York Health and Wellbeing Board

CQC Local System Review

October – December 2017

Place Based Improvement Plan – January 2018

This draft illustrates the high level approach to the 13 recommendations and the proposed format of the plan.

Introduction

This document forms the high level action plan in response to the CQC Local System Review of York (published 22nd December 2017).

The interim national report and each of the local system reports, including York, can be found here: https://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems

The report makes 13 recommendations for improvement in York, supported by the range of findings from their inspection. For the purpose of the action plan these are re-ordered and grouped by theme.

Current Position

On 19th December 2017 the Accountable Care Systems Partnership Board agreed in principle to the establishment of a Locality / Place Based Improvement Board for York, to take forward the CQC Action Plan. The York Health and Wellbeing Board is responsible for this action plan and may approve the establishment of an Improvement Board at the meeting on 24th January 2018.

Next Steps

The York Improvement Board (YIB) will require practical support from a secretariat and will need to operate under Terms of Reference which would be developed and approved by the Health and Wellbeing Board.

A project management approach is proposed for the action plan, covering the recommendations in clusters. An additional enabling project focused on 'capacity, resources, efficiency and effectiveness' has also been suggested to address these issues which were not reflected in the CQC review.

The York System Overview Return (SOIR) and the CQC report provide a baseline for our starting position and when combined with other self-assessment information, will add value to the high level recommendations.

PROJECT ONE: **A SINGLE PLAN FOR CITY OF YORK**	**Lead Officer:** York Improvement Board

CQC said:

- The STP was not perceived as relevant to the City of York. The Health and Wellbeing Board had only recently refocused and as a result individual organisations were working to their own vision and strategies without any meaningful wider system alignment.
- The role of the Health and Wellbeing Board, until very recently, had been underdeveloped and a lack of integrated outcome measures meant monitoring of performance was siloed and in accordance with organisational performance measures.
- Governance arrangements in the City of York remained largely with individual organisations with limited sharing of performance information across the system. There was limited evidence of shared and agreed performance metrics to inform or support system performance.
- Historically relationships within the system had been challenging but these were improving. System leaders demonstrated a growing commitment to working together in a collaborative way.

Strategic Outcomes:

- Partners work towards a single vision for York, supporting more people at home
- Whole system leadership promotes integration to improve people's outcomes
- People experience joined up seamless services
- York makes the most of opportunities and assets, improving efficiency

Recommendations in this cluster	**Lead**	**RAG rating**

R1: Work is required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements, to prevent duplication.		
R2: Work should continue at pace to develop strong relationships across the system to address the lack of collaboration and trust between system leaders.		
R3: The system should build in clear evaluation of systems to demonstrate the impact on people and the system overall.		

Recommendation 1:	**Lead Officer:**
Work is required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements, to prevent duplication. **Aim:** Enhance the current arrangements between the STP and Place (York)	

CQC said:

- The STP did not capture with any relevance the challenges within the City of York area. As a result, work was required to develop a wider system vision for the STP and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements.
- System leaders across the City of York did not feel there was added value from the STP due to the challenges of the footprint. . . . it was difficult for the City of York system to have its voice heard in these wider systems to benefit the people of York.
- The STP had similar priorities to many other STPs nationally, including moving people closer to their home, dealing with demand, supporting frail older people, workforce and the role of primary care.
- The local authority workforce planning was linked to the STP where senior leaders were members of the STP workforce development strategy group and fed this into the local adult workforce strategy. However, this was seen as a challenge to implement locally due to competing organisational pressures and the lack of strategic direction at STP level with a limited scrutiny and oversight.

