



## Notice of a public meeting of the Health and Wellbeing Board

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

**Date:** Wednesday, 6 September 2017

**Time:** 4.30 pm

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

## **A G E N D A**

**1. Declarations of Interest** (Pages 3 - 4)

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

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

which they may have in respect of business on this agenda. A list of general personal interests previously declared is attached.

**2. Minutes** (Pages 5 - 18)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board, held on 12 July 2017.

### **3. Public Participation**

It is at this point in the meeting that members of the public who have registered their wish to speak can do so. The deadline for registering is **5.00 pm** on 5 September 2017.

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

#### **Filming, Recording or Webcasting Meetings**

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## **GOVERNANCE**

### **4. Appointments to York's Health and Wellbeing Board** (Pages 19 - 22)

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

**THEMED MEETING: AGEING WELL. THEME LEAD: SARAH  
ARMSTRONG**

- 5. Annual Report - Safeguarding Adults Board (Annex C available online only)** (Pages 23 - 50)  
This report provides information on the work of the Safeguarding Adults Board over the course of 2016/17.
- 6. Progress on the Ageing Well Theme of the Joint Health and Wellbeing Strategy 2017-2022** (Pages 51 - 64)  
This report provides an update on progress made against delivery of the Ageing Well theme of the joint health and wellbeing strategy 2017-2022.
- 7. Presentation: Introducing Ways to Wellbeing - York's Social Prescribing Service** (Pages 65 - 80)  
This report provides an introduction to 'Ways to Wellbeing'; York's Social Prescribing Service. The Chief Executive of York CVS will present the report using the slides at Annex A.
- 8. Report on York Older People's Survey** (Pages 81 - 98)  
This report provides a brief overview of some of the key results emerging from the survey of older people which the Board agreed to support at their meeting last July, work on which commenced in October 2016.
- 9. Ageing Well Performance Report** (Pages 99 - 104)  
This report outlines the current position against a set of performance indicators in respect of the Ageing Well theme within the Joint Health and Wellbeing Strategy 2017-2022.

**OTHER BUSINESS**

- 10. Developing Co-Production in York** (Pages 105 - 114)  
This report provides a progress update on developing an approach to co-production that can be used by all partners across the health and social care system in York.

- 11. Better Care Fund (BCF) Update** (Pages 115 - 162)  
This report updates the Board on progress in relation to the BCF submission for 2017/19.
- 12. Update on the Humber, Coast and Vale Sustainability and Transformation Partnership (STP)** (Pages 163 - 176)  
This report provides an update on the work of the Humber, Coast and Vale Sustainability and Transformation Partnership (STP).
- 13. Future in Mind Local Transformation Plan (LTP) Refresh 2017** (Pages 177 - 202)  
This report presents an overview of the work being carried out to implement the LTP, sets out themes for inclusion in the 2017 refresh and seeks authority for the Chair to approve the LTP for submission to NHS England in October.
- 14. Work Programme** (Pages 203 - 210)  
To note the Board's Forward Plan.
- 15. Urgent Business**  
Any other business which the Chair considers urgent under the Local Government Act 1972.

**Democracy Officer:**

Name - Fiona Young  
Telephone No. – 01904 552030  
E-mail – [fiona.young@york.gov.uk](mailto:fiona.young@york.gov.uk)

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

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

Contact details are set out above.

**This information can be provided in your own language.**

我們也用您們的語言提供這個信息 (Cantonese)

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

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

Bu bilgiyi kendi dilinizde almanız mümkündür. (Turkish)

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

 (01904) 551550

***Extract from the***  
**Terms of Reference of the Health and Wellbeing Board**

**Remit**

**York Health and Wellbeing Board will:**

- Provide joint leadership across the city to create a more effective and efficient health and wellbeing system through integrated working and joint commissioning;
- Take responsibility for the quality of all commissioning arrangements;
- Work effectively with and through partnership bodies, with clear lines of accountability and communication;
- Share expertise and intelligence and use this synergy to provide creative solutions to complex issues;
- Agree the strategic health and wellbeing priorities for the city, as a Board and with NHS Vale of York Clinical Commissioning Group, respecting the fact that this Group covers a wider geographic area;
- Collaborate as appropriate with the Health and Wellbeing Boards for North Yorkshire and the East Riding;
- Make a positive difference, improving the outcomes for all our communities and those who use our services.

**York Health and Wellbeing Board will not:**

- Manage work programmes or oversee specific pieces of work – acknowledging that operational management needs to be given the freedom to manage.
- Be focused on the delivery of specific health and wellbeing services – the Board will concentrate on the “big picture”.
- Scrutinise the detailed performance of services or working groups – respecting the distinct role of the Health Overview and Scrutiny Committee.
- Take responsibility for the outputs and outcomes of specific services – these are best monitored at the level of the specific organisations responsible for them.
- Be the main vehicle for patient voice – this will be the responsibility of Health Watch. The Board will however regularly listen to and respect the views of residents, both individuals and communities.

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## Health & Wellbeing Board Declarations of Interest

### **Patrick Crowley, Chief Executive of York Hospital**

None to declare

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

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

### **Mike Padgham, Chair Council of Independent Care Group**

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

### **Keren Wilson, Chief Executive Independent Care Group**

- Independent Care Group receives funding from City of York Council

### **Siân Balsom, Manager Healthwatch York**

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

### **Councillor Douglas**

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

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City of York Council

Committee Minutes

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Meeting

Health and Wellbeing Board

Date

12 July 2017

Present

Councillors Runciman (Chair), Cannon,  
Craghill and RawlingsMartin Farran (Corporate Director of Health,  
Housing and Adult Social Care, City of York  
Council)

Keith Ramsay (from 4:40pm)

Jon Stonehouse (Corporate Director of  
Children's Services, Education and  
Communities)Phil Mettam (Accountable Officer, NHS Vale  
of York Clinical Commissioning Group (CCG))Colin Martin (Chief Executive, Tees, Esk and  
Wear Valleys NHS Foundation Trust)Lisa Winward (Deputy Chief Constable, North  
Yorkshire Police)Sarah Armstrong (Chief Executive, York  
CVS)Julie Warren (Locality Director (North) NHS  
England)

Siân Balsom (Manager, Healthwatch York)

Fiona Phillips (Assistant Director, Consultant  
in Public Health) - Substitute for Sharon  
Stoltz)David Booker (Lay Member, Chair of Quality  
and Finance Committee) - Substitute for Keith  
Ramsay

Keren Wilson (CEO Independent Care)

Group) - Substitute for Mike Padgham

Apologies

Keith Ramsay (arrived at 4:40pm), Sharon Stoltz, Mike Padgham, Patrick Crowley

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## **72. Declarations of Interest**

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

There were no further declarations.

