Priority	Progress/Action Planning already underway
Top Priority: Reduce loneliness and isolation for older people	• **Understand more about poverty and its contribution to loneliness and social isolation:** The JRF (Joseph Rowntree Foundation) 'We Can Solve Poverty' document states that; 'Pensioner income poverty has reduced considerably in recent years, yet a substantial number of pensioners still have a low standard of living, especially if they are disabled or in ill health. Poor access to public transport restricts some older people from getting around, reducing their autonomy and increasing exclusion from social networks, sometimes leading to loneliness and isolation. Furthermore, stigma and lack of awareness mean that take-up of state support is often low. A case study is provided at Annex B to this report which further highlights the complexity of this. • The operational group has begun to focus on two issues; **fuel poverty** and **transport.** This is to understand more about what works well in the city and what more can be done to help reduce social isolation and loneliness. • **Fuel poverty:** Households are usually considered to be in 'fuel poverty' when they spend more than 10% of their total income to keep their house warm enough for health and comfort. National Energy Action (NEA), which is a fuel poverty charity, suggests that given the time-lag between collection of data and publication of the annual report the current scale of fuel poverty is greatly underestimated. NEA estimates that currently some 4 million (or 18.2%) of English households cannot afford sufficient warmth to maintain a warm and healthy living environment (www.nea.org.uk/government-fuel-poverty-progress-report-2-steps-back). In a report developed by City of York Council in 2008, it was estimated that 5976 households, 8.2%, were in fuel poverty in the city. Almost 18% of the total of the people affected were aged 55 and over. The operational group is aware of a number of services which can support people to gain access to information and advice which can help, and is in the process of mapping these so further awareness can be raised of what's available. • **Transport:** A group of York organisations, led by the York MS Society and Healthwatch York, is working together to see if it is possible to develop a community transport initiative for the city. There is a lot of interest in the project and a significant need identified by groups across York. The group has

Priority	Progress/Action Planning already underway
	met twice and is now developing ideas for a paid coordinator. This person will harness the existing enthusiasm to the next stage to engage more organisations, identify models and opportunities and develop a feasibility study, including costings, for what might be possible. The group hope that by working together they will be able to develop a service that helps people get out and reduces isolation across the city. • **Culture & Wellbeing Consortium**: reducing loneliness and social isolation is a principal focus for the Culture & Wellbeing Consortium. The Consortium was established in 2016 in response to the national Cultural Commissioning funded by Arts Council England and managed by National Council for Voluntary Organisations. With a consultant's support the Consortium mapped York's Health and Wellbeing priorities against the cultural sector's strengths and capacity, producing their own Ways to Wellness statement as a result. The overall aim of the Consortium is to overcome the psychological barriers to social and cultural engagement and in turn positively affect the health and wellbeing of older people in York. In 2017 the Consortium bid for and was awarded a City of York Council contract to pilot cultural commissioning. Sample projects are: o Cuppa and a chorus: Age UL working with Converge and the National Centre for Early Music o Culture on Prescription: the Consortium working with the social prescribing service to enhance the range of available options o Up for Arts: the Consortium working with BBC Radio York to celebrate older people's participation in the arts and to encourage continuing engagement.
Other Priorities:	
Continue work on delayed discharges	• The multi-agency Complex Discharge Task and Finish Group (a sub-group of the A&E Delivery Board) oversee a Complex Discharge Programme. The Programme aims to reduce unnecessary delays for patients in hospital and there are a number of projects underway to support this – including the integration of discharge liaison teams, redesign of key discharge processes, integration of intermediate

