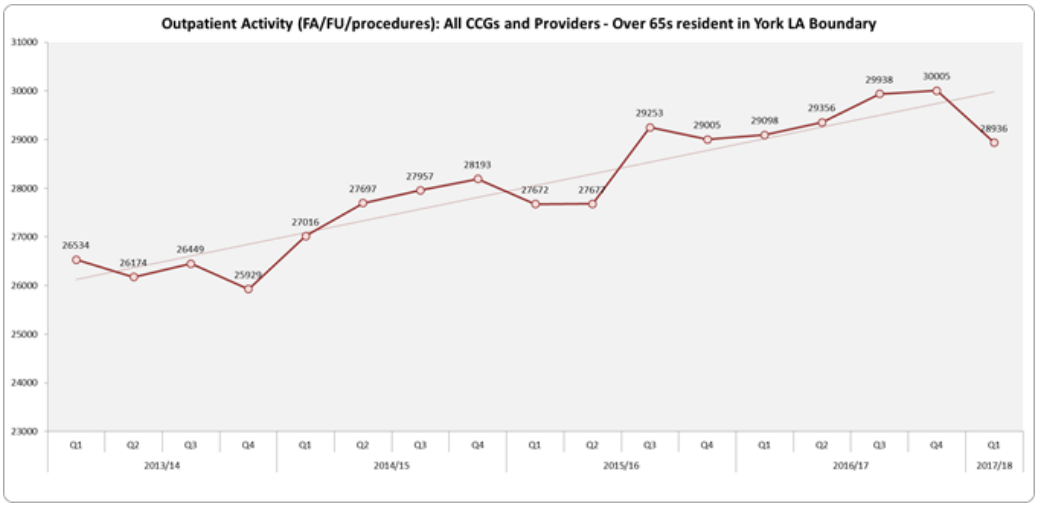
The CCG does not capture, record or report its overall spend by age category. However, it is captured and recorded for acute secondary hospital activity. Since 2013, the national tariff for this activity has changed, there have been coding and counting changes from providers and there may have been case mix changes making comparison inconsistent.

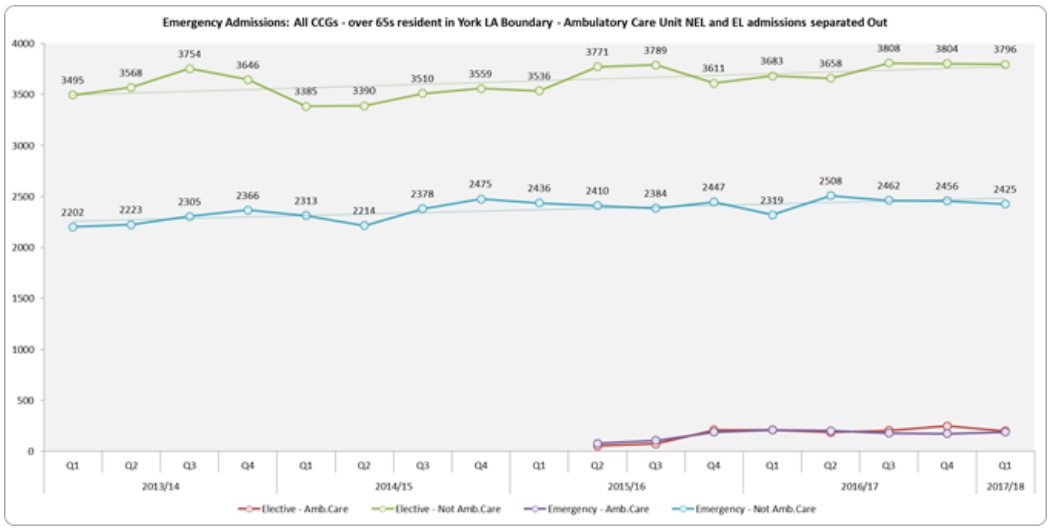
This assessment is based on activity for over 65s resident within the Council boundary:

- **A&E attendances – steady increase for over 65s (16.2% since 1st April 2013), levelling off since Q2 of 2016/17.**
- **Outpatients – 13.6% increase in the total activity since 2013/14.**
- **Admissions - steady increase in elective and non-elective admissions since 2013/14. The Ambulatory Care unit started in 2015/16. Overall figures show 8% rise in Elective admissions since 2013/14 and an increase of 13.5% in emergency admissions. However, excluding the Ambulatory Care unit activity, these increases are 3.3% and 6.6% respectively.**
- **Note: 10.4% increase in the number of over 65s resident within the City of York Council boundary since the 1st April 2013.**

Annex B







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Section 2: People who use services, their families and carers

8. How does your system(s) engage with older people their families and carers in how it designs, commissions and delivers services at the interface of health and social care? [max 500 words]

[For example, co-production; consultation; service user and carer representation]

[Tip: Describe any gaps in your engagement activities and explain how engagement is evaluated]

Ageing Well: our social capital

Activism and participation in the many strands of public life, along with a proud history of philanthropy in the city, are signs of great richness in our social capital and community capacity.

Our partnerships work together to maximise these benefits for all our communities.

Shaping Strategy

York's vibrant voluntary and community sector provides a solid foundation for traditional consultation, public involvement and engagement work across health and social care. Well established networks exist for engaging local people in the design, planning, commissioning and evaluation of services. The HWBB consulted widely when developing the Joint HWB Strategy and the Ageing Well theme. The Ageing Well Forum owns the strategy and leads its implementation.