Objectives:

1. Improve recognition of the relationship between Humber Coast and Vale STP and City of York
2. Give York a stronger voice within the region
3. Include consideration of relationship with STP in wider system leadership developments

4. Clarify accountabilities for each part of the wider system through refreshed governance and assurance
5. Maximise opportunities arising from shared and aligned priorities, minimise duplication
6. Identify how the STP agenda can support the local integration agenda

Measureable Outcomes / Milestones:

- Full engagement at STP events with York well-represented in strategic discussions
- Strategic connections can be evidenced between York plans and STP priorities
- York priorities recognised within STP arrangements
- Access to funding, expertise and resources via STP

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 2: Work should continue at pace to develop strong relationships across the system to address the lack of collaboration and trust between system leaders. **Aim:** Promote and sustain positive working relationships among system leaders to enable collaboration and integration	**Lead Officer:**
CQC said: • The City of York had experienced historical challenges in close partnership working and lack of trust at system leadership level. • On the whole, interagency working in York was underdeveloped. • While organisational visions were not yet aligned to the same objectives recent changes in leadership were providing an opportunity to develop a more collaborative strategic approach across organisations. • There was not a clear framework for interagency collaboration across the health and social care interface. • There was not a collaborative, system-wide workforce strategy recognised by leaders across the parts of the system.	

- System leaders dealt with financial pressures by engaging in commissioning strategies to support their own priorities and did not fully consider how priorities could be addressed jointly to achieve the best outcomes for people using services.

Objectives:

1. Build on the existing HWBB arrangements to provide strategic leadership to the **York Improvement Board (YIB)**
2. Improve communication and information sharing among system leaders
3. Identify common priorities, areas of mutual interest and joint action, sustain existing areas of good practice in joint work
4. Develop the vision and strategy for integration (BCF national condition), shift away from "hospital-centric" system
5. Establish joint leadership, shared systems and processes and joint services

Measureable Outcomes/ Milestones:

- Use of the CQC Relational Audit tool as a baseline with regular review
- New governance arrangements in place and working well
- Shared vision for integration developed and approved by HWBB
- More examples of joint working are in place and held up as positive examples for future ways of working

Date Plan Approved:	Review Date:

Ref.	Actions	Lead	Date for Completion	Progress	RAG

Recommendation 3: The system should build in clear evaluation of systems to demonstrate the impact on people and the system overall. **Aim:** Use information and data better so that we are clear about the progress we are making, and can make sound decisions together based on shared evidence.	**Lead Officer:**
CQC said: • Frontline staff . . . were aware of the reporting and governance structures within their own organisations but not on a system wide level and were not always clear about the overall responsibility for performance at a system level. • The A&E delivery board was very active and had key partners involved to deliver the Better Care Fund plan and its governance arrangements. However, we found the risk management and risk sharing approach across the system was less well defined. • Commissioners for health and social care had systems in place to monitor and respond to performance issues, however, this was in individual organisations rather than as a whole system. • There were not robust processes in place for the system to be assured that resources were being used to achieve sustainable high-quality care. Spending in health and social care systems did not reflect joint priorities. • System partners did not have assurance that resources were being used effectively within safeguarding. • The joint protocol for the transfer of care was implemented across the system in May 2016. . . However, no audits had been completed at the time of our review, therefore no assurance had been gained as to the protocol's effectiveness.	
Objectives:	

1. Enable the HWBB and **YIB** to drive whole system improvement
2. Establish a consistent and rounded “single version of the truth” for York and communicate it clearly, consistently and confidently
3. Make the best use possible of available data, adopting the “COUNT” principle (collect once, use numerous times)

Measureable Outcomes/ Milestones:

- Increased number of shared arrangements to monitor and manage performance, using data collectively, for example the BCF Performance Framework
- Joint projects have clear agreements in place, with progress clearly documented and reported
- Clear terms of reference for inter-agency groups / partnerships, reviewed regularly
- Commitments to audit elements of joint work, such as Transfer of Care Protocol, are carried through

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

PROJECT TWO: **ENABLING INTEGRATION**	**Lead Officer:**

CQC said:

- While the BCF had facilitated some integrated working between health and social care, budgets remained very separate. There were still legacy cultural issues particularly in relation to finance and associated risk sharing.
- The local authority had commissioned a report, with the involvement of external partners, and the recommendations made had been used to stabilise and shape the adult social care market. This included planned investment in community based services, affordable housing and social prescribing to support local people remaining in their own homes. However, this was at a draft stage and had not yet been implemented to assess the impact.
- Market pressures remained a significant challenge for the City of York and the extent to which system leaders worked collaboratively to address them was limited. Initiatives in this area of provision were very much led by the local authority.

- Information governance arrangements were at the early stages of integration. Health and social care used different records systems that often led to confusion and duplication of effort. There was a shared use of NHS numbers although more work was required to fully implement this.