Priority	Progress/Action Planning already underway
from hospital	care and reablement teams. The group are using the national 8 High Impact Changes to Reduced Delayed Transfers of Care. We have recently conducted audits of patients in hospital over 7 days (to understand what they are waiting for) and the needs of patients in community inpatient units.
Celebrate the role that older people play and use their talents	• **Culture & Wellbeing Consortium**: The Consortium is planning an application for 'Celebrating age Funding' which will put older people in the position of commissioning as well as enjoying the arts and culture.
Enable people to recover faster	• We have re-provided intermediate care services with an increased capacity to provide home based intermediate care. This has allowed an increased number of patients in 2017 to access intermediate care – which provides multi-professional input to support people to remain independent following a crisis.
Support the vital contribution of York's carers	• City of York Council and the Vale of York CCG currently commission York Carers Centre to deliver a wide range of support services to adult and young carers in the city. The existing contractual arrangements commenced on 31st October 2013 and are due to expire on 31st March 2018. A significant extension of the existing Carers Centre contract was agreed in 2016 to support the creation of a Carers Hub, a highly visible referral point where carers could be offered early-stage assessment and preventative support in order to reduce and delay the need for more complex interventions. • Under the branding of the Carers Hub York Carers Centre has successfully established itself as highly visible, front-door contact point in the city which responds rapidly to carers' needs. Carers therefore have one clear point of contact; a competent and highly respected provider who is able to offer immediate support - or signpost to an appropriate partner agency.

Priority	Progress/Action Planning already underway
	• The Carers Hub has delivered strongly against the strategic priorities set out in the new operating model for Adult Social Care, particularly the principle of 'preventing, reducing and delaying the need for ongoing care and support'. • Through a combination of early intervention, proportionate assessment and triage for more complex cases of need the Hub provides a highly responsive, integrated and flexible carers support model - one which has proved effective in sustaining carers in their care giving role and reducing the demand for permanent, long-term care. This in turn has led to measurable cost savings across the health and social care system. • Specific examples of achievements since the establishment of the Carers Hub in May 2016 include the following: ○ A 10% growth in the number of new registrations with York Carers Centre (i.e.2,844 current registrations compared with 2,584 in May 2016). ○ Targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016. (1,095 new referrals have been received against a target of 980). ○ 1,119 customer contacts have been provided during extended opening hours (Friday / evening cover) since the contract uplift from May 2016. ○ The target for Carers Assessments of Need has been exceeded by 17% (88 completed assessments against a target of 75). ○ The waiting list for Carers Assessments in the city has reduced from 90 to 21 since May 2016. ○ Carers now have to wait for a maximum of 4 weeks for a carer's assessment, compared to an average wait of over 8 weeks in May 2016. ○ Three permanent outreach hubs for carers have been established in Acomb, New Earswick and

Priority	Progress/Action Planning already underway
	Tang Hall with numerous additional pop-up outreach activities and events taking place in other neighbourhoods across the city. ○ Case studies evidence that a complete breakdown of the care giving role has been avoided for at least 207 households in the 11 month period May 2016 to March 2017 including; ○ Prevention in admissions to residential care / reduction in the take up of domiciliary care packages (16% of case studies). ○ Prevention of a significant deterioration in carer mental health (59% of case studies). ○ Prevention of a significant deterioration in carer physical health (12% of case studies). ○ Sustaining carers in employment and alleviating financial hardship (13% of case studies).
Increase the use of social prescribing	**'Ways to Wellbeing'** is York's social prescribing service. It connects people to local community support to make them feel better. Nationally, 20-25% of patients consult their GPs for social problems, e.g. loneliness. This service reduces use of GP appointments for social issues, helping people stay safe and well at home for longer. Over 200 people have accessed the service since it officially began in February 2016 and 75% of people using the Ways to Wellbeing service reported feeling more confident and 80% improved their wellbeing. Recent evaluation has demonstrated that people accessing this service see much less of their GP – appointments on average have reduced by 30%. Funding for this work ended in March 2017 and although the service has continued it has no recurring funding source. Therefore maintaining this service is the first priority, and increasing it is the second priority. Funding applications are in progress at the time of writing this report.
Enable people to die well in their place of choice	• Improve communications and standardised care records to work towards seamless care provision from different providers • Stimulate the market further to ensure more flexible and higher skilled home care provision across all localities • Ensure that dying well in someone's place of choice remains a focus of the transformation agenda

Annex A

Priority	Progress/Action Planning already underway
	• Continuously act on lessons learnt from concerns raised by patients, their families and other stakeholders • To work across health and social care providers to develop a palliative/end of life care register. Additionally, the experience of health professionals themselves and service delivery could be improved through changes to the current multi-provider model. Transforming local services will be achieved through the development of local place-based services to implement fully integrated out of hospital care and achieve improved quality of the last year of life for all patients.