Respondents to the Older People's survey(8.1) provided feedback about problems or weaknesses they saw in the survey itself. The survey was changed and the next time a higher return rate was achieved, offering greater insights into older people's experiences.

We also engage via other surveys including Annual Social Care Survey, the bi-annual Carers Survey and specific individual pieces of work such as a review of Advice and Information Services in 2016, by an external partner.

HWBB approved guiding principles for Co-production(8.2) **in September 2017, following local events arranged to coincide with national co-production week in July.**

During the summer, 2017, the CCG began a series of 'big conversation' public events to:

talk openly and honestly about the local £40million financial challenge.

- **focus the discussion on how we can involve our local population in enabling them to have a real input into the formulation of plans and ideas.**
- **collate a range of views and feedback and use this as part of our decision-making process.**
- **ensure that people attending the events feel listened to and have been able to feed into discussions in a meaningful way.**

Service Design

In the recent past numerous developments have been co-designed with older people. For example:

- **'One Team'(8.3) (continuing with a Public Reference Group)**
- **Future Focus project enshrined principles of co-design and co-production**
- **Comprehensive public consultation regarding the proposals for a new hospital for York, outlined as a principal TEWV ambition when the contract for Mental Health services was awarded in October 2015**

VOYCCG has carried out a wide range of engagement activities with local people, for example:

- **Integrating services and providing care closer to home**
- **Improving care and support for patients with long term conditions - Proactive Health Coaching**
- **Community Equipment and wheelchair services – following complaints raised**
- **Patient transport services**
- **Gluten free prescribing**
- **Out of Hours service redesign**

Personalisation and self-directed support

Future Focus, Ways to Wellbeing **and** Local Area Co-ordination **are enabling individuals to design their own support solutions.**

We recognise the need to improve level of take up of direct payments and personal health budgets. The CCG faces a challenging target for PHBs, which are focused primarily on continuing health care and are not widely understood by the workforce or the market

word count 499 / 500

9. How are you assured that older people are currently experiencing person-centred, coordinated and appropriate care as they move across different parts of the health and social care system(s)? [max 500 words]

[Tip: What feedback mechanisms are in place and how do you use this feedback to improve service user experience?]

[Tip: Describe where there are areas for improvement]

Quality is Key

York has numerous mechanisms providing a level of assurance on the quality of services across the system. Contract monitoring and customer feedback are key.

Healthwatch York provides detailed investigation reports on the quality of services and patient / customer experience. For example, their report in May 2015, highlighting poor experience of community equipment and wheelchair services resulted in a change of service provider from December 2016. Action taken by service in response is reported to HWBB.

The Adults Commissioning Team works closely with CQC in the sharing concerns and information relating to provision through its own monitoring process (Quality Assessment Framework).

Information from the Council's Quality Assurance programme is shared with CCG colleagues and meetings take place between the "quality and service improvement leads" in both organisations on a regular basis. The teams undertake joint visits where there are safeguarding concerns.

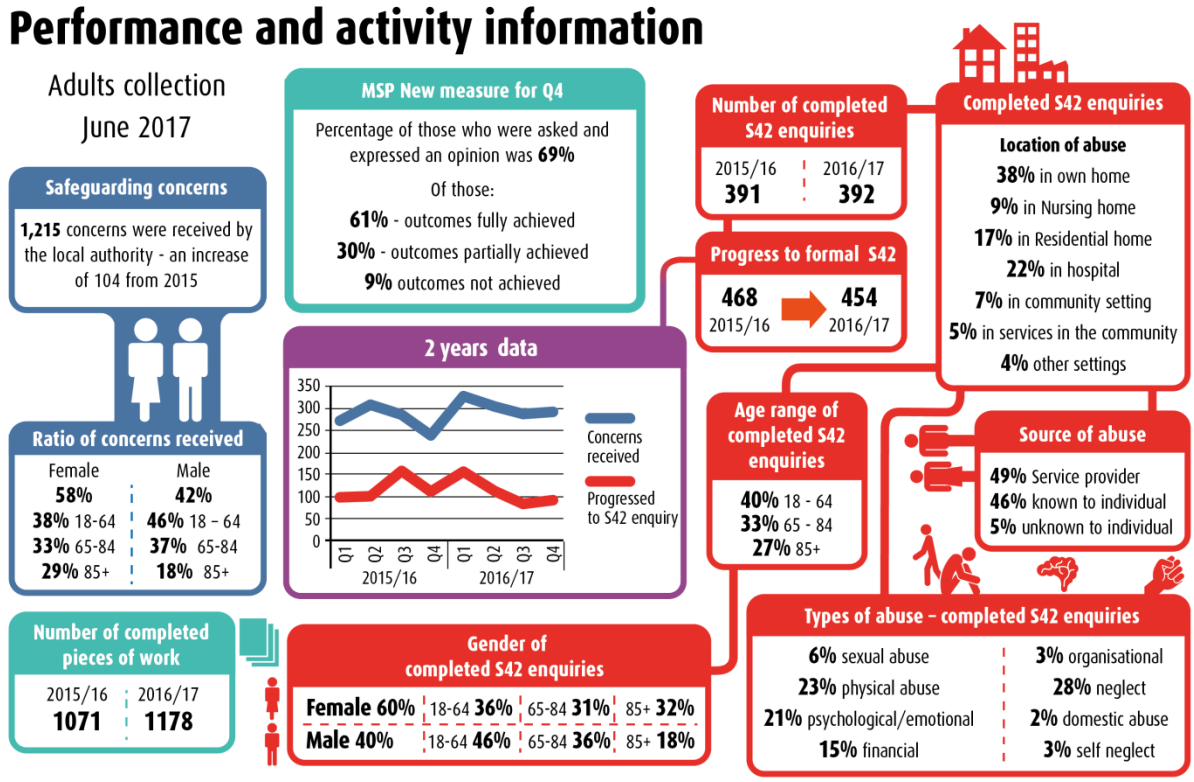
CYC Commissioning and Contracting team makes calls to customers – sampling user experience, gaining direct feedback on their experience of services and levels of satisfaction to feed into the contract management arrangements. A full report has been provided to the HWBB.