Strategic Outcomes:

- Partners work together behind the scenes
- York makes the best use of resources and increases efficiency
- It is easier for everyone to understand our system and we communicate with each other clearly and consistently
- People in York experience seamless services, and we listen to their feedback to understand what needs to improve

Recommendations in this cluster	**Lead**	**RAG rating**
R4: There needs to be a greater emphasis on moving towards joint commissioning across the system.		
R5: There needs to be a system-wide response to effectively managing the social care market and domiciliary care capacity.		
R6: 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.		

Recommendation 4:	**Lead Officer:**
There needs to be a greater emphasis on moving towards joint commissioning across the system. **Aim:** Use the **YIB** plan to guide our whole system commissioning for outcomes.	

CQC said:

- There were similar, separately commissioned services that led to duplication of effort and potential inefficiencies. In addition, the lack of a central information and advice system led to unnecessary referrals and multiple points of entry to the health and social care system that made the system difficult to navigate for people using services.
- There was confusion among front line staff, managers and providers in relation to the various service offers and which services they could refer into.
- Frontline staff were aware of the winter plans for their own organisation but were not always aware of a system-wide plan. There was a lack of resource commitment for the implementation of the winter plan from the Vale of York CCG at the time of our review.
- Overall the system had significant financial challenges. While this was putting services under pressure it also meant that the system was beginning to recognise it needed a different whole system approach and to adopt a joined-up strategy around a different way of commissioning, centred on a prevention and demand management approach. However, this was in its infancy at the time of our review.
- Future commissioning plans were focused on prevention, reduction, delay and management of need. At the time of our review these were still to be implemented sand commissioning was fragmented and based on meeting national objectives and targets rather than taking a coherent system-wide approach.
- Commissioners for health and social care had systems in place to monitor and respond to performance issues, however, this was in individual organisations rather than as a whole system.
- There was no coherent plan to increase the uptake of more personalised options for purchasing care and supporting the informal workforce in the City of York.
- While the BCF had facilitated some integrated working between health and social care, budgets remained very separate. There were still legacy cultural issues particularly in relation to finance and associated risk sharing.

Objectives:

1. We will improve our whole system approach to commissioning for outcomes.

2. York will deploy our strengths, assets and resources at a local level to prevent, reduce, delay and

manage need. 3. York will contribute appropriately to the wider community and region, recognising the multiple footprints of all organisations in our partnership. 4. We will share skills and reduce duplication, minimising bureaucracy.
Measureable Outcomes/ Milestones:

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Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 5 : There needs to be a system-wide response to effectively managing the social care market and domiciliary care capacity. **Aim:** Support York people to remain living at home as their needs change.	**Lead Officer:**

CQC said:

- Older people's transfer home or to a new place of residence was often delayed due to a lack of adult social care provision, care packages and patient choice.
- The City of York faced significant challenges in relation to the social care market in terms of available capacity and affordability.
- Although there was increased provision of nursing home care had enabling greater access to nursing care in the community, limited social care capacity overall was putting pressure on other parts of the system, including care packages and care home availability.
- This higher proportion of self-funders created a buoyant market where providers were not reliant on the local authority to exist; they could charge higher prices and be selective about the clients they supported.
- The review found that the "hospital-centric" nature of the system was partly due to limited community-based alternatives.
- Market pressures remained a significant challenge for the City of York and the extent to which system leaders worked collaboratively to address them was limited. Initiatives in this area of provision were very much led by the local authority.
- Developing the capacity and capability of the health and care workforce was recognised as a key challenge for the system posing a potential risk to the future delivery of plans. However, there was no collaborative system-wide workforce strategy.

