Notice of a public meeting of
Health, Housing and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Cullwick (Vice-Chair), Cuthbertson, Flinders, Richardson, K Taylor and Warters

Date: Wednesday, 12 December 2018

Time: 5.30 pm

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

A G E N D A

1. Declarations of Interest (Pages 1 - 2)

At this point in the meeting, Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda.

2. Minutes (Pages 3 - 8)

To approve and sign the minutes of the meeting held on Wednesday 14 November 2018.

3. Public Participation

At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **5:00 pm on Tuesday 11 December 2018.**

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The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at: http://www.york.gov.uk/download/downloads/id/11406/protocol_for_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

4. Half Yearly Report of the Chair of Health and Wellbeing Board (Pages 9 - 20)

This report provides the Health, Housing and Adult Social Care Policy and Scrutiny Committee with an update from the Chair of the Health and Wellbeing Board. The Chair of the Health and Wellbeing Board will be in attendance at the meeting to present the report.

5. York - An Evolving Asset Based Area (Pages 21 - 54)

The report provides an update on the progress to develop an asset based approach in the city, responding to challenges in society, and in particular reflecting the new operating model for Adult Social Care. It highlights key developments and progress made on recognised asset based models and approaches in the city.

6. The Impact of the Elective Surgery Criteria (Pages 55 - 60)

This report provides an overview of the impact on elective surgery that Vale of York CCG's Health Optimisation policy has had since its inception in February 2017. It will specifically provide clarification of the use of BMI in activating this policy, indicating numbers affected, the support that is available to them and a summary the feedback that the CCG has received.

7. Work Plan (Pages 61 - 64)

Members are asked to consider the Committee's work plan for the municipal year.

8. Urgent Business

Any other business which the Chair considers urgent.

Democracy Officer:

Name- Chris Elliott
Telephone – 01904 553631
E-mail - Christopher.elliott@york.gov.uk

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

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

☎ **(01904) 551550**

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Agenda Item 1

Health and Adult Social Care Policy and Scrutiny Committee

Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor Doughty	Member of York NHS Foundation Teaching Trust.
Councillor Richardson	Ongoing treatment at York Pain clinic and ongoing treatment for knee operation.
	Niece is an Adult Care Manager at CYC

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City of York Council	Committee Minutes
Meeting	Health, Housing and Adult Social Care Policy and Scrutiny Committee
Date	14 November 2018
Present	Councillors Doughty (Chair), Cullwick (Vice-Chair), Cuthbertson, Flinders, Richardson and K Taylor
Apologies	Councillors Warters

38. Declarations of Interest

At this point in the meeting, Members were asked to declare any personal interests not included on the Register of Interests, any prejudicial interests or any disclosable pecuniary interests which they may have in respect of business on this agenda. None were declared.

39. Minutes

Members requested that the following amendment be made to minute 35 (Implementation of the Extension of HMO Licensing).

a) Amend line to read as follows:

- "Officers stated that the rough estimate on the amount of rooms to be lost by the ~~Council~~ *City*, as a result of the new minimum requirements, would be 70 out of the 495 *and a total of 400-500 rooms by 2021".*

The Chair informed the committee that during the most recent meeting of the Children, Education and Communities Policy and Scrutiny Committee, it was decided that the potential joint scrutiny review into Tenant Engagement would not be taken forward in this municipal year.

40. Public Participation

It was reported that there had been three registrations to speak under the Council's Public Participation Scheme.

Gwen Vardigans, a member of *Defend Our NHS York,* had submitted a question to the committee prior to the meeting regarding the treatment of children with severe autism. The question and the replies from Michael Melvin and Maxine Squire, Interim Corporate Director's

for Health, Housing and Adult Social Care and Children, Education and Communities, are attached as an annex to this minute.

John Brown, speaking on behalf of the York and Selby Service Users Network (SUN) spoke on the proposed changes to the Mental Health Support Line. Mr Brown stated that the consultation on the reduction in hours of the Mental Health Support Line had been inadequate and that the TEWV Crisis Line did not provide an adequate alternative as it was not a listening service. Mr Brown went on to suggest that the current situation offered an opportunity to improve what is currently a fragmented provision of intermediate mental health support and create a service which fit the needs of its users.

Councillor Denise Craghill also spoke to the committee regarding the Mental Health Support Line. Councillor Craghill highlighted that there had been little strategic insight in the report provided and that the rationale behind the reduction in hours was still not clear. Councillor Craghill asked the committee to set up a task group to investigate all aspects of telephone based mental health crisis support involving all the necessary stakeholders.

41. Mental Health Support Line (MHSL) Review and Refresh

Officers updated the committee on the review and refresh of the Mental Health Support Line (MHSL).

Officers informed the committee that:
- The use of the line had declined in recent years
- The Mental Health Support Line was not a bespoke service and had been created to respond to a need and prior to TEWV's (and other agencies) involvement in York.
- It was an opportune time to review the MHSL provision

Members were keen to understand why this service was being provided by the Council and not the CCG. Members were informed that the Council stepped in to provide a service that was required at the time.

In response to member's questions, officers highlighted that:
- Mental Health Services were moving towards bespoke help for individual patients and away from assessments.
- Whilst a listening service was valuable, it was not clear that the MHSL was that service

- 22 The Avenue was primarily a supported living service and that the MHSL was being operated overnight by the same member of staff in charge of the patients using the supported living service.

Members were concerned at the reduction in hours of the MHSL and whether a valid alternative was being provided. Members requested further information to inform the need for a task group on the issue.

42. Home First Engagement - Initial Feedback Report

Officers presented the initial feedback from the Home First project which has been designed to help understand the needs of service users when being transferred from hospital to home.

Officers explained that Home First, which will be named 'Why not home? Why not today?' when it is developed into the new Joint Protocol for the Transfer of Care, was an important first step in understanding the needs of service users with co-production at the heart of the service being created.

Officers also explained that medical professionals are just beginning to understand the significant negative impact of staying in hospital, especially for older patients, where muscle wastage can be a serious issue.

Under questioning from Members, officers informed the committee that the next steps for the Home First project was to continue to reach out to more forums and service users for a second round of engagement.

Members were pleased to hear about the significant level of consultation and engagement with residents on this topic.

43. Healthwatch York: Performance Monitoring / Six Monthly Review

The Manager of Healthwatch York presented the organisation's biannual report.

Under questions from Members, officers gave an update on the Burnholme Project, the publishing of the recent investigation into the experiences of LGBT patients and also on why there was a projected overspend.

The officer did point out one correction from the report, that the dates from the Finance section of the report should have read, April 2018 to October 2018.

Members asked the officer to elaborate on the item of 'Healthwatch Visits', to explain where and when these visits took place. Members were highly complimentary of Healthwatch and of its management in what has been a tricky time for the organisation.

Members also offered their support to Healthwatch, suggesting further links with Parish Councils and their support in promoting the programme. The Chair was also keen to point out to officers that should there be any issues with regard to particular services, then they should feel free to raise them to this committee.

44. Suicide Prevention and Self-harm Overview Report

Officers presented an overview report into Suicide Prevention and Self-harm, outlining the current work taking place in this area.

The officers highlighted to the committee that this is a particularly challenging area of public health work and whilst recently there had been a slight drop in deaths by suicide in York, the longer trend still showed an upward trajectory.

Members and officers discussed the provision of training and its sustainability. Officers pointed out that continued support from statutory service providers would be required if the current training provision were to continue and even expand in the future.

Members were keen to understand how the ambitious aims in the York Suicide Safer Community Strategy were to be evaluated. They were informed that it is difficult to report on this area of work and it would be submitted to the Health and Wellbeing Board.

Members discussed the recommendations attached to the report, which showed a high level of detail and thought and it was decided that Members from the committee would meet outside of the meeting to discuss how best to take forward the recommendations listed.

45. Update on Oral Health in the City of York

The committee received an update on Oral Health in the City and officers also outlined the aims of the Oral Health Improvement Advisory Group (OHIAG).

The officers explained that the OHIAG had been created in order to investigate York's high numbers of hospital admissions for dental care. Officers also highlighted that it did not seem to match the statistics suggesting that children's oral health in York was good.

Under questioning from members, officers stated that they were not yet in a position to understand the reasons for this anomaly. Officers mentioned that it could be a matter of custom and practice and they would continue their work in this area.

46. Work Plan

Members discussed the work plan for the 2018/19 municipal year.

Following the earlier suggestion that a report be requested on the types of Mental Health Support Services currently being provided in York, the Interim Corporate Director of Health Housing and Adult Social Care informed members that he would report back to the committee on this. This report will then assist the committee in deciding whether it was necessary to set up a task group. It was also agreed that an informal meeting of the Committee be arranged by the scrutiny Officer to discuss the recommendations in the Suicide Prevention and Self-harm report.

Cllr P Doughty, Chair
[The meeting started at 5.30 pm and finished at 8.30 pm].

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Health, Housing & Adult Social Care Policy & Scrutiny Committee **12 December 2018**

Report of the Chair of the Health and Wellbeing Board

Half Yearly Report of the Chair of Health and Wellbeing Board

Summary

1. This report provides the Health, Housing and Adult Social Care Policy and Scrutiny Committee with an update from the Chair of the Health and Wellbeing Board (**Annex 1 refers)**. The Chair of the Health and Wellbeing Board will be in attendance at the meeting to present the report.

Background

2. It was agreed as part of the working protocol between Health, Housing and Adult Social Care Policy and Scrutiny Committee, the Health and Wellbeing Board (HWBB) and Healthwatch York that the Chair of the HWBB would bring reports to this Committee. This protocol has recently been reviewed and it has been agreed that the Chair will provide two reports per year in December and June, with the June report being the Annual Report of the HWBB.

Consultation

3. Not applicable to this report.

Options

4. This report is for information, there are no specific options associated with the recommendations in this report.

Analysis

5. This report is for information only.

Council Plan

6. This report has links to all three elements of the Council Plan 2015-19 – a prosperous city for all; a focus on frontline services and a council that listens to residents.