The council undertakes annual monitoring visits. These are appropriate to the services provided and comprise an Observation visit and / or a Quality Assurance Visit and consultation with residents / customers. Reports are shared with the provider and with CQC colleagues to inform their programme of inspections.

Healthwatch has joined up with the City of York Council Adults Commissioning Team to provide a joint approach to involving people who receive services and inform the quality of service provision in Care Homes. This approach prevents duplication and avoids residents being over consulted. Healthwatch has recruited and trained volunteers to carry out the role of Care Home Assessors to support the Consultation & Observation visits that are undertaken.

The CCG Partners in Care Forum engages providers in the quality and improvement programme.

York Safeguarding Adults Board(9.1) monitors the referrals and enquiries to the Safeguarding Adults Team by age group. The annual report for 2016-17 publishes the latest available analysis for a complete year. It shows that older people, over the age off 85 are over represented in safeguarding enquiries (referrals that proceed to an investigation). 90% of people reported that their desired outcomes were fully or partly achieved through the Safeguarding process.



Learning from compliments, complaints and incidents.

The journey of patients through York Hospital is monitored and reviewed at each point by the Elderly Medicine Senior Team and Corporately, from arrival either via Emergency Department or GP admission, through to their experience on wards and discharge processes. This is reported to Trust Board and Commissioners through the Trust reports.

YTHFT Patient Involvement Groups

- **Elderly Medicine Directorate Manager attending the York Ageing Well Forum, Chaired by York CVS.**
- **Foundation Trust governors**
- **The Trust engages patient and groups relating to particular conditions, including many older people. Increasingly hospital staff reach out to community groups, e.g. Different Strokes and the Alzheimer's Society.**

Word count 495 / 500

Section 3: Market shaping

10. How are you collectively working as a system(s) to shape a high quality, diverse and sustainable health and care provider market that will enable older people to get the right care, in the right place, and at the right time? [max 600 words]

[For example, collaborative working around provider fees; measures to avoid competition amongst commissioning bodies; adopting a consistent approach to quality assurance]

Market Leadership and Management

The HWBB provides the strategic leadership and direction **for the sector.**

The A&E Delivery Board and BCF Delivery Group bridge the strategic and operational responsibilities for "making it happen**".**

The Council Plan and Joint Health and Wellbeing Strategy set out the outcomes and ambitions for the city.

The JSNA, Market Position Statement(10.1) and Local Account(10.2) provide the strategic overview for partners, including providers. These include statistics about demographic change and future models of care and support. This year it will include a section about the council's Future Focus operating model.

The CCG is developing its contracting and commissioning intentions**, as part of its forward plan, in line with NHS requirements.**

The BCF plan commissions specific services and schemes **to build capacity**

where it is needed most. However, resources are tight, limiting the scale and scope of developments. Commissioners and providers worked together to review the effectiveness of previous schemes to ensure value for money when preparing for the 2017-19 plan. The Older People's Community Services contract was re-commissioned and awarded to Age UK.

Our new accommodation plans aim to maximise the use of two of York's existing Sheltered Housing with Extra Care schemes, increasing the support available at each venue.

Word count 204

How do partners work together to ensure capacity is available to meet demand?

[Tip: What systems are in place to predict demand and how can existing capacity be flexed to meet spikes in demand?]

The A&E Delivery Board meets monthly. It co-ordinates system wide winter planning to ensure a robust Winter Escalation Plan(10.3) **is in place, owned by all partners. This year's plan was reviewed and partners' submissions tested at a session on 15th August.**

We recognise gaps in our collective understanding of capacity and demand. We have requested national support (currently unavailable). We have undertaken a review of patients 'stranded' in hospital, developing our knowledge of what support patients need to leave.

The council has made arrangements to obtain additional placements in the community **to ease pressure in the hospital, though funding remains an issue.**

Housing and accommodation developments support older people's independence.

VOYCCG participated in the Actual Cost of Care exercise in 2016, agreeing fee rates with the independent sector for a three year period. The independently facilitated exercise was undertaken across North Yorkshire with both councils.

Commissioners ensure sufficient capacity in the independent sector through

quality initiatives, using CQC reports as part of the picture. The council and CCG are working closely on care home contracts, including infection control and Safeguarding**. The Scrutiny Committee receives a half yearly report on the quality of care services across the City.**

Weekly monitoring of placements, care packages and known trends enables capacity to be mapped in a challenging environment where occupancy levels in care homes are around 98%. New and innovative methods such as time banding, an asset based approach and partnership working enable the market to flexibly meet surges in demand.