## **73. Minutes**

Resolved: That the minutes of the meeting of the Health and Wellbeing Board held on 17 May 2017 be approved as a correct record and signed by the Chair.

## **74. Public Participation**

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

## **75. Appointments to the Health and Wellbeing Board**

Board members received a report which asked them to confirm new appointments to its membership.

Resolved: That Dr Shaun O'Connell, Medical Director at NHS Vale of York Clinical Commissioning Group, be appointed as the clinical representative for the CCG and Dr Andrew Phillips, Medical Director at NHS Vale of York Clinical Commissioning Group, be appointed as the first substitute for Dr Shaun O'Connell, Medical Director at NHS Vale of York Clinical Commissioning Group.

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

**76. Progress on the Starting & Growing Well Theme of the Joint Health and Wellbeing Strategy**

Members received a report from the Corporate Director of Children's Services, Education and Communities that presented them with the progress on the starting & growing well theme of the joint health and wellbeing strategy 2017-2022. Members were asked to note the progress made.

The Corporate Director of Children's Services, Education and Communities presented the report and highlighted the following points:

- The new locality teams would develop a closer understanding of the communities which they served and would take an early intervention approach to working with families;
- There was a Headteacher led project on improving pupil attendance and a focus in Key Stage 2 (KS2) on writing;
- The Corporate Director of Children's Services, Education and Communities would report back on the progress of educational outcomes with reference to 'Narrowing the Gap';
- The Children's Safeguarding Board which had met that day received a report on dental health and improvements to the service for vulnerable mothers;
- The need to ensure that York was a breast feeding friendly city was noted.

Board members welcomed the report and made a number of responses which are summarised below:

- The Assistant Director - Consultant in Public Health explained that the reason for the high number of dental extractions for under 5 year olds was not known and a deeper needs assessment may need to be undertaken to assess this. The Manager of Healthwatch York advised that Healthwatch York would be compiling a survey on dental health. Board members were requested to assist with the distribution of the survey;
- With regards to the staffing of the Healthy Child Service, the Corporate Director of Children's Services, Education and Communities advised the Board that the structural changes would be in place from August. He explained that it had been a complicated restructure process with some movement of people. However, there was a strong complement of staff with experience and there would be further recruitment;

- With regards to the support for the parenting group, on being asked whether there were resources available to develop parenting mentors, it was explained that the Local Area Teams had been set up to include capacity for the provision of this.
- It was clarified that the Healthy Child Service would be examined by the Children, Education & Communities Policy & Scrutiny Committee

Resolved: The Health and Wellbeing Board noted the report.

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

#### **77. Performance Management: Starting & Growing Well Theme of the Joint Health and Wellbeing Strategy**

Board members received the Starting and Growing Well Performance Report from the Corporate Director of Children, Education and Communities. The report detailed a performance summary that outlined the current position against a set of indicators in respect of the starting and growing well theme within the joint health and wellbeing strategy 2017-2022.

The Corporate Director of Children, Education and Communities provided an update on the School Wellbeing Service and gave an explanation of how this was funded. He also drew attention to the outcome data for young people's emotional health and wellbeing.

The Chair thanked the Corporate Director of Children, Education and Communities for the report. A Board member asked whether it would be a useful time to capture the activities of what is going on for the 11 to 12 year old age group. The Corporate Director of Children, Education and Communities advised that York was well placed with activities in the city and suggested that he could look into the work of Ward Committees and Shine magazine. He further suggested that the YorOk Board could be asked to undertake an audit of activities and report back to the HWBB at a future meeting. The Chief Executive of York CVS mentioned their intention to map what was happening in the city against all themes and priorities of the joint health and wellbeing strategy in order to identify gaps. This

was being done as part of the ageing well operational activity and would take place later this year. This would be reported back to the Health and Wellbeing Board at a future meeting.

In response to a question relating to outcome data for young people's mental health, a Board member asked if there was potential research on why young people's mental health was getting worse in order to identify the causes of this. The Corporate Director of Children, Education and Communities explained that the mental health of young people in York was less good than it was 10 years ago. He added that the Schools Wellbeing Service was helping with this and there was also a need to listen to what was happening elsewhere to gain a better understanding.

Resolved: That the Board;

1. Note the content of the performance report.
2. Request any further information on specific areas of work.

Reason:

1. To ensure understanding of the progress made against the Health and Wellbeing Strategy.
2. To ensure Board members have the required level of detail.

## **78. Student Health Needs Assessment**

Board members gave consideration to a report on the recently completed York Student Health Needs Assessment (SHNA). The report asked the Board to approve the publication and dissemination of the SHNA. The report also asked the Board to support the main recommendation from the SHNA which was the formation of a multi-agency partnership to continue to develop the student health agenda based on the SHNA findings.

In presenting the report, the Public Health Specialist Practitioner Advanced explained that the SHNA had been a valuable piece of work with a focus on those students attending higher education institutions. He reported that 15% of the population in York were students in further or higher education and that there had been 1827 survey responses. He gave a summary of the SHNA findings to the Board.