Objectives: 1. We will work together as a single system to create a stable market place for care at home and in care homes. 2. We will support initiatives to promote careers in health and social care. 3. We will work in partnership with service providers to continuously improve and personalise services and remain sustainable and resilient. 4. People in York will make choices about the care and support they receive, and have those choices supported.
Measureable Outcomes/ Milestones:

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 6: 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. **Aim:** Use information and data to improve all aspects of the York system from business intelligence and performance management to joined-up care at the frontline.	**Lead Officer:**

CQC said:

- There was no single shared case record within the City of York system. This resulted in people having to repeat their story. There was a poor history of sharing data and business intelligence across organisations in the system.
- Progress with the local digital roadmaps had been slow with a view that the local digital roadmap (LDR) footprint should, ideally match the STP footprint and conversations had taken place to understand whether governance arrangements could support this.
- There was a lack of sharing of IT systems within the City of York. We saw that GPs working in urgent care frequently had no access to any medical records for the people they were seeing. This presented a particular challenge in terms of identifying what medication the person using services had been prescribed.
- Information governance arrangements were at the early stages of integration. Health and social care used different records systems that often led to confusion and duplication of effort. There was a shared use of NHS numbers although more work was required to fully implement this.

Objectives:

1. We will become more efficient through our use of technology.

2. We will analyse, interpret and exchange information to manage services and resources better.

3. We will improve people's experience of services by joining up care records, trusting joint assessments

and limiting wasteful repetition and delay. 4. We will overcome barriers and adapt systems in the interests of improving outcomes for people.
Measureable Outcomes/ Milestones:

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 7 : Work should be undertaken to share learning and experience between staff at the interface so there is shared trust and so understanding and historical cultural barriers are broken down. **Aim:** Translate the **YIB** vision for integration into collaborative working relationships at the frontline that improve outcomes for people.	**Lead Officer:**

CQC said:

- There were few opportunities or mechanisms in place to support frontline staff to work across organisational boundaries.
- There was confusion among front line staff, managers and providers in relation to the various service offers and which services they could refer into.
- Frontline staff were aware of the winter plans for their own organisation but were not always aware of a system-wide plan.
- We found evidence of learning at an individual organisational level; however it was less apparent that this learning was being shared across partner organisations within the local area.
- We heard from frontline staff and providers that they were unclear as to how to raise governance concerns and risks across the system. We heard of instances where concerns had been raised but no feedback had been given or no remedial action taken. An example of this included unsafe discharges to a nursing home.

Objectives:

1. Establish a **YIB** network of workforce and organisational development specialists.

2. Establish a YIB network of frontline managers to work on areas of shared interest or common problems.

3. Use communications channels to share examples of transformational change. 4. Foster and reward good practice, including lessons learned events.
Measureable Outcomes/ Milestones:

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

PROJECT THREE: **RIGHT CARE, RIGHT TIME, RIGHT PLACE**	**Lead Officer:**

CQC said:

- It was difficult for people using services, their families and carers to find out what services were available in the City of York area as there was not one portal or place where this information could be accessed.
- Developing the capacity and capability of the health and care workforce was recognised as a key challenge for the system posing a potential risk to the future delivery of plans. However, there was no collaborative system-wide workforce strategy.
- Although there was a positive approach to prevention in primary medical services and good support at home from the voluntary sector, there was limited evidence of multi-disciplinary team working for effective outcomes. In addition, the lack of clearly defined pathways and a single point of contact meant that people using services did not always experience care and support in the right place at the right time by the right people. As a result, people's experiences varied considerably.
- The extent to which the high impact change model, one of the national conditions for the BCF, had been implemented was limited.
- The lack of seven day working meant a significant number of people were not being discharged at weekends.

- We saw that GPs working in urgent care frequently had no access to any medical records for the people they were seeing. This presented a particular challenge in terms of identifying what medication the person using services had been prescribed.
- . . . no preventative work was being undertaken in terms of medicines optimisation or admission avoidance.
- People eligible for CHC funding were identified appropriately in the City of York but a recent review had identified that there was some lack of awareness from health and social care staff into CHC and personal health budgets. There was a lack of awareness into continuing healthcare funding amongst front line staff and it was felt these were not always focused on the person using services.

Strategic Outcomes:

- People are supported to maintain their wellbeing, to prevent, reduce, delay and manage their needs
- People make positive choices about their lives
- People achieve the best outcomes possible

Recommendations in this cluster	**Lead**	**RAG rating**
R8: Work should be undertaken to communicate more effectively with people who use services		
R9: An effective system of integrated assessment and reviews of the needs of people using services should be introduced.		
R10: The system should prioritise work towards improved performance against the high impact change model.		
R11: The full implementation of seven day working should be reviewed across the system to ensure the people of York are able to return to their usual place of residence at the earliest opportunity		
R12: Medicine optimisation should be fully embedded in the system.		