In response to mounting financial pressure for the CCG, which included reductions in grant funding for the voluntary sector, a Prevention Partnership has been initiated, led by York CVS. The partnership's purpose is to strengthen the role of the voluntary and community sector in early intervention and prevention**.**

The Joint Commissioning Plan **(being developed) will enable all partners to agree the key priorities and shape a programme of activity that will enable commissioning to be focused on key areas and avoid duplication and competition between areas.**

Word count 396

Total 600 / 600

11. What is your approach to system-wide workforce planning to make sure you have the workforce you need so that older people receive the right care, in the right place at the right time? [max 500 words]

[For example, system-wide workforce analysis; succession planning; working with local education providers]

<u>All Aboard!</u>

Workforce planning is happening between partner organisations, and across sectors.

The York Workforce Strategy Group(11.1) **is chaired by CYC HHAS Executive**

Director. Its vision:

"To ensure that partners within the City are working together to attract, retain and develop, a skilled, confident and competent social care workforce. A workforce that delivers truly person centred care and promotes independence, choice and control to improve the lives of people in York."

Its subgroups:

- **Recruitment, retention and careers**
- **Service redesign and positive risk**
- **Broader Profile**
- **PA Development**

HCVSTP Local Workforce Action Board **(LWAB) is jointly chaired by Health Education Yorkshire and Humber and YTHFT. The Board has senior membership from all sectors.**

LWAB is working to improve recruitment and retention of clinical staff across professional disciplines including medical, nursing and paramedic.

Word count 134

What progress have you made against these plans?

The LWAB's major work streams:

- **developing Advanced Practitioners and**
- **developing health and social care support staff at scale.**

We have developed a framework of stakeholder engagement and a system leadership programme with senior participation from statutory and voluntary sectors.

We have been approved as an Excellence Centre by the National Skills Academy in June 2017. The LWAB has supported, providing infrastructure costs.

Our ambition is to develop a career framework for care givers that is relevant to all sectors, attracting and keeping people in caring roles by offering progression opportunities which maximise their individual potential.

Within YAS, NHS 111 is improving clinical recruitment and developing the Clinical Advisory Service. YAS plans to provide a more integrated workforce including advanced skilled clinicians to support safe and appropriate treatment without transferring people unnecessarily to Emergency

Departments.

TEWV works closely with the University, offering job opportunities to employment-ready graduates, and also works with the Open University financially-assisting non-qualified staff to complete their nursing degree via a programme

In York by the Trust and Council hold joint recruitment events.

City of York Trading Ltd (CYT Ltd) - formed in November 2011- is wholly owned by City of York Council, providing agency staff to CYC and to other public, private and commercial organisations in York and the surrounding towns. It has since 2012 provided temporary care staff in Adult Social Care as well as a number of social workers and administrative/project based staff.

Dementia Friendly York

CYC has delivered person centred dementia care training in the past 12 months (98 care staff in the Provider services) and Virtual Dementia Tour (307 CYC staff/ 54 external Provider staff). There is also a range of types of training which all have an element of person centred approach. This has been recognised in previous CQC inspections in terms of the effective domain using best practice.

In addition in the Older People's Homes staff have previously received training from 'Dementia Care Matters' 'Bradford University School of Dementia Studies', and use research from Stirling University and Kings Fund.

In terms of good practice through supervision over the past 2 years we have worked with staff to change the culture and ensure language is positive.

Word count 366

Total Word count 500 / 500

Section 4: Integrated service delivery

12. How does your system(s) enable person-centred, coordinated local service delivery that supports the safe and smooth movement of older people through the health and social care system? [max 1000 words]

[Tip: beneath each heading, provide examples of innovative/good practice, evidence of success and impact, and describe gaps and challenges]

We prize the good general health of our older population in York, with above average outcomes and life expectancy. However, there remain inequalities between the most and least deprived areas. We target our resources to those areas where the need is greatest, for example, the Clifton Falls **initiative, where evidence pointed to higher than average risk for the local older population.**

Supporting people to remain independent begins with good Information, Advice and Guidance(12.1)**. CYC's refreshed IAG strategy was approved earlier in 2017.**

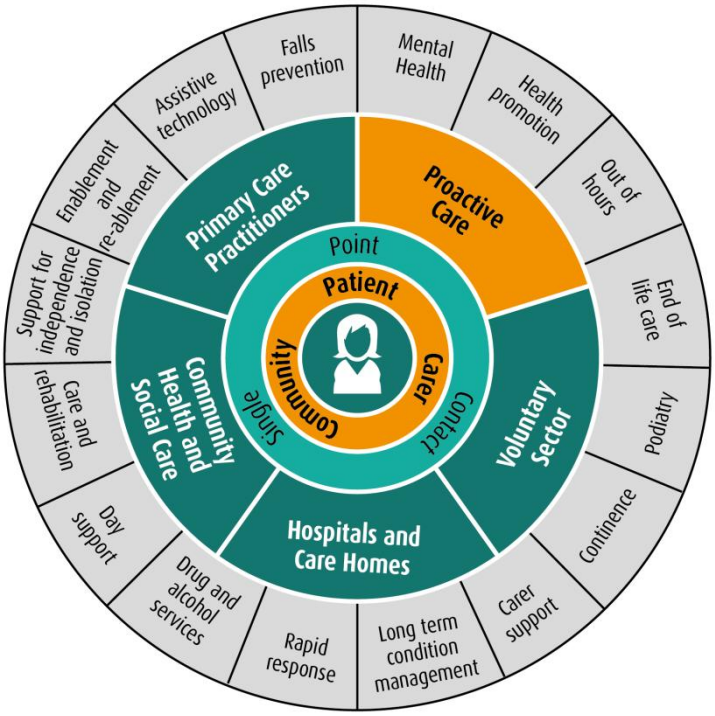
Signposting through the initial referral screening process ensures people without eligible needs (Care Act), including self-funders, access advice and low level support in their community.