7. It also has direct links to the joint health and wellbeing strategy 2017-2022 and the all age mental health strategy 2018-2023

Implications

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

Risk Management

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

Recommendations

10. Members are asked to note the contents of this report.

    Reason: To keep members of Health, Housing and Adult Social Care Policy and Scrutiny Committee up to date with the work of the Health and Wellbeing Board.

Contact Details

Author:
Tracy Wallis
Health and Wellbeing Partnership Co-ordinator
Tel: 01904 551714

Sharon Stoltz
Director of Public Health

Approved ✓ 04.12.2018

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
None

Annexes
Annex A – Report of the Chair of the Health and Wellbeing Board

Abbreviations
HWBB - Health and Wellbeing Board

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Update from Councillor Carol Runciman - Chair of Health and Wellbeing Board (HWBB)

December 2018

1. On 25th July 2018 I presented the Health and Wellbeing Board's Annual Report to the Health, Housing and Adult Social Care Policy and Scrutiny Committee. This half-yearly report provides a snapshot of work undertaken by the HWBB since then.

2. The first update I have is that there have been a number of changes to the membership of the Health and Wellbeing Board in recent months. As Chair of the HWBB I would like to thank Martin Farran, Jon Stonehouse, Patrick Crowley, Ruth Hill, and Sarah Armstrong for their contributions to the Board and to warmly welcome new replacement members to the Board. The changes in membership have also meant a change to the lead board members for the joint health and wellbeing strategy themes. I can confirm that our lead board members are now as follows:

    - Interim lead for the starting and growing well theme – Maxine Squire (Interim Corporate Director for Children, Education and Communities, City of York Council)

    - Lead for the living and working well theme – Sharon Stoltz (Director of Public Health for the City of York)

    - Interim lead for the ageing well theme – Sharon Stoltz (Director of Public Health for the City of York)

    - Lead for the mental health theme – Patrick Scott (Director of Operations, York and Selby at Tees, Esk and Wear Valleys NHS Foundation Trust)

3. As there have been so many changes to both members and substitutes on the board an induction pack has been created for new members. This is an electronic resource that is also available to the public.

4. **Formal Meetings**: The HWBB met on 11th July 2018 and 17 October 2018. The board continues to base the first half of its meetings around one of the themes in the joint health and wellbeing strategy 2017-2022. The second half of each meeting is focused on core business.

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5. **July 2017: Starting and Growing Well**: the top priority in the joint health and wellbeing strategy for this theme is to provide *'support for the first 1001 days, especially for vulnerable communities'*. Additional priorities are *'reduce inequalities in outcomes for particular groups of children'; 'ensure children and young people are free from all forms of neglect and abuse'; 'improve services for students'; 'improve services for vulnerable mothers'; ensure that York becomes a breastfeeding friendly city'*.

6. **Context:** as of July 2018 there are approximately 200,000 residents in York of which just over 36,500 are aged between 0-17 (inclusive); just over 10,500 of these are aged 0-4. There are 200 children in care and 133 children on protection plans.

7. 21.7% of York's population is aged 0-19 and there are over 22,000 full time students in the city.

8. As part of the work to refresh York's Joint Strategic Needs Assessment (JSNA) a number of reports are being prepared by the JSNA Working Group to describe **inequalities within the population** of York. These are intended to offer a more detailed insight into health and wellbeing in York and to help focus resources and effort into areas of greater need.

9. The first of these is focused around the starting and growing well theme in the joint health and wellbeing strategy 2017-2022. The full report can be accessed here and it takes a deeper look into differences of experience for children and young people growing up in York. The report focuses on three interlinking themes, childhood obesity, self harm in young people and childhood poverty. These topics were chosen according to national research demonstrating the presence of inequality and the availability of good quality local data that describes the picture for York.

10. The report was initially discussed at a HWBB workshop where the HWBB began to look at the action that would need to take place to address the indentified areas of inequality. Further detail of the discussion at the workshop and how the HWBB decided on the next steps is contained within the July 2018 meeting papers for the board.

11. The HWBB ultimately agreed that the existing multi-agency Healthy Weight Steering Group would continue to work with Public Health England, looking at all partners and how future proposals can be

developed to tackle childhood obesity with a focus on behavioural change rather than treatment led interventions. The HWBB also felt that this would be a good opportunity to pilot the 'Health in All Policies' approach.

12. The Healthy Weight Steering Group has had several meetings and is in the process of producing a draft Healthy Weight Strategy covering all ages. At the Steering Group meeting where the group considered recommendations relating to children, the work from the HWBB Workshop was incorporated into the discussion. The aim is to have a draft strategy for January 2019 which we will start to share with partners before formally consulting on it later in the year.

13. The Board also received a paper detailing some of the **ongoing work around the starting and growing well theme**; whilst not exhaustive the paper provided the Health and Wellbeing Board with reassurance that work is ongoing in this area and there is much to be proud of.

14. For our top priority *'support for the first 1001 days, especially for vulnerable communities'* one of the key highlights is a significant improvement in relation to the number of families seen by the Healthy Child Service. For example in 2015/16 Quarter 1 23% of families received a new birth visit within 14 days. In 2017/18 Quarter 4 this had risen to 86%. When including families receiving a new birth visit outside of 14 days the figure rises to 96% for 2017/18 Quarter 4. The percentage of families who receive a 12 month development review has risen from 18% (2015/16) to 72% (2017/18 Quarter 4).

15. Additionally there are multi-agency initiatives focused around reducing inequalities in outcomes for particular groups of children such as the work by the Oral Health Improvement Advisory Group which the scrutiny committee are already sighted on.

16. The children and young people's plan 2016-2020 is closely linked with the priorities in the joint health and wellbeing strategy and has a vision that children and young people are at the heart of our city and everything we do. It has four priorities namely; early help; emotional and mental health; narrowing gaps in outcomes and priority groups.

17. Taking this into account the Health and Wellbeing Board agreed last year that a range of partnership mechanisms across the city (including but not restricted to the YorOK Board and the

safeguarding children board) be used to deliver against the starting and growing well theme of the joint health and wellbeing strategy (2017-22). There are already multi-agency plans in existence that cover many of the key areas within the starting and growing well strategy theme; it would seem pertinent to use these rather than producing one single action plan.

18. A **Student Health Needs Assessment** was completed in 2017 and the Board received a progress report in July 2018 on how the Student Health and Wellbeing Network had progressed work around this agenda.

19. I can report that the network has been led and facilitated by Higher York and has:

    - provided a space for key stakeholders to focus on service provision from a multi-agency perspective;

    - enabled student support services to have a voice in a city wide multi-agency setting;

    - developed an action plan to effectively support the needs of students across the city;

    - provided a forum to raise, share, understand and respond to existing and newly identified needs around students;

    - allowed for open discussion and sharing of research between student service teas, health providers, student unions and the voluntary sector.

20. However it is unclear whether the Student Health Network has the capacity to continue this work.

21. **October 2017: Mental Health and Wellbeing**: the top priority in the joint health and wellbeing strategy for this theme is to *'get better at spotting the early signs of mental ill health and intervene early'*. Additional priorities are *'focus on recovery and rehabilitation'; 'improve services for mothers, children and young people'; 'improve the services for those with learning disabilities'; 'ensure that York becomes a suicide safer city' and 'ensure that York is both a mental health and dementia friendly environment'*.

22. Health and Wellbeing Board received their first report from the independent chair of the newly established Mental Health

Partnership. HWBB signed off the Terms of Reference for the Partnership and it will be reporting to HWBB at least annually on progress against delivering the all age mental health strategy 2018-2023.

23. Work is ongoing to ensure that the partnership works effectively and in a complementary way to existing groups. There is also some mapping work to undertake looking at work streams of other groups in the city to avoid duplication.

24. The Mental Health Partnership acknowledges that to make a significant difference a more collective approach is required to start making the cultural shifts to fully aligned delivery. There is an ambition to work in a more integrated way using community strength based approaches at a neighbourhood level.

25. The Partnership have identified three priorities to initially focus on, namely;

    - Self harm
    - Housing/supported accommodation
    - Long term prevention

26. The Health and Wellbeing Board have also agreed to sign up to the Prevention Concordat for Better Mental Health. This concordat is underpinned by an understanding that taking a prevention focused approach to improving the public's mental health makes a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence based planning and commissioning to increase the impact on reducing health inequalities. Implementation of the concordat has been delegated to the Mental Health Partnership.

27. Additionally Health and Wellbeing Board received a report on two further mental health related matters:

<u>An update on the all age autism strategy</u>

28. The principles of the strategy are:

    ➢ People with autism and their families and carers are at the centre of everything we do
    ➢ Focus on people's strengths to overcome barriers

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- Guidance, information and support are easily available
- The right support at the right time
- Increased awareness of autism across the City of York Council living in your community and being included

29. The six areas of focus identified in the strategy are:

    1. Inclusive communities
    2. Assessment and diagnosis
    3. Transitions
    4. Training/education
    5. Employment
    6. Parent/carer support

30. The report detailed the progress made against these areas of focus and asked the Health and Wellbeing Board to endorse the action plan in order to maintain progress and to actively promote York being an autism inclusive city. The Health and Wellbeing Board agreed to this. You can read the full report here.

31. In addition to the establishment of the Mental Health Partnership, the Learning Disability Partnership was established in June 2018. It will meet quarterly, and the main area of its business initially is the development of an all age Learning Disability Strategy. The partnership is a multi-agency group which includes people with learning disabilities and carers. The partnership is supported by a working group. The draft strategy is scheduled for the March 2019 meeting of the Health and Wellbeing Board.

Refresh of the local transformation plan

32. The Local Transformation Plan reflects the aims and ambitions for children's emotional wellbeing in the local area and describes how it is working collaboratively to deliver them. The plan is refreshed annually and endorsed by the Chair of the Health and Wellbeing Board before being submitted to NHS England. You can read the full report here.