Board members welcomed the SHNA findings and made the following comments:

- The Chair asked if, as a result of this piece of work, things were improving in relation to student health and it was confirmed that they were;
- The health needs of international students were included within the needs assessment;
- A Board member queried if the educational institutions in the city contributed financially to the police or health services for the increased demand on services from students. The Chair responded by saying that they didn't necessarily do this but the University of York and York St John University had spent money on supporting their students in other ways such as investing in student mental health services at the University of York and setting up a drop in centre at York St John University;
- A Board member highlighted the findings for students' mental health and the Public Health Specialist Practitioner Advanced advised that more detailed data on this was available;
- A Board member asked if health services in the city received resources to support the 31,000 students in addition to the permanent York population. It was explained that GP surgeries received funding based on their practice population. The North Yorkshire Police Deputy Chief Constable explained that the funding formula for the police did not take into account the transient population and only included the permanent population;
- The SHNA report had been distributed to key people in York's educational institutions;
- The Chair suggested that information could be provided during Freshers' weeks. The Manager of Healthwatch York suggested that this could be picked up by Healthwatch York. It was further suggested that students who were campus community champions could present such information at Freshers' weeks.
- It was suggested that the HWBB (or representatives of) present the SHNA to the Higher York Board



- For recommendation two in the report (re: formulating a multi-agency partnership) the HWBB felt that rather than setting up a wholly new body, the existing York Student Mental Health Network (YSMHN) could be re-purposed to address student health and wellbeing more broadly. This group already contained most of the key student health agencies in York. Links could also be made to other existing groups where appropriate.

Board members thanked the Public Health Specialist Practitioner Advanced for his report.

- Resolved: That the Health and Wellbeing Board:
1. Approved the SHNA report for publication and dissemination;
  2. Supported a multi-agency partnership leading this work;
  3. Agreed to receive an annual report from the multi-agency partnership at the next Starting and Growing Well themed meeting;
  4. That the HWBB (or representatives thereof) present this report to the Higher York Board

Reason: To keep the Health and Wellbeing Board up to date in relation to the work around student health needs.

## **79. Update from the JSNA/JHWBS Steering Group**

The Board received a report from the Deputy Chair of the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group. The report provided the Board with an update on the work that had been undertaken by the Joint Strategic Needs Assessment/Joint Health and Wellbeing Strategy Steering Group since it last reported to the Board in March 2017. The Board was asked to note the update and;

- i. Approve the Terms of Reference for the Health and Wellbeing Board (HWBB) Steering Group and the Joint Strategic Needs Assessment (JSNA) Working Group at Annexes A and B,
- ii. Approve the draft integrated impact assessment at Annex C and indicate if any further steps were needed.

The Deputy Chair of the Steering Group gave an overview of the new

HWBB Steering Group's draft Terms of Reference. She referred Board members to the membership of the HWBB Steering Group and asked Board members whether, when HWBB Steering Group members could not attend meetings their nominated HWBB substitutes could represent them. The Board broadly agreed with this.

In relation to the draft minutes for the JSNA Working Group it was suggested that a data representative from TEWV be included in the membership.

Under the Key Responsibilities of the HWBB Steering Group, the Deputy Chair of the JSNA/JHWBS Steering Group highlighted that a key responsibility was to develop a Pharmaceutical Needs Assessment in accordance with national guidance. She confirmed that the Pharmaceutical Needs Assessment would be completed in March 2018. She suggested the addition of a further bullet point under section 4 of the draft HWBB Steering Group Terms of Reference to read: *'to receive and consider notifications of changes to and applications for pharmaceutical services in York and respond to these where appropriate'*.

Board members welcomed the report and made the following comments:

- Board members noted the need to ensure that the JSNA aligned with the Joint Strategic Intelligence Assessment (JSIA);
- The HWBB Steering Group would report to the Health and Wellbeing Board and a report would be added as a standing item to HWBB agendas;
- The minutes of the HWBB Steering Group meetings would not be published but a summary of them would be included in update and progress reports to the Health and Wellbeing Board;
- In relation to the integrated impact assessment for the joint health and wellbeing strategy the following two suggestions were made:
  1. there should be clinical input to the integrated impact assessment
  2. once completed both the integrated impact assessment and the joint health and wellbeing strategy should be taken to senior level boards within all organisations represented at the Health and Wellbeing Board.

Resolved: That the Health and Wellbeing Board;

1. Noted the update;
2. Approved the Terms of Reference for the HWBB Steering Group and the JSNA Working Group at

Annexes A and B with the suggested amendments;

3. Approved the draft integrated impact assessment and agreed that there should be clinical input and once completed this should be shared with HWBB organisation's senior boards;
4. Agreed that a progress/update report from the new HWBB Steering Group should be a standing item at future HWBB meetings.

Reason: To update the Board in relation to the work of the JSNA/JHWBS Steering Group

## **80. Better Care Fund Update**

The Health and Wellbeing Board received a report from the Joint Chair(s) of the York Better Care Fund (BCF) Performance and Delivery Group. This was a status report on the draft Better Care Fund (BCF) Plan for 2017/19 that updated the Board on progress in relation to the development of the BCF submission for 2017/19.

The Director of Joint Commissioning NHS Vale of York Clinical Commissioning Group updated Board members on the process for compiling the report. She advised that the planning guidance had been issued on 4 July 2017 and the BCF submission would be rewritten in line with the newly received guidance.

The Director of Joint Commissioning NHS Vale of York Clinical Commissioning Group reported that good progress was being made towards the draft investment schedule and there was a balanced investment plan against the £15.3million budget. In response to a question from a Board member she explained the process of agreement and expenditure of the balanced plan. Board members were advised that the investment plan had been taken to and supported by the Better Care Fund Task Group.

In terms of existing schemes support from the Local Government Association (LGA) and NHS England to ensure monitoring and effectiveness remained a part of ongoing arrangements, the intention was to invest in those schemes which were already in place and then add to the scope and spread of services. There was no intention to establish a risk sharing agreement this year. It was reported that the BCF submission needed to be submitted to NHS England by 11 September 2017 and this would be brought to the HWBB meeting on 6

September for sign off by the Board.

The Director of Joint Commissioning NHS Vale of York Clinical Commissioning Group reported that in terms of guidance, there was a requirement to:

- i. Agree the delayed transfers of care; and
- ii. Approve a minimum reduction of 3.5% by 21 July 2017.