Case studies of person-centred support accompany the SOIR(12.2-5).

Ways to Wellbeing – showing 30% reduction in people needing to see their GP(12.6).

The CCG is promoting Integrated Primary Care Hubs **to keep care as close to home and joined up as possible, including for people in care homes. In York these are** York Integrated Care Team **(YICT) and** Primary Care Home**.**

YICT has reduced excess bed days for their admitted patients by 33% over the last financial year – identifying those at risk and pulling people out of acute care to be looked after closer to home. Targeted onward signposting to other services takes place in up to 2/3 of discussions. A social worker attends the daily MDTs.

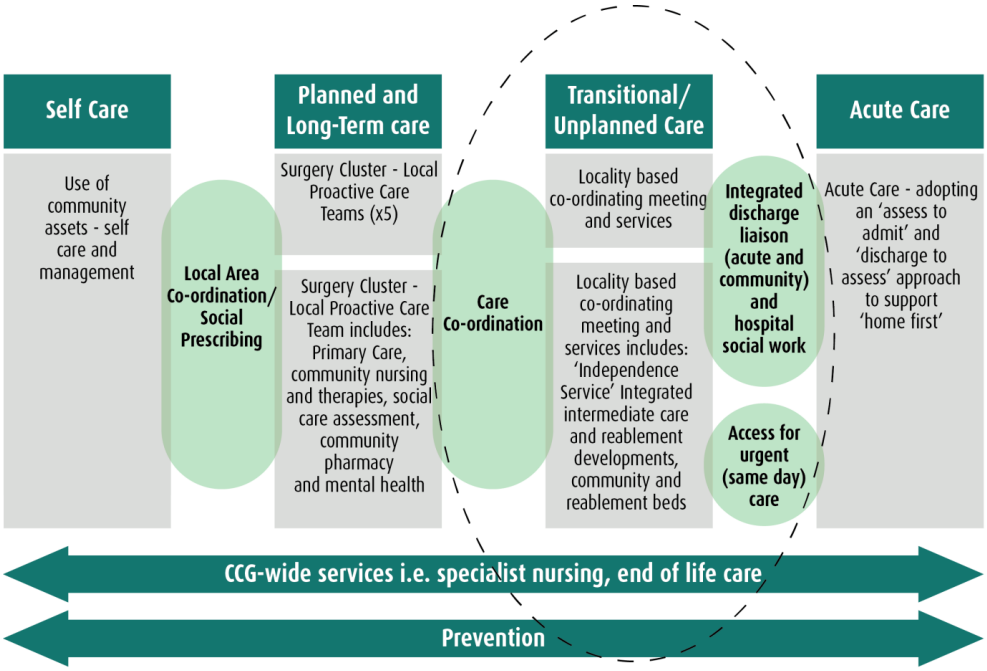


The advent of Local Area Co-ordination **in areas of greatest social need supports and builds community capacity to respond to individuals at home before they experience crisis.**

The development of asset based community social work is already showing positive benefits of the Future Focus **model. 38% people who received a home visit from the** Intensive Support Service **did not go on to need a service. During the pilot: 100% of respondents said the advice and information had a positive impact.**

word count 303

Offering alternatives to/avoiding older people entering acute hospital care as a result of a changing need or crisis



Since July 2016, Front Door Streaming **has managed people from the Emergency Department into the right place: a medical ward, a GP, community pharmacy or social care depending on the initial triage. This ensures people access the right support quickly.**

The Rapid Assessment Team(RATS) is a well-established, integrated health and social care team made up of social workers and therapists working alongside medical and nursing colleagues to prevent the need for older people to be admitted to hospital.

We have expanded this service to work from 8am to 8pm, seven days of the week. The team avoids admissions for 80% of the patients they review in the department.

We recognise there are gaps in the services we currently provide at home to prevent hospital admission. This includes home based sub-acute services, for example intravenous antibiotic therapy at home and overnight services

People managed by the Ambulatory Care Unit **come via ED presentations, directly from GPs or attending for return treatment and checks – reducing numbers at out-patient and GP clinics. Outcomes for these patients are rapidly achieved: 90% are discharged with some treatment – enabling them to stay at home.**

The CCG secured funding from NHSE to provide a CORE 24 service model for Mental Health within YDH. TEWV also have a dedicated Care Home and Dementia Team who work with care homes across VOYCCG. NHSE recently completed an IST review of dementia services across the economy. The outcomes of this review are now being implemented.

Word count 244

Ensuring smooth discharge planning and access to ongoing health and social care for older people

The DTOC protocol is in place, with daily monitoring and weekly multi-disciplinary SITREP meetings between all partners at YTHFT. TEWV align to the protocol, hosting a weekly DTOC multi agency meeting to discuss delays in their Older Peoples' wards, with a clear focus on delivering the best possible discharge outcomes for individuals.

YTHFT has accessed support from ECIP, and is working towards the SAFER bundle and Estimated Date of Discharge, but this is not yet embedded. The development of Trusted Assessors is another area where more needs to be done to support people getting out of hospital.