33. **Other key pieces of work** – in addition to the above information which focuses on the board's joint health and wellbeing strategy the Health and Wellbeing Board have considered the following:

    - **Health Protection** – Health and Wellbeing Boards are required to be informed and assured that their health protection

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arrangements meet the needs of the local population. The scope of health protection is wide ranging and includes:

- National programmes for vaccination and immunisation
- National programmes for screening, including those for antenatal and newborn; cancer (bowel, breast and cervical); diabetic eye screening and abdominal aortic aneurism screening
- Management of environmental hazards including those relating to air pollution and food
- Health emergency preparedness and response, including management of incidents relating to communicable disease (e.g. TB, pandemic flu) and chemical, biological, radiological and nuclear hazards
- Infection prevention and control in health and social care community settings
- Other measures for the prevention, treatment and control of the management of communicable disease as appropriate and in response to specific incidents**.**

34. An inaugural meeting of a local health protection committee to support a multi-agency approach to addressing health protection issues for the city will take place this year and will be led by the Director of Public Health.

35. **The HWBB Steering Group:** the HWBB Steering Group meets on a monthly basis and continues to effectively manage the HWBB's business and ensure they fulfil their statutory duties. It receives regular updates from the JSNA Working Group. As well as leading on the inequalities reports I mentioned earlier in my report the JSNA Working Group have also published 2 topic specific needs assessments as follows:

- The sexual health needs assessment was a rapid assessment of the sexual health needs of York's population; it looked at the current and emerging sexual health needs of people living in York and concluded with a number of recommendations
- The homeless health needs assessment has helped to inform a new homeless strategy for the city; 'preventing homelessness together.'

36. **The York Health and Care Place Based Improvement Partnership** is a strategic level, action focused partnership. It supports cross-organisational change by collectively and proactively

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working together to address delivery of longer-term improvements across the city's health and social care services. Its programme of work is focused on the improvement plan following the 2017 Care Quality Commission's (CQC) Local System Review. The partnership have identified 3 work streams:

- Digital
- Workforce
- Capital and Assets

37. These align with the priorities of the Humber, Coast and Vale Sustainability and Transformation Partnership.

38. **Care Quality Commission -** In September 2018 the government announced that York would be one of three areas to undergo a follow up review by Care Quality Commission, to check our progress against the action plan submitted after the Local System Review of 2017. Progress against the plan has been reported to the HWBB and to the scrutiny committee over recent months.

39. CQC requested an updated plan, a System Overview Information Return as well as a two day site visit comprising interviews with system leaders and focus groups. This took place on 19th and 20th November 2018. The report is expected to be presented by CQC at the HWBB workshop in January. However, these details are to be confirmed. The headline feedback at the end of the visit acknowledged some progress had been made, and that they had seen evidence of great commitment to joint working from frontline staff. It was recognised that further progress is needed; this is in part due to recent and forthcoming changes in senior offices, notably in the Council's adult social care directorate and children's directorate, York CVS, Healthwatch York, York Teaching Hospital NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust.

40. **Building Relationships** – as Chair of the HWBB I continue to meet with key partners in the city including, the Chairs of the CCG, York Teaching Hospital NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and the Chairs of both the Adults Safeguarding Board and the Children's Safeguarding Board.

41. **Communications** – Health and Wellbeing Board now produce a seasonal newsletter. The most recent of these can be found here.

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42. **York Festival of Ideas -** Health and Wellbeing Board, in collaboration with One Planet York took part in the Festival of Ideas. The theme for this year's festival was 'Imagining the Impossible'. As part of this wider city conversation the HWBB and One Planet York held an event on 12th June 2018 focused on healthy city and place called 'Paradise Found: How Can One Place Can Work for Everybody'. The event was very well received and a post-event summary can be found here.

Cllr Carol Runciman

Chair of Health and Wellbeing Board

Background documents

York Joint Strategic Needs Assessment: Starting and Growing Well in York - Inequalities Report

All Age Autism Strategy

Local Transformation strategy

Health and Wellbeing Board Newsletter 2018

Conference Report: Paradise Found, How one place can work for everybody.

Abbreviations

CQC Quality Commission

HWBB- Health and Wellbeing Board

JSNA - Joint Strategic Needs Assessment

NHS England- National Health Service England

TB- Tuberculosis

TEWV Tees, Esk and Wear Valleys NHS Foundation Trust

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Health, Housing and Adult Social Care Policy and Scrutiny Committee **12 December 2018**

Report of the Head of Commissioning (Early Intervention, Prevention and Community Development)

York an evolving Asset Based Area

Summary

1. The report provides an update on the progress to develop an asset based approach in the city, responding to challenges in society, and in particular reflecting the new operating model for Adult Social Care. It highlights key developments and progress made on recognised asset based models and approaches in the city.

Background

2. CYC, led by Adult Social Care, introduced in 2016 a new 'community operating model' endorsed by the Council's Executive, and with the commitment and leadership from our Corporate Management Team. The community operating model supports the council wide vision of supporting people to enjoy healthy, active and independent lives. It is based on enabling people in York to have control over how they manage social care needs with a strong emphasis on the use of personal and community assets and working in partnership, reflecting the principles of co-production. A strong Voluntary, Community and Social Enterprise Sector (VCSE) is key to delivering this agenda, and builds on the Council's Corporate Plan and key strategic objective of 'A prosperous city for all' where local businesses, including community business and enterprise thrive.

3. Our strategic intention has been to move away from our previous model, in which CYC adult social care often intervenes at a point of crisis in people's' lives. This often risks creating a dependency between the person and the council. The new model, built on an asset based community development and an early intervention and prevention approach, will use the individual and their community's capacity to self

care and manage as the first option and encourage active citizenship. Moving to a model based on self care and community assets also underpins the Health, Housing and Adult Social Care Directorate plans to reduce costs, in commissioned community support, residential and nursing care.

4. This is complemented, by a significant workforce development and systems change programme - 'Future Focus' – which is supporting culture change across social care staff regarding assessment and care management. We have commissioned NDTI (National Development Trust for inclusion) to work with us on this programme, reflecting their expertise in the 'Community Led Support' social care model, which is based fundamentally on a coproduction approach. From April this year we have been building up community Talking Points and have now seen over 100 customers (not including 'drop-ins' and carers appointments). Talking Points are community locations that offer residents the opportunity to have a face-to-face conversation with social care staff. The idea is to bring social care skills out into the community, to become more responsive and accessible. The 'booked in' group are residents who after the initial conversation without Customer Access and Assessment Team (CAAT), would have otherwise been put on a waiting list to receive a full social care assessment the average waiting time for which before the project began was around 9 weeks. As a result of offering the Talking Point option, we have been able to see these customers much more quickly; the waiting time for these is currently just over around 8 days as opposed to 9 weeks. This quick response reduces the risk of them experiencing a crisis situation, and enables us to provide a more proportionate response, earlier on in the social care process.

5. This paper focuses on the 'Asset Based Area' framework as a model to consider our understanding of York's position on 10 key points that are recognised as needing to be in place for a whole area to move to asset based working. A number of planning and support models are also explored to help the city make progress on this agenda alongside citizens and cross sector partners

The Asset Based Area

6. In an age of austerity increasing attention is often paid to what councils and the NHS 'cannot' do, making it vital to gain some clarity on what the organisations and people of an area 'can' do. Reflecting principles of co-production, every area and its citizens can achieve more when they

combine their expertise, time, creativity and resources. This approach has been modelled through the development of the new Volunteering and Social Action strategy in the city - People Helping People - and York becoming a City of Service in November 2017, where we work in collaboration with communities and citizens to respond to shared city priorities.

7. Decades of evidence based practice and research shows that this happens best when:

    - Everyone shares an asset based mindset; looking first for what individuals, families and communities can, or could do, with the right support, rather than focussing exclusively on needs and problems

    - Services and organisations are co-produced with the people whose lives they touch. This means that everyone included identifies priorities, co-designs services and systems, and works together wherever possible to co-deliver the work that takes place.

8. Every area, and York is an excellent example of this, already has at least some organisations, professionals and local people who take these approaches, but for them to have a wider and deeper impact, whole systems and areas need to be aligned around an asset-based approach. Many asset based practitioners argue that people can lead that change only when acting as local citizens, not when acting in professional or service leadership roles. Our Cities of Service ‘impact volunteering’ model has enabled us to explore this and re-imagine social action in the city linked to the People Helping People strategy.

9. Asset based theory suggests that an asset based public body does not have ‘customers’ (who’s only responsibility is to pay taxes), rather it views everyone, including people with long term support needs, as citizens, with rights and responsibilities. Rather than ‘providers’, asset based areas have partners, who share responsibility for system design and the best use of resources. An asset based area is responsive to need, but always looks for capability and potential. It is confident in the things it can do, and the difference its citizens’ skills and expertise make, but it has the humility to recognise its limitations, namely to fix people or communities.

10. The Think Local Act Personal Building Community Capacity Network has produced guidance on Asset Based Area thinking and the key

features of an asset based area, which York has contributed to. It also complements recent work in the region to launch a Strengths Based Charter for Health and Social Care. This report outlines how the Council has developed an asset based approach in Adult Social Care and has in place practice and programmes reflecting the ten key features of an 'Asset Based Area', recognising that enabling and developing such an approach at scale is challenging, but not necessarily complex. The Local Area Coordination programme Leadership Group, Chaired by the Executive Member for Health, Housing and Adult Social Care has explored with partners the extent to which these ten key features are in place in York. It concluded that there is strong evidence of such required programmes and practice, reflecting coproduction across health and social care and a strategic investment in early intervention, prevention and community development, alongside growing focus on how social action can help augment public services and subsequently deliver better outcomes for citizens.

Features of an Asset Based Area:

- Maintains a living **map of local assets** including community groups and charities, social action, services. Private sector and enterprise, buildings and land.
- Actively relocates **'power'** with its citizens, seeing its role as working with, not for, people and bringing individuals and groups together. It sees partnership as its default mode with all its staff and partners trained in asset-based thinking and co-production
- Invests in **early intervention and prevention** and community capacity building, understanding their outcomes and increasing investment in programmes which work.
- Expects all its activities and services to build people's **resilience** and social connections with investment in models which demonstrate this.
- Uses the **Social Value** Act principles by default in all contracting and grant making.
- Builds and sustains **social and community enterprise** to increase the range of support models and accessible activities, in addition to developing and nurturing partnerships with local business.