It was noted that the template for this hadn't been received and it wasn't known where the baseline for this would be taken from; it was therefore difficult for the Board, at this stage, to approve the minimum reduction.

The Accountable Officer, NHS Vale of York Clinical Commissioning Group (CCG) explained that nationally, there had been a good alignment of the Better Care Fund. He commended the work of the Corporate Director Health, Housing and Adult Social Care, City of York Council's team and he thanked Corporate Director Health, Housing and Adult Social Care, City of York Council and his team for their work.

Director of Joint Commissioning NHS Vale of York Clinical Commissioning Group confirmed that the LGA and NHS England would produce the baseline figure. A number of Board members expressed concerns as to the timescales and the 3.5% reduction when it was not known what the baseline figure would be.

Resolved: That the Health and Wellbeing Board note the issues set out in the report.

Reason: HWBB oversight of BCF.

## **81. Mental Health and Learning Disabilities Partnership Board**

Board members considered a report on the future of the Mental Health and Learning Disabilities Partnership Board

The report set out a proposed way forward in light of recent governance changes to the Health and Wellbeing Board (HWBB), the launch of the joint health and wellbeing strategy 2017-2022, the development of a new mental health strategy for York and the proposal to develop a learning disabilities strategy for York.

The Board was recommended to approve a proposal to split the Mental Health and Learning Disabilities Partnership Board into two separate groups, with one focused around mental health and another around learning disabilities.

Resolved: That the Board approved the proposal to split the Mental Health and Learning Disabilities Partnership Board into two separate groups, with one focused around mental health and another around learning disabilities.

Reason: To enable successful delivery against the joint health and wellbeing strategy, the mental health strategy and the forthcoming learning disabilities strategy.

## **82. All Age Autism Strategy**

Board members welcomed a report that asked them to ratify the All Age Autism Strategy and receive annual updates from the All Age Autism Strategy Group.

In presenting the report the Commissioning Manager from the Directorate of Housing, Health and Adult Social Care and Specialist Advisory Teacher highlighted the following points:

- The key areas of work were diagnostic support, inclusive communities, transitions, training/education, employment and parent/carer support;
- Behind the Strategy sat action plans for each area of work which were owned by sub-groups for each priority area. The action plans were working documents and updated on an ongoing basis
- The sub- groups had been set up and met three times a year, reporting to the All Age Autism Strategy Group, which held responsibility for operational delivery of the actions plans.

Board members thanked the Commissioning Manager from the Directorate of Housing, Health and Adult Social Care and the Specialist Teacher Physical Disabilities/Health Needs for their work on the report.

Resolved: That the Health and Wellbeing Board;  
1. Ratified the All Age Autism Strategy

2. Receive annual updates from the All Age Autism Strategy Group.

Reason: To give a formal mandate for the All Age Autism Strategy and allow work to progress in achieving the actions within the Strategy.

**83. Healthwatch York Annual Report; Stakeholder Evaluation; Awareness Survey**

Board members received and considered the Healthwatch York Annual Report and Independent Evaluation. Comments were invited and a Board member noted that it was a good piece of work.

Resolved: That the Annual Report be accepted.

Reason: In accordance with the Health and Wellbeing Board's role in supporting public and patient engagement activity.

**84. Director of Public Health's Annual Report**

Board members received and noted the Annual Report of the Director of Public Health.

Resolved: The Board noted the presentation.

Reason: To give all members of the Board an overview of the Annual Report of the Director of Public Health and a shared understanding of the issues highlighted.

**85. York Skills Plan (Online Only)**

Board members received the draft York Skills Plan 2017-2020. Members were encouraged to comment on the draft plan if they had not already done so.

Resolved: The Health and Wellbeing Board noted the York Skills Plan 2017-2020.

Reason: In accordance with the Board's role in supporting the York Skills Plan.

## **86. Work Programme**

Board Members were asked to consider the Board's Forward Plan for 2017/18.

Resolved: That the Forward Plan be approved.

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

## **87. Urgent Business**

The Corporate Director of Health, Housing and Adult Social Care, City of York Council, reported that York was one of 12 sites subject to a review of the Health and Social Care system. This would be led through the Care Quality Commission (CQC). He reported that there were no agreed Terms of Reference or methodology for the review to date.

The Corporate Director of Health, Housing and Adult Social Care advised that it was not known when the review would take place. He added that the review could take up to 14 weeks.

Board members were advised that there were six key metrics included in the review:

1. Emergency admissions for the 65+ population
2. 90<sup>th</sup> percentile length of stay
3. Total delayed transfers of 91 days
4. Proportion of people at home after discharge
5. Proportion of older people receiving rehabilitation
6. Weekend discharges

The Corporate Director of Health, Housing and Adult Social Care reported that a core group would need to be established for the review. He further reported that Healthwatch York would be a part of the review and the Manager of Healthwatch York responded that she would welcome a partnership approach to this.

Resolved: That the Board noted that York was one of 12 sites subject to a review of the Health and Social Care system.

Reason: To keep the Board informed of the review of the York and Health and Social Care system.

Cllr Runciman, Chair

[The meeting started at 4.30 pm and finished at 6.40 pm].





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**Health and Wellbeing Board****6 September 2017**

Report of the Assistant Director, Legal and Governance

**Appointments to York's Health and Wellbeing Board****Summary**

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

**Background**

2. The Council makes appointments at its Annual Meeting, to Committees for the coming year. However, the Health and Wellbeing Board is able to appoint to or update its membership separate of Full Council. Therefore the following changes are put forward for the Board's endorsement:
3. To appoint Tom Cray (Senior Strategic Community Development Lead at City of York Council) as the second substitute for Martin Farran, Corporate Director, Health, Housing and Adult Social Care at the City of York Council.
4. To appoint John Clark (Chair of Healthwatch York) as the first substitute for Siân Balsom, Manager of Healthwatch York.
5. To appoint Maxine Squire (Assistant Director, Education and Skills at City of York Council) as the second substitute for Jon Stonehouse, Corporate Director of Children, Education & Communities at City of York Council.
6. These appointments have been brought to the Board to allow for their confirmation.