We are working towards full implementation of the High Impact Changes. The Complex Discharge Task and Finish Group **has undertaken a self-assessment(12.7). The project has four key work-streams: 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).**

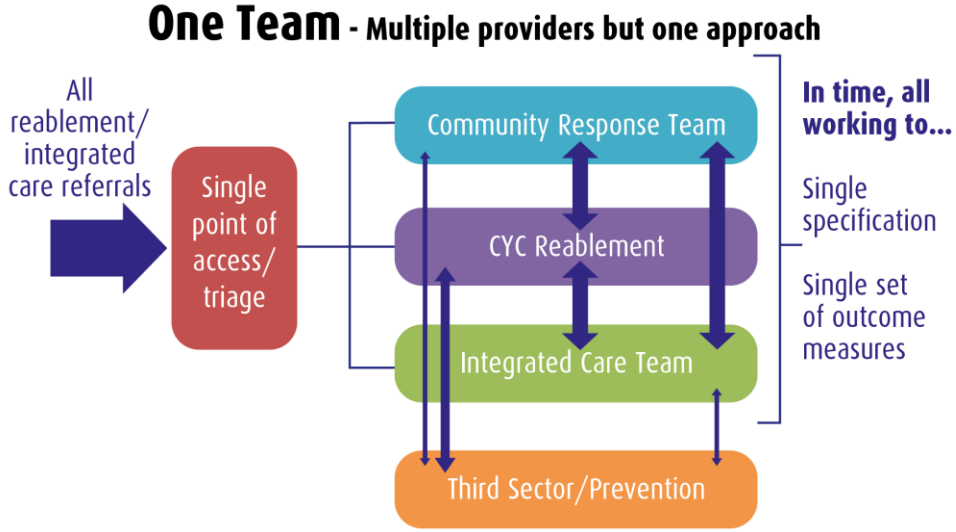
We have worked collaborated between health and social care to deliver a project testing three Discharge To Assess(12.8) **pathways during 2016/17.**

The council undertook a small scale telehealth pilot with Priory Medical Group to reduce admissions into hospital, and piloted Discharge to Assess at one of our Older People's Homes. We are also reviewing the possible use of step down and short breaks services in our Independent Living Communities.

We have decreased beds and increased the number of people who are supported by the home based intermediate care team as an alternative to admission.

This is an increase from 45 to 65 patients per month on average, who have been able to access intermediate care (home and bed based) and increased the proportion delivered at home from 33% to 50%.

The One Team **project brings together health intermediate care (Community Response Team and primary care short term care service) 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.**



Word count 337

Ensuring older people in reablement reach their maximum goals/ have a timely return to their normal place of residence or a new place of residence that meets their needs

The new Reablement specification(12.9), - going live October 2017 to coincide with the development of the integrated intermediate care service – will increase the capacity of council's direct contact hours in Reablement by approximately 40%. The Service will promote rehabilitation and recovery, enabling Customers to attain the optimum level of independence through the provision of both personal care and practical support. By helping Customers to maximise their independence the Service will minimise the ongoing need for, or intensity of, longer term care packages. It will deliver support on the basis of a documented, structured and individual goal plan agreed with the Customer, their aim being to support Customers to achieve their optimum level of independence.

Word count 114

Total word count 998 / 1,000

Section 5: Monitoring performance and progress

13. What is the vision and strategic aims for the next five years to improve quality and outcomes for older people at the interface of health and social care? [max 500 words]

[Tip: This question is asking you to think beyond the day-to-day operational plans and to outline the bigger strategic shifts and new care models planned for your area]

York's Joint Health and Wellbeing Strategy 2017-2022 provides the over arching vision for York. Integral to this is Ageing Well**.**

We want to see York as a fantastic place to grow old, with our increasingly ageing population able to stay fit, healthy and independent for longer, and (though it is a sensitive topic) also a good place in which to die.

Our top priority is to reduce loneliness and isolation for older people.

We also want to:

- **ensure that there is sufficient community-based support to tackle the problem of delayed discharges from hospital**
- **celebrate the role that older people play in making York such a special place**
- **enable people to recover faster and remain independent for longer**
- **recognise and support the vital contribution of York's carers**
- **increase the use of social prescribing, ie, linking patients in primary care with sources of support within the community**
- **enable people to die well in a place of their choosing and encourage people to prepare advanced directives.**

The Ageing Well lead is Sarah Armstrong, Chief Executive York CVS, supported through the Ageing Well forum.

Word count 186

What practical arrangements are in place to deliver this?

Related plans are:

- **BCF integration plan**
- **BCF Schemes to build community capacity – focusing on early intervention and prevention. These are a jointly owned system response.**
- **Older People's accommodation programme – 900 new units by 2020**
- **Mental Health multi agency accommodation project**
- **Unplanned Care Programme, delivered through the Central locality delivery group**
- **Complex Discharge Programme(13.1)**
- **YTHFT Out of Hospital Strategy(13.2)**
- **CCG operational plan**
- **CYC forward plan for adult social care**

Word count 77

How do you assure yourselves that you have the capacity and resilience to achieve this?