- Builds **mutualism** and shared ownership, including through use of the Localism Act, which increases year on year the proportion of the public service workforce who have current and lived experience of using services

- Thinks in terms of **neighbourhoods** rather than statutory boundaries, and invests in connecting people within and between those neighbourhoods, alongside developing community capacity using a variety of asset based models.

- Measures all forms of **social action** including volunteering, and increasing investment in them, rather than seeing volunteering as 'free'.

- Has a shared set of **outcomes measures** for changes in people's lives, such as wellbeing, resilience, independence, access top peer support and the ability to self-care. These measures can be use to understand the impact and cost effectiveness of services

Key features of asset-based panning and support models

11. There are a wide range of asset-based models upon which to draw, which York has strategically invested in, reflecting a mix of commissioning and attracting external grant programmes. These recognise that effective and sustainable models tend to:

    - Draw on an evidence base and identified model that can be co-produced with local people.
    - Build local capacity and expertise, rather than relying on outside support.

12. Most approaches start by mapping an area's assets and reflect the approach adopted in York through mapping assets linked to our Ward Committee arrangements and the work of the Health and Wellbeing Board, mapping assets linked to the priorities of the Health and Wellbeing Strategy and in particular the strategic Ageing Well priority. The Local Area Coordinators now operating in seven wards within the city, also undertake a comprehensive community mapping exercise when commencing their roles, to enable them to have excellent knowledge of local activities and groups to connect people to and build greater levels of inclusion and active citizenship.

13. The development of York's Local Area Coordination (LAC) programme is an excellent example of a nationally recognised asset based

approach. LAC is an evidence based approach to supporting people as valued citizens in their communities. It enables people to pursue their vision for a 'good life' and to stay safe, strong, connected, healthy and in control. As well as building the skills, knowledge and confidence of people and the community, LAC is an integral part of system transformation. It simplifies the system and provides a single, accessible, local point of contact for people in their local community. Following the successful pilot in three areas of the city; Tang Hall, Westfield and Huntington and New Earswick , the LAC programme was expanded in September to a further four areas including; Clifton, Haxby & Wigginton, Guildhall and Acomb into Holgate. Since the inception of the LAC programme in August 2017, the Local Area Coordinators who are all 'place based', have now worked alongside over 700 'vulnerable' people, supporting them to take individual action on a journey towards a 'good life' reflecting a person centred approach and action planning on a mix of personal challenges. The top three issues or reasons why people ask to work with a Local Area Coordinator include mental health, social isolation and housing. A series of 'stories' which form one of the key qualitative performance measures for the programme and helping to inform system change, are captured at Appendix 1.

14. York is recognised within the national LAC Network of 13 cities as a high performing area with excellent strategic leadership of the programme and traction in the city. Members of the LAC team have recently returned from the national 'Social Care Futures' Conference where they facilitated workshops in asset based approaches and person centred working. York was also featured in the recent Centre for Ageing Better national report into 'Age Inclusive Volunteering' reflecting links with the People Helping People Strategy. The University of York is currently carrying out an evaluation of the York LAC programme and expects to report the initial findings in early 2019.

15. York's complementary Social Prescribing programme, delivered by York Centre for Voluntary Service (CVS), *Ways to Wellbeing* also continues to develop positively and receive national recognition. The recently scaled up social prescribing service is now expanding relationships with GP practices in the city, reflecting strong links with the Primary Care Home model. Performance continues to be positive and a recent analysis of people who had worked with the Ways to Wellbeing team and benefited from being connected to local voluntary groups and activities, has resulted in a 32% decrease in patients attending GP appointments. This reflects that approximately 30% of people attend GP appointments with non-clinical conditions including worries about debt,

isolation and depression and can benefit from a social prescribing solution. The York LAC and social prescribing teams recently wrote a blog together for the Network, reflecting the collaboration between the two models, and how this is supporting the delivery of positive outcomes for citizens and enabling clear referral routes. The Network blog article is attached at Appendix 2 and York's model has been recognised nationally by the Office of Civil Society as an example of best practice.

16. Both programmes were also commended in the recent CQC System review and recommendations made to sustain and scale up Local Area Coordination reflecting its focus on prevention and co-production. Expansion of LAC and social prescribing is currently being considered through the review of the Better Care Fund and wider funding opportunities potentially available to Adult Social Care, linked to the budget. Members' views on scaling and expansion plans are welcomed, reflecting our remit to deliver the Health and Wellbeing Strategy and Adult Social Care community operating model.

17. CYC Adult Social Care has also partnered with the national Community Catalysts Charity to deliver a project to address a key priority within the Health and Wellbeing Strategy. The Community Catalysts Community Enterprise project will explore how social and community enterprise solutions can be co-designed with citizens to help address loneliness and isolation experienced by older people in the city. York is one of only two areas nationally that was successful in applying to this externally funded programme, by the Esmee Fairburn Community Foundation. Through partnering with Community Catalysts, another of the recognised family of asset based approaches, we are exploring how enterprise can evolve in the city linked to this important priority. The project will run for three years and aims to grow 25 new community enterprises, attract 45 volunteers and work with 200 beneficiaries. Birmingham University are carrying out an external evaluation of the project which will aim to develop a 'business case' for future investment and evidence of the model. Community Catalysts case studies are attached at **Appendix 3**

18. Adult Social Care has also invested in a further two recognised 'asset based approaches' Home Share and Shared Lives Plus. Homeshare matches someone who needs some help to live independently in their own home (householder) with someone who has a housing need (homesharer). In return for low cost accommodation the homesharer provides a minimum of 10 hours of support per week to the

householder. Householders are often older people or people who need support to continue to live in their own homes. They will have some support needs or may have become isolated or anxious about living alone. The idea is that with reassurance and companionship householders will continue to live full, happy and healthy lives. Householders will also be able to pass on their skills and experience to enrich the lives of those that share with them. Homesharers are often younger people, students, or key public service workers who cannot afford housing where they work. They are happy to give their time to support the needs of older people.

19. Homesharing benefits and enriches the lives of both the householder and the homesharer and is a fantastic example of intergenerational working. It is not just about providing support but is also a great way to widen horizons, learn new skills and meet new people. The York Homeshare Coordinator has been in post two months and is currently developing the logistics and governance arrangements for the York project ahead of identifying Homeshare 'matches'.

20. Shared Lives Plus is the UK network for family-based and small-scale ways of supporting adults, often with learning disabilities or poor mental health. Members are Shared Lives carers and workers, and micro-enterprises. They use different approaches to enable people to achieve goals such as: being in control of their services and their lives; pursuing ordinary lives with their chosen families and relationships; and being valued by their communities and feeling like they belong. Once again reflecting principles of co-production, Shared Lives supports asset based thinking around active citizenship, contribution and inclusive communities. The new Shared Lives Worker will commence their new role in December 2018.

21. Adult Social Care has also invested £225,000 over three years through the Ward Committees, which have been distributed in grants to help deliver health and social care outcomes. This has positively resulted in a variety of local social action projects being developed, including a number of befriending schemes, grants to Voluntary and Community Sector (VCS) groups and support to community activity including coffee mornings and social connection activity helping to address loneliness and isolation. Following an analysis by the Communities and Equalities Team, and after a slow start, approximately £360,000 has now been

invested in health and wellbeing projects, which is more than the original direct investment from Adult Social Care budgets.

22. This more focussed ward investment and development of associated prevention type projects, benefited from a series of Ward Committee workshops delivered on the Local Account and Ageing Well during 2016 / 2017. Facilitated by the Head of Commissioning (Early Intervention, Prevention and Community Development) this also included a mapping of existing activities that addressed loneliness and isolation, reaffirming this as a local ward priority in 17 of our 21 wards. Recent evaluation of ward committee projects using the 'social value' research engine developed by 'Rose Regeneration' consultants and utilised by the Communities and Equalities team, has identified 'social return on investment (SROI) figures of between £2 and £12 for every £1 invested. The ward arrangements and associated project development reflect the council's focus on 'neighbourhoods' community capacity building and maximising of social value in our local commissioning arrangements, all key features of the 'asset based area'.

23. Adult Social Care has also commissioned the Arts and Culture Partnership to explore the role of cultural prescribing in the city. Reflecting the significant expertise and skills of the cultural and creative industries in the city, organisations have been mobilised more directly around the delivery of ageing well outcomes. This two year programme has seen the development of a variety of activities in the city enabling older people to connect with cultural opportunities and improve their health and wellbeing. This has included singing and dance to promote wellbeing outcomes and 'culture on prescription' through improved marketing and communications. The Partnership presented their year one findings to the Health and Wellbeing Board in 2018 and are currently delivering year 2 of the programme. Members of the partnership are hoping to secure Arts Council funding to sustain their work. The partnership also funded the development of the community mural and co-designed Live Well York logo.

24. A further 'impact volunteering' project highlighted within the People Helping People Strategy is Goodgym which also applies asset based thinking within its approach and how it can contribute to ageing well. GoodGym encourages volunteering by channelling the energy that people spend on exercising and turning it into positive social action, alongside tackling loneliness and social isolation. It arose out of frustration with normal gyms being a waste of energy and human potential. In the model, runners sign up to get fit by doing physical tasks

like manual labour for community organisations, preceeded by group runs to get there. Goodgym also offers committed runners the chance to do regular runs to make social visits to isolated older people who act as 'coaches' – motivating someone to run on a cold winter's day when they might not have otherwise. We are currently exploring wider development opportunities with GoodGym including a 'home from hospital' project to support people leaving hospital to be welcomed home safely and have household tasks completed including furniture adaptation supporting reablement.

25. GoodGym has been running in York since January 2017 and is the fastest growing group in the country and going from strength to strength. The group regularly attracts over 50 runners each week and will be fully self sufficient and sustainable by year two. Impact metrics and outcomes are impressive. To date:

    - 86 missions to help older people facing issues of loneliness and isolation have been made, including gardening tasks or help around the home.
    - 140 group runs to community projects including helping the renovations of community centres, schools and green spaces in the city
    - Nearly 200 'coach' visits to an isolated older person, where the Goodgym runner befriends an older person
    - 93% of isolated older people feel more connected after being visited by a Goodgym runner
    - 92% of runners agree that Goodgym increases their motivation to exercise.