R13: Continuing healthcare arrangements should be more robust and person centred.		

Recommendation 8: Work should be undertaken to communicate more effectively with people who use services **Aim:** Continually communicate clearly, consistently and openly with local people.	**Lead Officer:**

CQC said:

- There was confusion among front line staff, managers and providers in relation to the various service offers and which services they could refer into.
- It was difficult for people using services, their families and carers to find out what services were available in the City of York area as there was not one portal or place where this information could be accessed.
- People's involvement in discharge planning varied. There was a lack of representation of people using services on the locality boards.
- There was confusion among service users, their families and carers and providers in terms of alternatives to going to see a GP.
- There was more that could be done to bring information about these services together in one place for people to access.

Objectives:

1. Engage more people more effectively in health and social care system.
2. Hear the voices of local people and listen attentively to their messages.
3. Ensure people have the information they need when they need it.

Measureable Outcomes/ Milestones:

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for**	**Progress**	**RAG**

			Completion		

Recommendation 9 : An effective system of integrated assessment and reviews of the needs of people using services should be introduced. **Aim:** Implement nationally recognised best practice.	**Lead Officer:**

CQC said:

- The lack of a central information and advice system led to unnecessary referrals and multiple points of entry to the health and social care system that made the system difficult to navigate for people using services.
- The local authority's adult social care system included a large number of teams, many hand-over points where people could fall through the gaps and a large volume of people within the system which was leading to blockages and capacity issues.
- Within the case tracking we found some evidence that people at increased risk of falls had been referred to the falls clinic but the majority of cases reviewed did not show any indication of how frailty or people at risk had been identified within the community. This was a more significant risk as the hospital staff could not see GP records.
- The service also reported to have challenges around links back to primary care for advanced care planning in the community. There was a lack of an elderly frailty framework for supporting and identifying a community response when eligible people had been identified.

Objectives:

1. Build on existing programmes of work to develop joint assessments.

2. Increase pace of change on good practice.

3. Reduce risk to individuals and improve quality of care and support.	
Measureable Outcomes/ Milestones:	
Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 10: The system should prioritise work towards improved performance against the high impact change model. **Aim:** Implement nationally recognised best practice.	**Lead Officer:**

CQC said:

- The extent to which the high impact change model, one of the national conditions for the BCF, had been implemented was limited.
- . . . we heard from people who use services, their families and carers and other providers that people did not feel involved and discharge planning seemed rushed at the point when the person was deemed as medically fit for discharge.
- . . . there was a potential opportunity for more people to be managed at home without the need for conveyance to hospital.
- . . . more people were waiting longer in A&E than the national target and national average.
- . . . people were admitted inappropriately and admission could have been avoided, given the correct

level of support in the community.

- A lack of evidence of discharge planning was seen in the medical records reviewed, where we saw no expected date of discharge in any medical record.
- There was a lack of evidence of any formal frailty pathway in place across the system and no formal audit in relation to how step-down beds were utilised.
- Take up to reablement services in the City of York was significantly lower than the national average.
- due to a poor referral service, stretched resources and the lack of a single point of communication, people frequently remained in hospital beds unnecessarily and could potentially suffer from secondary issues which escalated their needs.

Objectives:

1. Build on existing programmes of work to implement High Impact Changes.
2. Increase pace of change on good practice.
3. Reduce risk to individuals and improve quality of care and support.

Measureable Outcomes/ Milestones:

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 11 : The full implementation of seven day working should be reviewed across the system to ensure the people of York are able to return to their usual place of residence at the earliest opportunity. **Aim:** Implement nationally recognised best practice.	**Lead Officer:**

CQC said:

- A new multi-agency project for seven-day working had been included in the plan, however it was not scheduled to start until 2018/19.
- We found evidence that people were not being appropriately discharged at weekends due to the lack of seven-day services across the system. Nursing/care homes and the hospice were very reluctant to accept people who were discharged between Friday afternoon and Monday morning due to incidents of poor discharge that had occurred at weekends where people were discharged with no medication or discharge summaries.
- There was an apparent reluctance from medical staff to discharge at weekends from the medical wards. . . .There was a variety of reasons given as the rationale for this, including no access to reablement at weekends, a lack of seven-day social care working, challenges obtaining new packages of care and lack of senior medical cover.
- People using services were not always receiving the right care in the right place, at the right time. . . .The lack of seven day working meant a significant number of people were not being discharged at weekends.