Over the past two years our Systems Leaders have invested in capacity and organisational resilience through:

- **Active relationship building between leaders**
- **Additional capacity has been added to the leadership of CCG, despite its financial challenge.**
- **Drawing on the strengths and assets of the VCS**
- **As series of multi agency vision and strategy workshops – adopting place based approaches and shared design principles agreed by all partners**
- **Promoting "prevent, reduce, delay, manage"**
- **Investing in community infrastructure**
- **Looking outside York for integration exemplars**
- **External support, such as KPMG**
- **Establishing leadership capacity through interim and permanent appointments**
- **Committing to integration and joint commissioning**
- **Workforce development and succession planning (CYC Leading Together programme, NHSE presence in CCG)**
- **Communicating good news stories**

Challenges

Capacity and capability **are challenged by the prolonged period of under funding and cuts in resources available to the system. The ability to invest in innovative services or scale up projects where pilots have shown success is limited by the depth of the financial deficit. However, additional capacity to support joint commissioning has been resourced.** Capped Expenditure **has created a pressure to accelerate change.**

In the context of the Capped Expenditure **programme within the NHS, York locality finances cannot be managed separately.**

Legal Directions **and intervention by NHS England require VOYCCG to show a clear return on any investment.**

Word count 200

Total word count 491/500

14. Do you have a strategy for person-centred, coordinated care and support that all partners are signed up to? [max 1500 words]

[Tip: Please provide an overview to this strategy and attach any relevant strategic framework(s) referenced in this answer]

One York working towards One Plan.

The Board published York's Joint Health and Wellbeing Strategy 2017-2022 **in March 2017.**

HWBB provides stable and consistent leadership to the system, with all partners signed up to the strategy which sets out our aspirations for the way we will promote and sustain the health and wellbeing of the whole community, and particularly those people who need care and support.

As a system we recognise the value of harnessing the energy of all partners, including primary care, and the independent, community and voluntary sectors. We are co-producing approaches to improving preventative and out of hospital care, with a focus on creating long term sustainability in the system.

Key Principles for the Health and Wellbeing Board

Ensure **that we work together in true partnership for the good of the people of York;**

Involve **local people in identifying the challenges and redesigning services;**

Promote **equality of opportunity and access for all communities, and challenge discrimination if it arises;**

Treat **everyone with dignity and respect at all times;**

Recognise **and promote the vital role of unpaid carers who contribute so much to health and wellbeing in York;**

Champion **the role of the voluntary sector and the value its strength, diversity and knowledge brings in improving the health and wellbeing of our residents;**

Work **with the Adults' and Children's Safeguarding Boards to ensure that everyone always feels safe, and that the ways to report concerns are clear.**

In 2016 the Health and Wellbeing Board participated in a development programme facilitated by the Local Government Association to reflect on what was working well and what should change.

Partners agreed that the board should concentrate on strategic leadership, be more inclusive (and less like a council sub-committee) and to articulate its vision more clearly.

Partners recognised we could make better use of available data to improve our system intelligence. The HWBB is now operating to revised terms of reference.

In the current year the HWBB has approved a Joint Commissioning Strategy **which enshrines person centred approaches and commissioning for outcomes, and the** Co-production **guidelines and principles for our system.**

Our model is person centred and strengths based, fostering positive action as a fundamental element of individual rights, choice and control. We explicitly recognise the risk to a person's independence associated with hospital admission, institutional care and an over emphasis on safety.

Word count 391

What operational planning framework(s) do you use that converts the strategic framework into deliverable and measurable objectives?

The Better Care Fund **plan underpins the joint health and wellbeing strategy through the joint investment programme in services and schemes.**

Our BCF plan is optimistic and ambitious for the future, while realistic about the very real challenges our system faces in the immediate and medium terms. The plan sees the continuation of existing schemes, investment in new schemes, and deployment of the Improved Better Care Fund **monies (iBCF) to support the whole system.**

The 2016/17 BCF plan focused on the move to jointly commissioned activities contributing towards a set of shared strategic objectives. The 2017/19 plan 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 locally as part of the integration agenda.

The schemes are monitored through our contract monitoring and management arrangements and reported to the BCF Task and Finish Group. Existing schemes were jointly evaluated before this year's plan was agreed.

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 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**

The Unplanned Care Board **has agreed the** Unplanned Care PID **which forms the**

operational plan to reduce unplanned admissions to hospital.

The following groups are working to deliver the strategy at the frontline – A&E Delivery board, Central Locality Delivery Group, CDT&F group.

Separately, partner organisations retain operational management arrangements, performance managing progress against milestones.

In the council, a major transformation programme in Adult Services promotes early intervention and prevention in all that we do. The 'community operating model', endorsed in September 2016, includes working with partner organisations in NHS, community and voluntary services and reflects our strong partnership with York CVS. We are together, currently reviewing the volunteering strategy for the city, which will focus more on the growth of social action and impact volunteering, linked to challenges in society and public services. Tackling loneliness and social isolation is one of the key priorities within this strategy – 'People Helping People'.

Word count 395

What shared measures are in place to monitor performance against these plans?

[Tip: Please tell us about any shared Key Performance Indicators (KPIs) that system partners have agreed. For example, KPIs from Urgent and Emergency Care plans and Better Care Fund plans.]

Performance monitoring frameworks are evolving in York. Partners have not always had access to a shared dataset across the whole system, but have received high level reports and updates on project milestones by exception. HWBB tracks a suite of high level measures drawn from national outcome frameworks and incorporating local priorities.

The HWBB focused on the Ageing Well theme in September 2017(14.1). This included updates on the schemes and initiatives delivering the strategy as well as the formal performance report.

The six "Ageing Well" KPIs are:

- **More older people telling us they have as much social contact as they like (source: ASC User survey, annual)**
- **Reducing "unnecessary" admissions to hospital (source: CCG, annual)**
- **Reducing DTOC (source: NHS Digital, monthly)**
- **Older people still at home 91 days after discharge (source: ASCOF, annual)**

- **More volunteering opportunities for older people**
- **More older people telling us they are happy with the care they receive (source: ASC User survey, annual)**

Other frameworks include:

- **A&E Delivery Board performance report**
- **Complex discharge report(14.2)**
- **Winter escalation plan monitoring**
- **BCF Performance dashboard**
- **DTOC protocol monitoring**
- **A shared dashboard being developed for Intermediate Care and Community Response Team (CRT).**

Recent audits of specific areas of service have enabled a focused discussion on improvement and efficiency, such as the Community Beds Audit(14.2-3).