26. The new operating model also includes the provision of high quality information through a range of channels including the development of a new 'citizen wellbeing portal' Live Well York as a community based website for Adults and Families. The website can be used to find information and advice, discover hundreds of local groups and activities and find out what events are happening across York. It also provides a directory of services and products to meet individual needs. The site is particularly useful to Prevent, Reduce Delay need for statutory services as well as provide information for Self Funders and people receiving Direct Payments but is also designed to be useful to all citizens of York. The site has been designed in partnership with citizens, Age UK York,

Healthwatch York, York CVS, York Explore, York Mind, Vale of York CCG and the City of York Council.

27. Live Well York has been available to the public since February 2018 as part of the development phase leading to a full launch in January 2019. It delivers against the Care Act 2014 requirement to provide good quality information and advice to all citizens of York. We have deliberately taken a phased approach in the development of the site to ensure we are confident in the quality aspect of the content. It meets AAA Accessibility Standards, there is a named editor for each page and the pages have been checked by the readability group from Healthwatch York to ensure it is in plain English. The average star rating on the quality of the content is 4.28/5 (based on 731 individual feedbacks).

28. The site consists of over 450 community activities and 75 events per month with the more recent service and product directory starting to build. It is already used by around 1,000 new people per month which compares favourably with other local authority sites, particularly considering its early phase of development. We are now at the stage of raising the profile of the site including producing publicity material, setting up a twitter account and have carried out drop-ins for over 115 staff to ensure confidence in site navigation. The questions we get asked the most is about accessibility of information for people that do not use/do not have access to the internet. York Explore is one of our partners and the libraries alongside other community hubs provide access to internet and printing, in addition the Council will print and send personalised booklets on request. Practitioners, family and friends can also produce a personalised booklet from any of the pages in the site which can then be printed or requested to be printed in large font or another language.

Future Development

29. As set out earlier in the report, the wide range of asset based models and approaches we have described is not an exhaustive list. As ultimately all services can be offered in ways which aim to help people:
    - to build and maintain family and social connections and relationships above, there are several work streams that support
    - To build their confidence, knowledge and resilience

    However, the Council through in particular Adult Social Care's evolving 'community operating' model is demonstrating a systematic and

strategic approach to developing an ‘asset based approach’ in service design and its co-productive relationship with citizens. This is further complemented across the city through our work with partners on the People Helping People social action strategy and Cities of Service status, reflecting its core principles of’ Leadership, Deliberation, Collaboration and Results.

30. There are numerous ongoing debates about asset based approaches. Definitions of ‘community’ range from being place based to seeing communities of interest as more important. Some asset-based thinking is also very sceptical of the ability of organisations, particularly large organisations, to behave in a genuine asset based way and there are concerns that the language could be selectively appropriated to justify funding reductions for traditional services. Asset based approaches require a significant investment of time and resources, and whilst they may result in reduced demand for state services, they cannot be introduced successfully with that aim.

31. Members in their own ‘community leadership role’ are key to supporting and facilitating this narrative and ongoing work with the communities that they represent, reflecting a different relationship between citizens and the state. The council’s ward arrangements are also evolving to reflect this, exploring how social action and an asset based approaches within the city can enable the delivery of co-designed public services, alongside specific programmes like our Enabling Social Action Partnership status.

32. The new national Civil Society Strategy launched in August by Government alongside the Jo Cox Loneliness Strategy *A Connected Society*, fundamentally recognise these challenges. The Civil Society strategy is intended to help government strengthen the organisations, large and small, which hold our society together. It hopes to convert into action, the argument at the core of the strategy, that the complex challenges facing society cannot be solved by the government alone, but by bringing the energy and resources available across society together. The strategy reflects a vision of a UK with better connected communities, more neighbourliness and businesses which strengthen society. With technology enabling strong communities rather than enabling disconnection and isolation. A more connected society in which everyone can (and should have the right) to play their part.

33. Much of this evolving national policy thinking reflects York’s own direction of travel to becoming a genuine ‘asset based place’ and

complementary narrative within the People Helping People strategy. This is something that should be celebrated, recognising York's best practice and leadership in this area and the Council's own leadership role as a 'City of Service'. Members view on how we can continue this narrative with communities and raise the profile of York's best practice amongst our citizens are welcomed.

Council Plan

34. These proposals support the council plan priorities in ensuring that we listen to residents and provide support services to those who need them and that vulnerable people stay safe and are protected from harm. It also supports the commitment to review adult social care, through exploring more deliberate co-production with citizens and the role of social action in co-designing services.

Implications

35. The proposals are key to CYC's delivery of its responsibilities under the Care Act 2014 and to ensuring this is done within the necessary budget.

- **Financial:** There are no direct financial implications associated with this report as the funding associated with the programmes and Adult Social Care teams that have been referenced as examples of asset based approaches have been dealt with through other Executive reports and programme management arrangements associated with external funders. Naturally, the planned strategic expansion of Local Area Coordination will require further reports to be travelled through the Executive.

- **Human Resources (HR);** There are no HR implications associated with this report

- **Equalities:** The asset based approaches referred to in the report have at their heart principles of equality, diversity and inclusion, reflecting their strong value base and focus on social justice.

- **Legal:** There are no legal implications associated with this report

- **Crime and Disorder:** There are no crime and disorder implications associated with this report

- **Information Technology:** Digital inclusion issues have been addressed within the Live Well York project and build on our

Information and Advice strategy and comprehensive research into digital exclusion in society

- **Property:** There are no property implications associated with this report
- **Other:** There are no 'other' known implications associated with this report

Risk Management

36. Whilst not a key policy driver, the asset based approach and associated programmes outlined in the report will help mitigate against potential budgetary and performance risk for the CYC.

Recommendations

37. Members to note the progress made on the evolving asset based approach in the city and its role in the delivery of adult social care 'community operating model'.

38. Comments are welcomed on how Members through their own 'community leadership' role and through 'scrutiny arrangements' can support this ongoing narrative with communities.

    Reason: To inform Members of the evolving asset based approach to supporting wellbeing.

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Approved

✓ 28 November 2018

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

Civil Society Strategy – Building a Future That Works for Everyone

Appendices

Appendix 1 – Local Area Coordination 'stories'
Appendix 2 – Ways to Wellbeing and LAC Blog for National LAC Network
Appendix 3 – Community Catalysts Enterprising Communities York Story

Abbreviations

AAA Accessibility Standards
CAAT- Customer Access and Assessment Team
CYC – City of York Council
CQC - Quality Commission
GP - General practitioners
LAC - Local Area Coordination (LAC)
NHS - National Health Service
NDTI - National Development Trust for inclusion
SROI - Social Return on Investment
VCS – Voluntary Sector
VCSE - Voluntary, Community and Social Enterprise Sector
York CVS- York Community Voluntary Services
York CCG- York Clinical Commissioning Group

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Appendix 1

Local Area Coordination 'stories'

Dawn's Story

Introduction (New Earswick)

Dawn was introduced to me by the local school.

Situation

Dawn lives in New Earswick with two children and husband. Unfortunately last year Dawn lost her leg due to a rare cartilage cancer called Chondrosarcoma. Unfortunately there is no cure for this illness or any treatment available except removal of tumour as it doesn't react to chemo or radiotherapy, the survival rate is not the best, so everyday that Dawn is alive then it is a miracle. The only cure for Dawn was removal of her leg along with the tumour at a specialist unit in Birmingham. Dawn continues to be under close monitoring and have scans, tests etc every three months to make sure that the cancer doesn't return as secondary.

During the day Dawn was alone at home when the children were at school and spent her days cleaning the house over and over again; cooking in the kitchen (She loves making cakes). Dawn takes the children to school herself either by propelling in her wheelchair which is very hard work. The paths in New Earswick are not made for wheelchairs they are very narrow, Dawn had a 4mph scooter which is very slow and had broken down loads (it has been condemned by the scooter shop) it's on it's way out, plus it's not ideal as it's too small and with being an amputee makes balancing difficult. Dawn just wanted to have some independence again and be able to go to Monks Cross alone or get involved in the Open Shop and other community groups which she would have love to attend but couldn't, due to current scooter.

What happened?

Together the LAC and Dee started to look at funding options for Dee to get a scooter to be able to get out and about and to be an active citizen in the local community. The LAC and Dee wrote a funding bid to the local resident group. The group turned the bid down but out of that the citizens in the group decided to start a small community group called Community Mobility Scheme and they raised money so that Dee could get a scooter which was suitable. Dee was able to get out and about picking up her children from school, getting involved in community projects and being independent.

Outcomes / What difference for the person

- Dee's depression improved
- Dee became an active citizen and was no longer isolated
- It gave a purpose to other people in the community. It put 'fire in their bellies'
- People helping people
- Dee has much more confidence and can see a future.
- Dee has felt more confident to hold her previous GP practice to account.

Critical elements (what mattered in the practice or made the difference)

- Collaboration between the local school and LAC

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	Y	How? – through challenge to JRHT grants panel
Attending health appointments as appropriate?	N	Taking medication correctly?	N	Supported to formally volunteer?	Y	Require formal service from Adult Social Care?	N	
Supported with accommodation?	N	Does the individual feel safer in the community?	Y	Supported to share skills in their community?	Y	Referred to Public Health service?	N	
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N/A	Does the individual feel more confident?	Y	Were family / carers / friends supported?	Y	How? Engagement of partner and children in the process
Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:								
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.								

- Children now attending school regularly
- Dawn's wellbeing has significantly increased, resulting in less reliance on services
- Dawn passionately shared her story publicly at the Volunteering People Helping People conference in 2018
- Dawn is now feeling more confident and contributing to a number of community groups and considering becoming a Community Health Champion

Magda's Story

Introduction

Magda was introduced to the LAC at a church coffee morning

Situation

Magda is an elderly widow living alone in her own house which has a big garden. Her only son lives a 1 hour drive away. Previously very independent, she was feeling overwhelmed by the amount of work to be done on her garden, she could no longer manage this herself following a stroke. Magda felt frustrated as a result of her isolation and not knowing how she could find help (especially as she had previously been very active), also not wanting to be a burden on family, and having limited finances to spend on a gardener. She could not ask her son as he had his own family commitments.