Objectives:

1. Build on existing programmes of work to implement High Impact Changes.

2. Increase pace of change on good practice.

3. Reduce risk to individuals and improve quality of care and support.

Measureable Outcomes/ Milestones:

Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 12 : Medicine optimisation should be fully embedded in the system. **Aim:** Maximise existing good practice and enhance medicine optimisation.	**Lead Officer:**

CQC said:

- There was a lack of sharing of IT systems within the City of York. We saw that GPs working in urgent care frequently had no access to any medical records for the people they were seeing. This presented a particular challenge in terms of identifying what medication the person using services had been prescribed.
- The medicines management team were a very under-resourced team with no specific focus on the frail, older person. There was one part time head of pharmacy employed by the CCG with a further four shared across four CCGs in North Yorkshire. As a result of this, no preventative work was being undertaken in terms of medicines optimisation or admission avoidance.

Objectives:

1. Benchmark York practice against national and regional standards.
2. Map all the available medicines management support across the system
3. Identify areas for improvement and any gaps in support.
4. Implement change to ensure York people benefit from best practice models.

Measureable Outcomes/ Milestones:	
Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**

Recommendation 13: Continuing healthcare arrangements should be more robust and person centred. **Aim:** Ensure York is compliant with national framework.	**Lead Officer:**

CQC said:

- There was recognition by system leaders and front-line staff in the system that providers and commissioners had a history of difficult relationships around continuing healthcare (CHC), leading to delays in reaching agreements. There had been a lack of shared assessments or trusted assessors, unresponsive processes and disagreements around funding.
- People eligible for CHC funding were identified appropriately in the City of York but a recent review had identified that there was some lack of awareness from health and social care staff into CHC and personal health budgets. There was a lack of awareness into continuing healthcare funding amongst front line staff and it was felt these were not always focused on the person using services.
- From a local Healthwatch York review into CHC issues between 2014/16 it was concluded that some

health and social care staff lacked awareness about CHC and personal health budgets and were therefore unable to provide adequate support to people using services, their families and carers. It was also felt that the CHC assessments were not always person centred.
Objectives: 1. Deliver improvements in process and patient experience. 2. Ensure CHC pathways are understood in York and operate smoothly. 3. Ensure people eligible for CHC and their carers / families experience person centred, seamless services. 4. Link this action plan to the integrated commissioning plan approved by HWBB.
Measureable Outcomes/ Milestones:

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PROJECT FOUR: **CAPACITY, RESOURCES, EFFICIENCY AND EFFECTIVENESS**	**Lead Officer:**
CQC said: • Frontline staff were dedicated to providing a high quality person-centred approach to care. However, the demand for services was often greater than the capacity to deliver, due to the nursing and care staff	

vacancies within the City of York.

- Financial challenge was a key risk identified by each organisation, including the CCG and York Teaching Hospital NHS Trust. These were shared with and considered by system partners in organisational planning. For the local authority, the financial risk was that both the acute trust and CCG were in financial deficit which impacted on options and collaborative working.
- Overall the system had significant financial challenges.
- There were not robust processes in place for the system to be assured that resources were being used to achieve sustainable high-quality care. Spending in health and social care systems did not reflect joint priorities.
- The BCF plan aimed to commission specific services and schemes to build capacity where it is needed most. However, resources in the City of York are stretched, limiting the scale and scope of developments.

Strategic Outcomes:

- Ensure the sustainability of services in York
- Ensure we achieve value for money with the resources we have
- Maximise our assets.
- Shift to a strengths based model
- Prevent, reduce, delay and manage need

Local System Recommendations in this cluster TBC	**Lead**	**RAG rating**

Recommendation : **Aim:**	**Lead Officer:**
CQC said:	
Objectives: 1.	
Measureable Outcomes/ Milestones:	
Date Plan Approved:	**Review Date:**

Ref.	**Actions**	**Lead**	**Date for Completion**	**Progress**	**RAG**