Word count 223

How are you currently performing against these plans? [Please provide a recent KPI performance report as an attachment]

Separate reports are attached in emails as background evidence to support the SOIR.

ECS performance is recognised as a barometer for the overall system flow. Achieving the local performance for ECS has been challenging and bed occupancy rates are consistently above the recommended levels to sustain flow. Recognising the pressure in the local system, the winter plan is targeted on achieving the bed occupancy target of 92%.

Word count 67

Performance against the 6 domains of the NHS and Social Care dashboard is summarised below.

Emergency admissions of OP/100,000	**90_percentile length of stay of emergency admissions**
March 16 – Feb 17: 26,056 (rank 89/152) April 16 – March 17: 26,712	March 16 – Feb 17: 21 (rank 75 / 152) May 17 – July 17: 19
Story: The data on admissions includes assessment and ambulatory functions, which are operational at the York Hospital site. This is reflected in the reducing	**Story:** Improving picture – reflects wide range of work to improve flow, and reduce DTOC, including rise in short treatment episodes in recent months, mostly

length of stay for the over 65's.	weekdays, which do not increase proportion of weekend discharges.
OP receiving reablement after leaving hospital 2015-16: 2.2% (rank 108 / 152) 2016-17: c o.9% **Story:** An apparent drop in performance in 16-17 compared to previous year was the result of a reinterpretation of the NHS digital guidance. The decision to exclude NHS reablement providers reduces the people included as receiving a service. The numbers receiving a service from social care providers has remained stable.	**Older people still at home 91 days after leaving hospital** 2015-16: 75.6% (rank 135 / 152) 2016-17: 79.2% (93.3% excluding deceased) **Story:** position improving previous figures are disproportionately affected by the inclusion of deceased people, who in some areas are re-coded as end of life pathway.
Total days DTOC per 100,000 population, Feb 17 – April 17: 14.20 (rank 97 / 152) June 17 – Aug 17: 10.01 **NHS attributable** **Social Care attributable** Feb 17– Apr 17: 9.14 (rank 117/152) Feb 17– April 17: 4.54 rank 90 / 152 June 17– Aug 17: 5.61 June 17-Aug17: 4.19 **Story:** Decreases in all causes. Complex Discharge (multi agency) T&F group leading on the range of actions – no one single reason for reduction **NHS** delays for CHC = fewer customers each experiencing longer delays. **ASC** = higher number of individuals delayed for a shorter period	**Percentage of hospital discharges made at weekends** Oct 15 – Sept 16: 17.9% (rank 148 /152) April 2016- March 17: 17.6% **Story:** This is an area where we know we need to implement change. The implementation of Assessment units has resulted in shorter lengths of stay across York Hospital, with more patients 'turned around' in one day.

Word count c 378

Total word count 1,454 / 1,500

15. What strategic and operational plans are in place to facilitate information sharing across the health and social care system(s)? [max 500 words]

<u>"Our systems don't talk to each other, but our people do"</u>

The Digital Road Map sets out the intended direction of travel for IT developments between partners in York. However, we are disadvantaged by the history of a wide range of different systems in use among and within organisations. Therefore, information sharing around the needs of the individual patient or service user is achieved by close partnership working and sound practice in communications at the frontline.

Progress with Local Digital Roadmaps has been slow, with a view that the LDR footprint should ideally match the STP footprint (which they do not at present. Commissioning support (through Embed) is working with CCGs to develop Universal Capability Delivery Plans to support digital transformation.

Word count 124

What progress have you made against these plans?

Locally, interoperability is complicated by multiple systems. At present there has been no significant progress towards a single shared care record, but if this could be achieved it would make a big difference.

CYC (ASC) = mosaic

CYC (Housing) = multiple systems, currently being re-procured as a single system

GPs = SystmOne(60%) and EMIS (40%)

YTH (acute) = in house system CPD

YTH (community) = Systm1

TEWV = PARIS

To overcome these obstacles practitioners share information case by case.

Weekly and Daily meetings are held to discuss patients at risk of delayed

transfers of care and stranded patients. These meetings allow staff to actively manage the care pathways for individuals.

The introduction of the One Team is addressing the joins in step down care, with Reablement, Community Response Team, Intermediate Care, GP and social care co-located under one roof. As teams are co-located they are able to access individual systems in real time.

We have engaged with TPP (provider of SystmOne) to support our moves toward interoperability with EMIS and expect to commence a pilot this year.

We have developed our in-house hospital PAS system to enable Notifications for Assessment and Discharge to be created within the electronic patient record. Council teams access the hospital record to obtain relevant information and Social Care Records are linked to the NHS number.

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.

Enhanced Shared Care records are also being completed across a number of areas now, with support from the York Integrated Care Team. These contain a detailed record of both health and social issues and support the care plans in place. Additionally a trial for End of Life patients will be taking place with web-based software called MyRightCare which enables relevant information to be accessed by all teams rapidly.

The HCVSTP is working towards direct booking from NHS 111 for Yorkshire Doctors and Adastra, providing urgent care and out of hours services.

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