What happened?

The LAC sat with a group of ladies at the coffee morning and got chatting. In early Summer, several were concerned about how they would manage their gardens. The LAC told Magda about Goodgym (for the garden) and also gave a leaflet about York Neighbours and described the benefits of registering with York Neighbours, ie no job too small, Magda could always ask, and would not have to feel she was "saving up" jobs for her son.

Outcomes / What difference for the person

1. Magda phoned York Neighbours, who arranged for their volunteer to visit her to do the registration. Magda was delighted that the volunteer was actually an old friend of the family who she had not seen for 30 years. York Neighbours arranged for a volunteer to call and tackle some of the weeding which Magda was very pleased with. In a later conversation Magda mentioned a bathroom cupboard which needed repainting or throwing out (she wasn't sure which) and the LAC told her that again she could ask York Neighbours to send a

volunteer who would be able to advise, and if necessary help her to find a new one.

2. The LAC made a referral to Goodgym, who arranged for 2 cyclists (young couple) to visit Magda one evening. Magda thoroughly enjoyed using her own gardening expertise to tell the helpers what was a weed and what was a flower, she also showed them how to put a cutting in water to grow roots. The "icing on the cake" was when the volunteers offered to take Magda for a walk round her garden to look at the results – she was unable to do this on her own, for risk of falling. The couple told Magda they were about to move to Vancouver and Magda was delighted to be able to share local knowledge as she had previously lived there.
   The outcome as a result of both these referrals was that Magda felt much happier, more confident, better connected, knowing that the help she needed was out there in her community. Magda also told the LAC that she had tried inviting neighbours in for coffee, and would be interested in providing hospitality to other isolated older people in her community (which the LAC can support with).

Critical elements (what mattered in the practice or made the difference)
The presence of the LAC at the coffee morning meant that someone with knowledge of local help, was on hand to listen and give advice and information. The connection with York Neighbours and Goodgym seemed to have been a massive encouragement to Magda, boosting her sense of wellbeing, also knowing that she could ask the LAC again if she needed help. Magda's comments about wanting to be able to go for a walk (but needing support) were fed back by the LAC, to Goodgym who had been asking referrers for ideas about what else they could offer in their communities.
When asked if she would mind about the LAC sharing her story, Magda replied: Of course I don't mind, it really happened!

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	N	
Attending health appointments as appropriate?	N	Taking medication correctly?	N	Supported to formally volunteer?	Y	Require formal service from Adult	N	

						Social Care?		
Supported with accommodation?	N	Does the individual feel safer in the community?	Y	Supported to share skills in their community?	Y	Referred to Public Health service?	N	
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N/A	Does the individual feel more confident?	Y	Were family / carers / friends supported?	Y	
Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:								
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.								
- Magda is now feeling more confident and able to contribute to her community through volunteering, building her social networks and connecting with neighbours. - Possible avoidance of mental health support services through engagement with LAC worker and building emotional resilience through means other than accessing formal mental health services. - Reduced GP appointments - Connecting with civil society organisations and helping them to develop e.g. Walking and community health champions								

<u>Naomi's Story</u>

Introduction

Naomi was introduced to her LAC by her Counsellor at the Young Person's Counselling service. Naomi was 17 and experiencing severe depression and anxiety which was so unmanageable she was finding it hard to engage with the short term counselling sessions. Naomi's counsellor said she spent most of their sessions crying and found it difficult to talk, she had expressed suicidal ideation and described feeling stuck in her flat most days with very little to fill her time.

Situation

Naomi and her father shared a flat together. Naomi had moved in with him a few years ago when she could no longer live with her mother, who had a drink problem. Naomi had been struggling with her mental health for some time and found school hard, she had therefore left without any qualifications. The situation at home was difficult, finances were very limited and Naomi felt under a lot of pressure to get a job, although she did not feel well enough to work. This caused a lot of tension between Naomi and her father – she felt he didn't understand how depressed she was or how her mental health impacted on her. She described feeling 'lost and alone' and 'stuck' and was often tearful. Naomi was seeing her GP regularly and had previously been referred to CAMHS, but due to a negative experience she did not want to be referred back for treatment.

Naomi met her LAC following one of her counselling sessions at 30 Clarence Street. Naomi found it hard to imagine what a good or better life might look like other than working towards a time when she would feel different and happy.

What happened?
The LAC spent time visiting Naomi at home, listening and building a relationship with her so she felt able to open up and talk about what was important. This involved getting to know Naomi, her interests, passions and good qualities and to explore these. They also explored her practical options. This led to completing a PIP application together to alleviate some of the financial pressure to get a job she wasn't ready to. Together they explored volunteering opportunities working with animals, though these were very limited. Naomi expressed an interest in the environment and sustainable communities so the LAC introduced her to a local nature reserve and Ecocentre, St Nick's, where she showed interest in an Ecotherapy programme and conservation volunteering opportunities. When she visited Naomi quickly found this was a place she felt comfortable around like minded people.

Naomi shared this was a difficult time when some close friends started using substances heavily and she was very frightened about their wellbeing. A close friend had died suddenly three years previously and she was worried her other friends would die. This affected her deeply as she is a very caring and conscientious person.
The LAC offered emotional support and advice regarding Naomi rebuilding her relationship with her father and her friends, who she felt distanced from. The LAC gave Naomi information about self care and websites which provided useful tools for managing symptoms and learning CBT skills to change negative thinking patterns.

Naomi's confidence grew a little over the next 6 months – impacted by changing relationships with her father and friends. She was awarded PIP which helped her to

rebuild her social life. She also got a part time job with one of her sisters which is flexible as she can choose her own hours. This responsibility and reason to get up on a morning has made a big difference to her wellbeing and recovery. She is now applying to volunteer at St Nick's twice a week.

Critical elements

- The LAC was able to build a relationship with Naomi slowly at her pace, which was less pressure so she found it easier to talk. They talked about all sorts of things so the conversation wasn't just focussed on her mental health problems but also her interests, beliefs and things which were important.
- Naomi said "it helped when *the LAC* got involved as we looked at practical things and different options – before I felt like I had no options, finding out there were made a big difference. It helped me gain confidence to show my friends that they had options too."
- The LAC was physically able to support Naomi to go to St Nick's for the first time, which she found hard to do alone due to her anxiety. The flexibility of the service allowed this – even though it took a few attempts before Naomi was ready.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	Y	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	Y	How? - with PIP claim – spoke with assessor over the phone so she didn't have to attend a face to face assessment
Attending health appointments as appropriate?	N	Taking medication correctly?	N	Supported to formally volunteer?	Y	Require formal service from Adult Social Care?	N	What service?
Supported with accommodation	Y	Does the individual	Y	Supported to share	Y	Referred to Public	N	What service?

?		feel safer in the community ?		skills in their community ?		Health service?		
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N/ A	Does the individual feel more confident?	Y	Were family / carers / friends supported ?	Y	How? Support and advice offered to Naomi's father regarding benefits and MH
Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:								
i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.								
• Possible avoidance of mental health crisis through engagement with LAC worker and building emotional resilience through means other than accessing formal mental health services. • Reduced GP appointments • Naomi is now feeling more confident and able to contribute to her community through volunteering, paid work and supporting her friends. • Support with benefits/maximising income helped to improve quality of life and wellbeing for Naomi and her father, helping alleviate tensions at home which long term could have resulted in Naomi feeling forced to move out.								

<u>Ron's Story</u>

Introduction

The LAC met Ron at a Pay as you Feel Café at the local Community Centre. The LAC was there accompanying someone else she had been working with who had wanted support to attend the café for the first time. They ended up sitting at the same table and chatted over lunch.

Situation

Ron explained he was a single dad with two school age children. He had lots of experience working in the care sector with young people and was interested in looking in to some volunteer opportunities to utilise his skills and extra time he had during the day when his children were at school. Ron missed working and was keen to find a way to help others and feel useful whilst at the same time tackling his

own loneliness and isolation. The LAC told Ron about conservation volunteering opportunities at a local nature reserve and park – Ron was aware of these and had some involvement but was looking for something a bit different. The LAC signposted Ron to speak to the local library and other places he could access information and they also exchanged contact details, including details of her Facebook page and Twitter account where she often shared details of local opportunities as they arose.

What happened?
A few months later the LAC saw a colleague give a presentation at a meeting about a new Community Health Champions programme in York. The programme was looking for people to train up as Champions with an interest in supporting others in the community to increase wellbeing by setting up groups/activities or offering one to one mentoring. The LAC thought of Ron straight away. She got in touch with him, passed on information of the programme and how to book on the initial training. Ron was really grateful for the opportunity and keen to stay in touch to update the LAC on how he developed as a Community Health Champion who she would be able to link other people up to in future.

Critical elements

- The LAC met Ron whilst out in her local community and through her knowledge of the area she was able to discuss volunteering opportunities with him and direct him to where further information was available.
- The LAC's good network of links and awareness of new initiatives in the city reflects the advantage in being embedded in the system, particularly the Adults Contracts and Commissioning Team.
- This is a good example of Level 1 work within the LAC role and how naturally connections are made through the place based model.

Outcomes for individual:								
Assisted to access daily entitlements and/or benefits?	N	Connected with others in the community?	Y	Supported to groups/clubs in the community?	Y	Provided with advocacy?	N	How?
Attending health appointments as appropriate?	N	Taking medication correctly?	N	Supported to formally volunteer?	Y	Require formal service from Adult Social	N	What service?

						Care?		
Supported with accommodation ?	N	Does the individual feel safer in the community ?	N/ A	Supported to share skills in their community?	Y	Referred to Public Health service?	N	What service ?
Was the individual given fire safety advice?	N	Was the individual supported to access police advice?	N/ A	Does the individual feel more confident?	Y	Were family / carers / friends supported ?	N	How?