**Consultation**

5. As these are direct appointments of first and second substitutes to the existing Health and Wellbeing Board membership no consultation has been necessary in respect of these appointments.

## **Options**

6. There are no alternative nominations for the appointments.

## **Council Plan 2015-19**

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

## **Implications**

8. There are no known implications in relation to the following in terms of dealing with the specific matters before Board Members:
  - Financial
  - Human Resources (HR)
  - Equalities
  - Crime and Disorder
  - Property
  - Other

## **Legal Implications**

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

## **Risk Management**

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

## **Recommendations**

11. The Health and Wellbeing Board are asked to endorse the appointment as set out in Paragraphs 3 4 and 5.

Reason: In order to make this appointment to the Health and Wellbeing Board.

**Author:**

Angela Bielby  
Democracy Officer  
Telephone: 01904 552599

**Chief Officer Responsible for the report:**

Andy Docherty  
Assistant Director, Legal and Governance

**Report  
Approved**



**Date** 29/8/17

**Specialist Implications Officers**

Not applicable

**Wards Affected:**

All



**For further information please contact the author of the report**

**Background Papers**

None

**Annexes**

None

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**Health and Wellbeing Board****6 September 2017**

Report of the Independent Chair of the Safeguarding Adults Board

**Annual Report – Safeguarding Adults Board****Summary**

1. This report provides information on the work of the Safeguarding Adults Board over the course of 2016/17. A summary of the report can be found at Annex B of this report and the full annual report at Annex C (online only).
2. Kevin McAleese CBE, the Independent Chair of the Safeguarding Adults Board will be in attendance at the meeting to present the report (Annex A refers).

**Background**

3. The Safeguarding Adults Board is a multi-agency board whose role is to plan strategically and ensure the safety of vulnerable adults within the City of York Council's geographical area.

**Main/Key Issues to be Considered**

4. The Annual Report is for information only but clearly sets out the work the Board carried out over the course of 2016/17.

**Consultation**

5. This report is for information only.

**Options**

6. There are no options for the Health and Wellbeing Board to consider; this report is for information only.

**Analysis**

7. This section is not applicable to this report.

### **Strategic/Operational Plans**

8. The Safeguarding Adults Board has a statutory duty to produce an annual report.

### **Implications**

9. There are no implications associated with the recommendations set out in this report; the Annual Report is for information only.

### **Risk Management**

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

### **Recommendations**

11. The Board are asked to note the Safeguarding Adults Board's Annual Report.
12. Reason: To keep the Board apprised of the work of the Safeguarding Adults Board

### **Contact Details**

**Author:**

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Public Health Team  
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**Chief Officer Responsible for the report:**

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

**Report  
Approved**



**Date** 24.08.2017

**Specialist Implications Officer(s)** None

**Wards Affected:**

**All**

**For further information please contact the author of the report**

**Background Papers:**

None

### **Annexes**

**Annex A** – Presentation Slides

**Annex B**– Summary of Safeguarding Adult's Board Annual Report

**Annex C** – Safeguarding Adults Board's Annual Report (**Online Only**)

**For Health & Wellbeing Board, 6 September 2017:**

# **Annual Report 2016/17 of City of York Safeguarding Adults Board**

**Kevin McAleese CBE, Chairman**

# Safeguarding Adults Board (SAB) Annual Report 2016/17





→ [www.safeguardingadultsyork.org.uk](http://www.safeguardingadultsyork.org.uk)

## Contents

1. Introduction
2. Board's work and philosophy
3. Work undertaken in 2016/17
4. Performance and activity information
5. Peer review of safeguarding
6. Training
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8. New Strategic Plan from April 2016 onwards
9. Contributions from individual member organisations

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[2016/17](#)

## SAB Board members:

- City of York Council
- Healthwatch York
- Independent Care Group
- NHS England
- North Yorkshire Police
- Stockton Hall
- Tees, Esk & Wear Valley NHS Foundation Trust

- The Retreat
  - Vale of York Clinical Commissioning Group (CCG)
  - York Teaching Hospitals NHS Foundation Trust
  - York CVS
  - York House
- = Statutory partners and joint funders



# Work undertaken:



## ***Making Safeguarding Personal (MSP)***

This case involved a young woman under the care of Mental Health services, whose Care Co-ordinator raised a concern that she was being physically and emotionally abused by her mother. The concern suggested that the young woman's mother had recently assaulted her with an implement, from the injuries she had received.

This was a complex case because the young woman was at first reluctant to admit what had been happening, but eventually admitted that her mother had been physically abusing her. After several conversations with a worker from the team, during which the young woman was assured that she would decide what happened next, and all the possible options open to her were explored, she eventually agreed to speak to the police. Support was also given by a friend of the woman, who eventually accompanied her to the police station. At this stage, she was very clear that she wished to maintain her relationship with her mother and did not want the police to take any action. Her Mental Health worker worked alongside this intervention and gave the young woman some coping strategies.

Further long discussions took place between the young woman and the Safeguarding Team worker to explore all options and to support her, working in a person-centred way, i.e. at the pace of the young woman and without trying to impose any interventions that she did not want.



# Activity I

In line with the national picture, some 60% of both Concerns and Referrals involved female adults

Year	Alerts/Concerns	Referrals to Enquiries
2013	912	213 (23%)
2014/15	1,058	294 (28%)
2015/16	1,108	468 (42%)
2016/17	1,215	392 (32%)

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## 2016/17:

- People over 65 and above continued to be significantly over-represented in referrals, with 85s and over being the most over-represented

# Activity II

These patterns of abuse have been consistent in quarterly reports to the Safeguarding Adults Board, and reflect the national picture.

<b>2016/17: Type of abuse referred</b>	<b>%</b>
<b>Neglect</b>	<b>28%</b>
<b>Physical</b>	<b>23%</b>
<b>Psychological/emotional</b>	<b>21%</b>
<b>Financial</b>	<b>15%</b>
<b>Sexual</b>	<b>6%</b>
<b>Self-neglect or Organisational</b>	<b>6%</b>

# Activity III

As last year, the source of risk has most frequently been **people known to the adult with care and support need** and this has most frequently been located **within their own home.**

<b>2016/17: Location of risk referred</b>	<b>%</b>
<b>Own home</b>	<b>38%</b>
<b>Hospital</b>	<b>22%</b>
<b>Residential home</b>	<b>17%</b>
<b>Nursing home</b>	<b>9%</b>
<b>Other (incl community)</b>	<b>14%</b>

# Activity VI: Outcomes of Enquiries for 2016/17:

1. In 61% of all completed enquiries, the planned outcomes were said by the subject of the safeguarding actions to have been fully removed.
2. In 30% the planned outcomes were said to have been partially removed and in only 9% were the outcomes not achieved.
2. This was an improvement in the outcomes for adults with care and support needs on all previous years.





## The 2016/17 Peer Review of Adult Safeguarding found that.....

Staff have a “can do” attitude, and a sense of collective optimism in delivering the vision.

Good evidence of personalised approaches, and “Making Safeguarding Personal” rare through York’s social care practice like a stick of rock.

York’s front line staff are ‘amazing!’ and recognised as highly committed.

The Safeguarding Board understand the importance of talking through a case, and this demonstrates a learning organisation from the bottom up and top down.

Excellent work being done to support adults with care and support needs and safeguard them from abuse.

# Safeguarding Adults Reviews (SARs)

Under the Care Act 2014, an SAR must be arranged by the Safeguarding Adults Board (SAB) when “an adult in the area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

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SABs must also arrange a SAR if an adult in its area has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.”

## Not a Safeguarding Adults Review (SAR), but a Lessons Learned Case I

### Bernice

had severe learning disabilities with non-verbal communication, variable moods, frequent involuntary movements and sleep disturbances. Bernice could not express pain. It was known that her involuntary movements could sometimes result in an accidental injury to herself.

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Bernice had lived in supported housing with twenty four hour care for over twenty years, sharing with five other people. She attends day services in the city. In July 2015 Bernice was noted to have an injury to her arm and was taken to York hospital by care staff. An x-ray showed a fracture to a bone in her arm. She was treated over a number of months and required an operation to fix the bone until it healed.

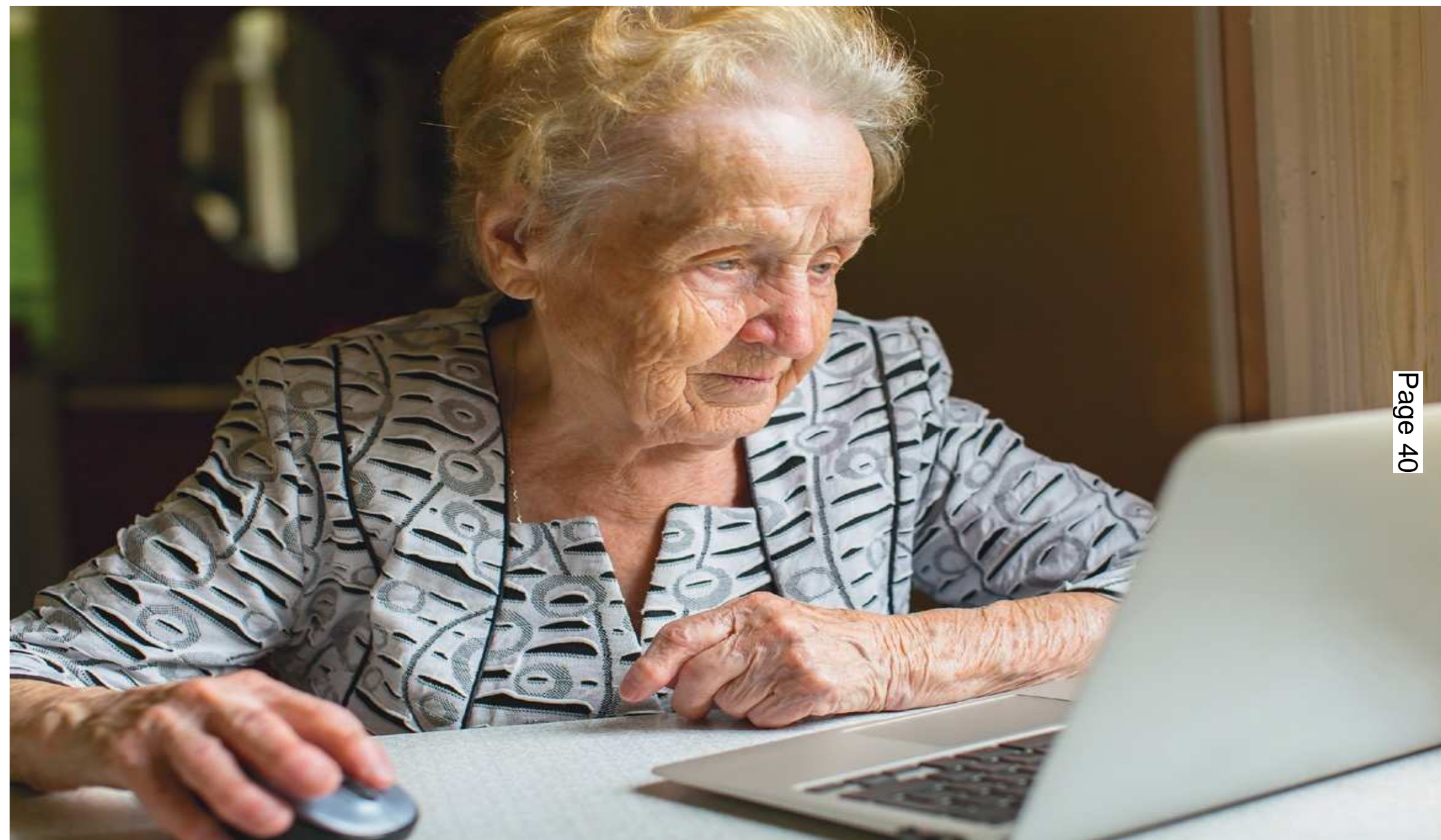
As the cause of the injury was unknown a safeguarding alert was made to the City of York Safeguarding Adult team. The subsequent investigation took six months to conclude, with a consensus that 'on the balance of probabilities temporary bed/bedrail entrapment had occurred which led to the injury.