<u>Any perceived/evidenced preventions or savings as a result of Local Area Coordination intervention:</u>

i.e. Reduction in health support, reduction in services, community providers/groups involvement, what may of happened without Local Area Coordination, etc.

- Being a single parent is a challenging and often lonely role. In this example a young single father was given advice and guidance to enable him to build a wider network of support and resilience through an opportunity to build on his own skills. He has taken an opportunity to upskill through free training and to help increase the wellbeing of others in the community.
- This is a good example of empowering someone to make a wider contribution whilst also improving their own wellbeing and sense of loneliness/isolation. This no doubt has had a wider positive impact on Ron's children and helped Ron to be a positive role model not just for his children, but also for other single parents in the area.
- The LAC's presence at a local community event and their links to knowledge and information facilitated an important connection in this instance.

Abbreviations

LAC – Local Area Coordination

Appendix 2

Ways to Wellbeing and LAC Blog for LAC National Network

The power of the relationships between Social Prescribing and Local Area Coordination in York – a blog by Jennie Cox and Jasmine Howard

Jasmine Howard is the manager of the Ways to Wellbeing Social Prescribing service in York. Jennie Cox is a Local Area Coordinator working in the same area of the city as Jasmine. Ways to Wellbeing has been operating in York for nearly two years, the Local Area Coordination was rolled out in York just over a year ago. When Jasmine and Jennie heard about the lack of cohesion of these approaches in other areas they were keen to share their reflections about how well they have worked together.

The wider context in York and cultural shifts

Jennie reflects – Local Area Coordination and Social Prescribing have evolved side by side over the last year in York at a time of shared vision and action. The groundwork had been set for a real culture shift within not just the Council and services but the wider community before I came in to post. Mine and Jasmine's roles play an important part in that. The approaches encourage a bigger picture way of thinking and the flexibility to work with individuals and families in the way that suits them and values their strengths and the strengths of others in their community.

Jasmine reflects – Jennie works in a defined geographical area with introductions coming from a range of people and places. I am based within primary care in the East of the city so receive referrals from a smaller base within a bigger area. Our work is therefore targeted in different ways. Between us, I think our reach is wide.

I have introduced people to Jennie when having a longer term relationship with someone has been important in building a positive vision for the future. But how we work together is bigger and more difficult to quantify than introductions and co-working, it is about culture. For me, the arrival of a new Head of Commissioning (Early Intervention, Prevention & Community Development) and Local Area Coordination bought with it a real culture shift from within the Council and across the city. This supportive context helped me feel more supported working in social prescribing. The environment has been such an important factor in how Jennie and I work together. We have never been pitted against each other but in contrast have been part of each other recruitment processes, have managers on each other's steering groups and have had shared training opportunities. Time has been spent articulating

to others where Local Area Coordination and Social Prescribing both sit in prevention. From the beginning the conversation has been around how we are better together.

Jennie reflects – The introduction of the Local Area Coordination programme has really benefited from the positive links already forged with the CVS. This gave us a strong ally in Jasmine, and the rest of her team as this expanded. We have widened these positive joint working practices to the development of a 'Practitioners Forum' which welcomes other services with social prescribing or community connection functions to meet regularly to share good practice and offer invaluable peer support. We are often asked if there is an overlap or duplication in our work, however we have forged such smart ways of working in co-production that I couldn't now imagine one without the other.

Jasmine adds to this – Jennie and I meet on a regular basis with other colleagues for peer support. This works so well, I think largely because we share the same values – being collaborative, person centred and strengths based. These meetings are a chance to share knowledge, skills and experience, to come up with creative solutions but also to have a coffee and get to know each other as people. This friendliness helps with cohesion. We all share spirit and pride in what we are doing. The power of relationships and the practicalities of co-production

Jasmine reflects – Local Area Coordination and Social Prescribing are both new ventures in York. There's been a lot to learn and I feel we have done some of this together. Jennie and I have talked a lot about the volunteering pathway within Social Prescribing as well as some of the other resources we have access to. I have found Jennie a great person to think outside the box with. We've had honest conversations about things we've set up that haven't gone to plan so we can both learn from this.

Both Local Area Coordination and Social Prescribing approaches consciously spend time building community connections. Jennie and I have worked together to build and maintain relationships, inviting people to our peer support meetings, meeting people together and knowing each other's roles well enough to put each other in touch with others.

Jennie reflects – Jasmine has provided an important link to health services which has facilitated collaborative working to produce better outcomes for the people I have been walking alongside. On a more personal note Jasmine is someone who is always at the other end of the phone and happy to talk through any situation with and will always ask 'is there anything I can do to

help?' We offer each other regular informal peer support and I feel our strong working relationship provides a good example to others in health and social care. We have supported each other when faced with challenges in the system and strived to join up resources to fill gaps in provision we have identified in the local area.

An example of an individual in our area who we have both worked with:
SB came in to contact with Jasmine through his GP as he was struggling with complex long term health conditions, physical and mental. He was homeless at the time but linked to appropriate housing services. Jasmine discussed his strengths and interests with him, discovering his love of music. She linked him to a 'Musication' programme at a local community group, Tang Hall Smart, where he flourished and formed a band with other group members. Through this connection to the community he was introduced to his Local Area Coordinator, Jennie. SB had fallen out of the housing system after an intentional homeless decision had been made and was living in a tent with deteriorating health conditions. Jennie helped him explore options around his housing and finances. Jennie contacted Jasmine to gain context of the previous situation and health information which helped to better inform options. SB now has a permanent bed in a hostel, a keyworker and a referral to a housing scheme which is his preference as it is linked to his local church. He is awaiting a decision from a PIP application. SB is keen to participate in his community and contribute in any way he can, connecting others to available services and groups. At a recent event as part of the Festival of Ideas in York, Jasmine presented regarding Social Prescribing and invited SB's band to play. Jennie came along to support the event. SB told Jasmine excitedly the week before 'Jennie's coming too'. At the end of the event SB said a few words and reflected on the ways Jasmine, Jennie and Tang Hall Smart all had a positive impact on his life.

The common thread through all of these reflections is positive relationships and how powerful these can be when they work well – working together really does work better – on all levels.

Abbreviations

GP- General Practitioner
LAC – Local Area Coordination
York CVS- York Community Voluntary Services

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Appendix 3

Community Catalysts Enterprising Communities York Stories

Namaste York!

The Enterprising Communities Project in York aims to reduce loneliness and isolation through the support and promotion of community enterprises.

I have been hearing the dreams and aspirations of those looking at establishing new ventures. People like Rimpa, a classically trained Indian musician who plans to start a brand-new venture called Namaste York.

My aim is to help people to be happy, and to make them smile; to bring people together via art, dance, and music. I would like to share the rich heritage of Indian culture and its remarkable ability to rejuvenate the mind and soul.

Rimpa, new enterprise leader

I introduced Rimpa to Julie Graham, The City of York Council's Active Communities Officer, who saw enormous potential in Rimpa's idea. With Julie's help, we have arranged for Rimpa to pilot her activity at the community room used by the tenants of Glen Lodge Independent Living Community (ILC), with a view to introducing this (and other activities) to the other ILCs throughout York.

Working with Mark has allowed me to take a more holistic approach to addressing the isolation that can affect our older tenants, strengthening our ability to deliver a range of different events and experiences that encourage people to step outside of their front doors and meet their neighbours.

Julie, Active Communities Officer

We are also working together to plan a small event in the near future. The event will highlight the work of local community enterprises and help to inspire more people and organisations to collaborate in the quest to alleviate loneliness and isolation in York.

Community Catalysts, the City of York Council, and all partners, are committed to this work and will continue to co-create opportunities for people like Rimpa to develop their ideas, connect with others locally, inspire genuinely beneficial change and increase the general well-being of the people of York.

Carers as partners…working together to change lives in York

Emily is an energetic and passionate parent and carer who works hard to ensure that her son Chris, who has a learning disability, lives a full and meaningful life. We first met at a Community Catalysts workshop in York, where we briefly discussed the possibility of channelling Emily's energy into some kind of creative endeavour. Shortly after, we arranged to meet again, this time with Chris and two of his personal assistants.

Chris currently has a team of eight personal assistants who, along with his mum, offer him plenty of care and support. However Chris was clear that something was missing in his life and the people around him could see how important this was to him.

I have Personal Assistants (PAs) and friends and go out quite a lot, but I would now like to meet a girlfriend, to spend time with and have fun, but at the moment I can't do this as there is nowhere to meet them.

Chris

As the lead of the Community Catalysts Enterprising Communities Project, my role is to identify the gaps in supports and services and then help local people establish new ventures to fill these gaps. Emily was keen to help Chris establish a dating agency for people with learning disabilities in York and this seemed an excellent fit with the project.

I linked Chris, Emily the team with an established organisation in West Yorkshire, who were running the kind of dating agency Chris and his Mum had in mind. Emily also made connections with another similar organisation and several emails were exchanged. As a result of this early fact finding some drawbacks to the dating agency plan were identified and after a quick rethink everyone decided to slightly change tack.

Chris's new plan is to set up an enterprise with a focus on friendship and social connection, particularly for people who feel lonely or isolated. Chris and Emily hope this new venture will offer people an opportunity to

meet new people, recognising the potential for friendships to develop into something more serious over time.

It feels particularly appropriate to share Chris and Emily's story as part of Carers Week in the hope it might inspire other carers to establish their own community enterprise and/or inspire the person they support to do the same.

It's important to have friends, and even a special someone in our lives, and this is no different for people with learning disabilities. We hope to see our new venture become a force of good within our local community by providing people with learning disabilities improved opportunities for meaningful social engagement - helping people to lift themselves out of loneliness, enhancing their quality of life and achieving greater personal independence

Emily

It's still early days for Chris and Emily's enterprise, but they are already in the process of enlisting the help of several other people, venues and organisations in York – making connections and making things happen – and I very much look forward to continuing to help them to help themselves and others to create the lives they want.