## Lessons Learned findings:

Concerns were raised about the way agencies worked together during the safeguarding process and a decision was taken to undertake a Learning Lessons review, whose purpose is not to reinvestigate the case or to apportion blame but to:

- Identify any lessons that can be learned about the way in which local professionals and agencies worked together to safeguard adults
- Inform and improve multi-agency practice
- Improve practice by acting on learning

A 'learning together' approach was used with representatives from all of the agencies involved in the care and treatment of Bernice coming together in a workshop to look at what the challenges were, how things could have been done differently and what needed to change. The recommendations from the review were reported to and agreed at the Safeguarding Adults Board in June 2017 and a final summary of the review will appear in next year's Annual Report.



## **2016/17 Planned SAB developments included:**

Agree a Media and Communications strategy

Develop an audit tool for use in case reviews

Publish an information leaflet on Adult Safeguarding

Establish a new Quality Assurance Framework

Revise the Safeguarding Referral Form

Establish a Board Risk Register

Agree revisions in local Operational Guidance across West and North Yorkshire and City of York and conduct briefing sessions for staff and service users

Publicise and present the SAB Annual Report to any community group requesting it

# Questions and comments?



## Safeguarding Adults Board (SAB)

# Annual Report 2016/17



## Executive Summary

# Introduction

## by the Chair of the Safeguarding Adults Board (SAB)

This is my fourth annual report as Independent Chair of the City of York Safeguarding Adults Board (CoYSAB) and covers the year ending 31 March 2017.

It's vitally important that local safeguarding adults services are as good as they can possibly be, because the City of York's population of 200,000 includes some very vulnerable adults needing support to help keep them safe from harm. They include:

- Almost 9,500 older people in York with a long-term health problem. By 2020 this number is expected to rise to 10,000
- Approximately 14,000 older people who are living alone. In the next 10 years this is expected to increase to some 16,000 people
- Around 4,000 people in the City with a learning disability, over 800 of whom are already over the age of 65
- Some 12,500 working age adults in York with a moderate or serious physical disability
- Around 9,500 working age adults who have a mental health condition



Kevin McAleese CBE  
Independent Chair, City of York Safeguarding Adults Board

York continues to be a great place to live and work and our job as the CoYSAB is to help ensure every adult's right to live in the City safely and free from abuse or neglect. We continually seek to ensure that agencies supporting adults who are at risk, or in vulnerable situations, are working together successfully both to stop abuse and neglect happening in the first place and to make sure that the adult's wellbeing and wishes are at the centre of any action taken.

On the basis of all the evidence available to it, the CoYSAB continues to believe that in 2016/17, the arrangements in place across the City of York for safeguarding adults are both effective and appropriate.

Kevin McAleese CBE

### Contents

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# Making Safeguarding Personal (MSP)

A key part of the Care Act is the establishment of a person-centred approach to safeguarding adults across all agencies. There has undoubtedly been progress on the matter, and if you look at the individual returns from Board partners in Section 9 of the full 2016/17 Report you will see evidence of that. MSP is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and may need assistance to do so. Also, many safeguarding situations are complex, often involving the actions of friends or relatives, and the problems created are seldom easy to resolve. The real MSP case study below illustrates how this has worked:



This case involved a young woman under the care of Mental Health services, whose Care Co-ordinator raised a concern that she was being physically and emotionally abused by her mother. The concern suggested that the young woman's mother had recently assaulted her with an implement, from the injuries she had received.

This was a complex case, the young woman was at first reluctant to admit what had been happening, but eventually admitted that her mother had been physically abusing her. She had not seen this as domestic violence, however. After several conversations with a worker from the team, during which the young woman was assured that she would decide what happened next, and all the possible options open to her were explored, she eventually agreed to speak to the police. Support was also given by a friend of the woman, who eventually accompanied her to the police station to talk to them. At this stage, she was very clear that she wished to maintain her relationship with her mother and did not want the police to take any action. Her Mental Health worker worked alongside this intervention and gave the young woman some coping strategies.

Further long discussions took place between the young woman and the Safeguarding Team worker to explore her options and to support her, working in a person-centred way, i.e. at the pace of the young woman and without trying to impose any interventions that she did not want. Recently the young woman rang the team to say that she now felt stronger and able to manage her mother's behaviour, knew that she could contact the police and did not require the team to be involved currently. She knows that if necessary she can come back for further support.

# How are we doing?

In January 2017 York City Council invited a team from a number of local authorities to conduct a “peer review” of Adult Safeguarding under the guidance of the Local Government Association. Some nine officers and others came to the Council’s offices in the week of the 23rd and conducted interviews with a full range of staff and service users, and inspected a range of documents.

In requesting the challenge, the Council sought an external view on the robustness of safeguarding arrangements plus the direction of travel that York was undertaking in the transforming of adult social care, and how York might improve outcomes for people using services, as well as a view on how the future sustainability of the health and social care system

The report resulting from the challenge highlights many of the strengths in both the Council and across its partnerships. It also provides useful analysis as to where further work may be required to ensure that these strengths are built on and services continue to improve.

The Peer Challenge report reflected that Council has a stable and committed senior management who are driving transformation of services based on a clear vision that is recognised by the council and partners. The peer team heard from staff with a “can do” attitude, and a sense of collective optimism in delivering the vision. The peer team found good evidence of personalised approaches, commenting that “Making Safeguarding Personal” ran through York’s social care practice like a stick of rock. York’s front line staff were described as ‘amazing!’ and recognised as highly committed.

The peer team found The Safeguarding Board understand the importance of talking through a case, and this demonstrates a learning organisation from the bottom up and top down

The peer team found that Council had strong partnerships and was both ambitious and lean. This means they need to continue to ensure that the right resources are always in place to enable the effective delivery of their ambitions

The Peer Challenge recognises the excellent work being done to support adults with care and support needs and safeguard them from abuse.