Mark Finch
York Community Catalyst
mark.finch@communitycatalysts.co.uk

Abbreviations

ILC Independent Living Community
PA – Personal Assistant

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12 December 2018

Health, Housing & Adult Social Care Policy & Scrutiny Committee

Report of the Clinical Chair, Vale of York Clinical Commissioning Group

The impact of the Elective Surgery Criteria

Summary

1. As requested by Members, this report provides an overview of the impact on elective surgery that Vale of York CCG's Health Optimisation policy has had since its inception in February 2017. It will specifically provide clarification of the use of BMI in activating this policy, indicating numbers affected, the support that is available to them and a summary the feedback that the CCG has received.

Background

Clarification of the use of BMI in activating Health Optimisation.

2. It should also be noted that at the time of implementation of this policy the CCG was under Legal Directions and was working within the confines of the NHSE capped expenditure programme. The CCG took learning from elsewhere that indicated that implementation of this policy could contribute to such confined financial management while providing the opportunity for improving the health of our population.

3. Health Optimisation is triggered at the point GPs have their initial discussion with patients about their lifestyle – this becomes the patient's 'time 0' position (please note, at present there isn't a time limit constraint on when 'time 0' was instigated – so in theory if this was done at the point when health optimisation was implemented patients would go through for surgery as they have exceeded the 12 month waiting period). The whole ethos of this policy was to encourage GPs to discuss, as early as possible, potential impact of being overweight etc. has on their current and future health.

4. So the criteria, covering all elective surgery is:

(i) If a patient's BMI>=30 their surgery if delayed/deferred until the following is achieved:

a. Their BMI is <30

b. They've lost 10% of their weight since their 'time 0' measure

c. They've not achieved (a) or (b) but have waited 12 months since their 'time 0' was measure

(ii) Need to note that we don't exclude GPs referring for opinion if a patient doesn't meet criteria, however a patient will receive a letter explaining they may not be able to access surgery immediately, if that's what's required.

(iii) There are a number of exclusions whereby patients will receive surgery even if they don't meet criteria these being:

Exclusions include:

- Patients requiring emergency surgery or with a clinically urgent need where a delay would cause clinical risk:
  1. Cholecystectomy
  2. Surgery for arterial disease
  3. Anal fissure
  4. Hernias that are at high risk of obstruction
  5. Anal fistula surgery
  6. Revision hip surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, recurrent dislocations, impending peri-prosthetic fracture, gross implant loosening or implant migration.
  7. Revision knee surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, impending peri-prosthetic fracture, gross implant loosening/migration, severe ligamentous instability.
  8. Primary hip or knee surgery which is clinically urgent because there is rapidly progressive or severe bone loss that would render reconstruction more complex.
  9. Nerve compression where delay will compromise potential functional recovery of nerve.
  10. Surgery to foot/ankle in patients with diabetes or other neuropathies that will reduce risk of ulceration/infection or severe deformity.
  11. Orthopaedic procedures for chronic infection.
  12. Acute knee injuries that may benefit from early surgical intervention (complex ligamentous injuries, repairable bucket handle meniscal tears, ACL tears that are suitable for repair).
  13. Other (please specify on the form)
  14. Lower limb ulceration
- Referrals for interventions of a diagnostic nature:
  15. Gastroscopy
  16. Colonoscopy
  17. Nasopharyngolaryngoscopy
  18. Laparoscopy
  19. Hysteroscopy
  20. Cystoscopy
- Patients with advanced or severe neurological symptoms of Carpal Tunnel Syndrome such as constant pins and needles, numbness, muscle wasting and prominent pain AND that are significantly affecting activities of daily living
- Patients who despite having a BMI >30 have a waist circumference of:
  - Less than 94cm (37 inches) male
  - Less than 80cm (31.5 inches) female
- Children under 18 years of age

Note: The CCG has now added male and female sterilisation to this list

Consultation

5. *Not applicable for this report*

Analysis

Data on the number of patients in York that have triggered the Criteria and average length until patients receives surgery.

6. As mentioned above a number of referrals for potential surgery originate from requests for opinion from GPs. These all go via the Referral Support Service, who identify which patients do not meet criteria and send them a letter indicating that surgery maybe not be accessed immediately until the BMI criteria is met. Since its inception of Health Optimisation in February 2017 the RSS have sent out 1,766 letters for patients that exceed BMI criteria .

Health Optimisation success rates

7. The CCG has had some anecdotal evidence that patients have reported to their GPs that as a result of losing weight, in accordance with the policy, the pain they were previously suffering from had dissipated. Some patients did not therefore require surgery.

8. The CCG also reported that during its first year of implementation and as a result of delaying surgery Health Optimisation has contributed to a reduction in spending of £2.2 million

Data on appeals to Health Optimisation including successful appeals

9. To date the CCG's Patient Experience Team have had 78 contacts from patients asking for clarification regarding the policy leading to the delay of their surgery. Following investigation, 4 patients were re-instated to the waiting list for surgery, subject to clinical appropriateness.

10. In addition the CCG has received the following applications for Individual Funding Requests (IFR), whereby patients are assessed against clinical exceptionality definitions to have their surgery

Total IFRs relating to received in relation to this policy	**1486**
Approved	**781**
Declined	**705**

(Please note: that the figures above relate to the whole locality covered by Vale of York CCG)

Support provided for patients undergoing Health Optimisation

11. The CCG is able to signpost patients to the support available to reduce weight etc. For City of York Council residents it would be to the new CYC supported HealthWise service *(* 'Better - Healthwise: Physical Activity GP Referral Scheme')

12. In addition to the letter sent to patients, an information leaflet 'Weight loss to improve outcomes after surgery' (https://www.valeofyorkccg.nhs.uk/rss/data/uploads/procedures-not-routinely-commissioned/optimising-outcomes/weight-loss-leaflet.pdf) describing the advantages to losing weight, in relation to a patient's health, as part of lifestyle change.

Options

13. Not applicable

Council Plan

14. Not applicable

Implications

15. Not applicable

Risk Management

16. Not applicable

Recommendations

17. Next Steps

Although the CCG being under Legal Directions and part of the NHSE Capped Expenditure programme may have expediated the implementation of this policy, it has also provided primary care clinicians with an opportunity to open a discussion, with their patients, about weight loss reduction and how outcomes on elective surgery can be impacted by this.

Moving forward, the CCG would welcome a discussion with the Scrutiny Committee about how health optimisation is taken forward in the future. We also welcome the involvement of HealthWatch with this. We would

like to address how we can support our population to lose weight whilst also balancing the need for surgery and how we can do this with our prevention partners

Reason: To inform members of the impact on elective surgery that Vale of York CCG's Health Optimisation policy has had since its inception in February 2017

Contact Details

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Chief Officer Responsible for the report:
Dr Nigel Wells
Clinical Chair
Vale of York CCG

Report Approved ✓ **Date** *Insert Date*

Specialist Implications Officer(s) Not Applicable

Wards Affected: **All** *Yes*

Abbreviations

BMI – Body Mass index
CCG- Clinical Commissioning Group
CYC- City of York Council
GPs - General Practitioners
IFR - Individual Funding Requests
NHSE – National Health Service England
RSS - Referral Support Service

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Health, Housing and Adult Social Care Policy and Scrutiny Committee

Work Plan 2018-19

20 June 2018 @ 5.30pm	**Housing** 1. Attendance of Executive Member for Housing and Safer Neighbourhoods **Health** 2. Business case for new mental health hospital for York 3. CCG report on Patient Transport Services for York 4. Unity Health Report on patient communication problems 5. Report on sexual health re-procurement. 6. Scoping report on Commissioned Substance Misuse Services 7. Work Plan 2018-19
25 July 2018 @ 5.30pm	**Health** 1. Attendance of Executive Member for Health and Adult Social Care 2. HWBB Annual Report including review of Health and Wellbeing Strategy and update on new Mental Health Strategy 3. End of Year Finance and Performance Monitoring Report 4. Six-monthly Quality Monitoring Report – residential, nursing and homecare services 5. Safeguarding Vulnerable Adults Annual Assurance Report 6. Work Plan 2018-19

11 Sept 2018 @ 5.30pm	1. 1st Quarter Finance and Performance Monitoring report **Health** 2. Update on Unity Health Actions to improve patient communications and CQC inspection. 3. Update report on Priory Medical Group proposals to relocate to proposed Burnholme Health Centre 4. Update Report on Elderly Persons' Accommodation 5. Delivery of CQC Local System Review Action Plan 6. Substance Misuse Services Scrutiny Review Update Report 7. Work Plan 2018-19
16 Oct 2018 @ 5.30pm	**Housing & Community Safety** 1. Safer York Partnership Bi-annual Report 2. Update on Community Policing – Lindsey Robson, York, Selby Commander 3. Update report on implementation of new licensing laws for HMOs 4. Work Plan 2018-19
14 Nov 2018 @ 5.30pm	**Health** 1. Mental Health Help Line 2. Report on engagement around Home First Strategy 3. Healthwatch York six-monthly Performance Report

	4. Overview report on self-harm and suicide prevention 5. Report on aims of Oral Health Action Team 6. Work Plan 2018-19
12 Dec 2018 @ 5.30pm	1. HWBB six-monthly update report 2. Update Report on progress of CYC Asset/Place-based approach to working. 3. CCG Chair Dr Nigel Wells, Introduction and Update on Elective Criteria Policy 4. Work Plan 2018-19
15 Jan 2019 @ 5.30pm	1. 2nd Quarter Finance and Performance Monitoring Report **Health** 2. Update Report on Unity Health 3. Overview report on student health services 4. Update report on Priory Medical Group proposals to relocate to proposed Burnholme Health Centre (TBC depending on funding agreements) 5. Six-monthly Quality Monitoring Report – residential, nursing and homecare services 6. Work Plan 2018-19
12 Feb 2019 @ 5.30pm	1. Overview report on mental health crisis support services in York. 2. Work Plan 2018-19
12 March 2019 @ 5.30pm	1. 3rd Quarter Finance and Performance Monitoring Report **Health** 2. Healthwatch York six-monthly Performance Report

	Housing 3. Safer York Partnership Bi-Annual report 4. Draft Work Plan 2019-20