# Performance and activity information

Adults collection  
June 2017

## Safeguarding concerns

**1,215** concerns were received by the local authority - an increase of 104 from 2015



## Ratio of concerns received

Female	Male
<b>58%</b>	<b>42%</b>
<b>38%</b> 18-64	<b>46%</b> 18-64
<b>33%</b> 65-84	<b>37%</b> 65-84
<b>29%</b> 85+	<b>18%</b> 85+

## Number of completed pieces of work

2015/16	2016/17
<b>1071</b>	<b>1178</b>

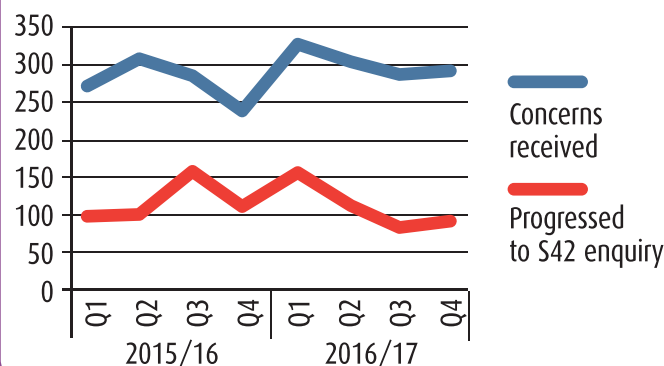
## MSP New measure for Q4

Percentage of those who were asked and expressed an opinion was **69%**

Of those:

- 61%** - outcomes fully achieved
- 30%** - outcomes partially achieved
- 9%** outcomes not achieved

## 2 years data



## Gender of completed S42 enquiries

<b>Female 60%</b>	18-64 <b>36%</b>	65-84 <b>31%</b>	85+ <b>32%</b>
<b>Male 40%</b>	18-64 <b>46%</b>	65-84 <b>36%</b>	85+ <b>18%</b>

## Number of completed S42 enquiries

2015/16	2016/17
<b>391</b>	<b>392</b>

## Progress to formal S42

<b>468</b>	➔	<b>454</b>
2015/16		2016/17

## Age range of completed S42 enquiries

<b>40%</b> 18 - 64
<b>33%</b> 65 - 84
<b>27%</b> 85+

## Completed S42 enquiries

### Location of abuse

- 38%** in own home
- 9%** in Nursing home
- 17%** in Residential home
- 22%** in hospital
- 7%** in community setting
- 5%** in services in the community
- 4%** other settings

### Source of abuse

- 49%** Service provider
- 46%** known to individual
- 5%** unknown to individual

## Types of abuse - completed S42 enquiries

<b>6%</b> sexual abuse	<b>3%</b> organisational
<b>23%</b> physical abuse	<b>28%</b> neglect
<b>21%</b> psychological/emotional	<b>2%</b> domestic abuse
<b>15%</b> financial	<b>3%</b> self neglect

# Training and development

The full Annual Report for 2016/17 shows that the Council's Workforce Development Unit (WDU) has continued to offer an extensive range of safeguarding training courses for staff from partner agencies. A total of 509 staff attended such training, of whom 57% were from organisations other than City of York Council. Level 1 courses continue to be offered free of charge, with £20 for other half-days and £40 for full-days. A charge of £50 continues to be made for non-attendance. Feedback from course attendees has continued to be highly positive.

During 2016/17 the WDU has worked with the Safeguarding Adults Board to revise both the Safeguarding and Mental Capacity Act training offers. Briefing events for both have been very well attended and have resulted in feedback which has been used to shape the new offers. The Safeguarding training offer which was launched in September 2016 has been revised to embed the principles of Making Safeguarding Personal. The new offer has received very positive feedback. The Mental Capacity Act offer will be launched in April 2017.

The WDU has also developed a new course on encouraging a risk-enabling approach to underpin the approach across services, to support people to take positive risks and to work in an outcome focused way, putting the individual and their wishes at the centre of decision making.

An Impact Assessment tool for use by managers with staff attending training has also been being piloted within the safeguarding courses this year. Feedback about the tool has been positive although more work needs to be done on raising awareness of the tool and how it can be used. This work is planned for 2017/18.

The CoYSAB's Training and Development sub-group is now meeting regularly and is providing helpful opportunities to ensure that learning and development opportunities are shared across agencies and any workforce development needs that arise through the SAR/Lessons Learned sub-group can be addressed on a multi-agency basis.



# Safeguarding Adults reviews and lessons learned

It is a requirement of the Care Act 2014 that the details of any Safeguarding Adults Reviews (SARs) conducted during the year must be in the SAB Annual Report. There were no Safeguarding Adults Reviews needing to be conducted during 2016/17, though a number of cases were considered to see if they met the threshold and became Lessons Learned instead. Below is an example of a Lessons Learned case considered during 2016/17:

John had a career in the Navy until his retirement following which he then worked until he was seventy years old. He was married to Margaret for thirty-five years, a second marriage for both of them and between them they had four children. John was in his eighties and Margaret was in her nineties, both had long-term illnesses but supported each other and managed well at home with some family help.

Margaret was admitted to hospital following a short illness. The family felt that John would not manage at home alone. Although he was independent in many ways, he also had a deteriorating health condition and some short-term memory problems. An assessment by Adult Social Care determined that John required three visits per day to help him with meals and reminding him to take his medications. However, despite strenuous efforts by staff no home care agency could be found to supply the visits that John needed. He became unwell with a chest infection and was given a course of antibiotics by his GP. Despite the efforts of several services and individuals stepping in to try to 'fill the gap', John unfortunately missed some evening doses of antibiotics. He was admitted to hospital in May 2015 and subsequently died three days later.

Following his death concern was raised by a family member to City of York Council in relation to care provided. John's family acknowledged that services tried to help him. They were concerned that despite recognising that he needed help that help was not always available in the community. Family members stated they did not want a big enquiry and weren't trying to find someone to blame but just didn't want this to happen to anyone else. A chronology of events from the agencies involved was compiled. A visit to John's step-daughter and his sister was made to better understand the situation from their and John's point of view. John's family agreed that this summary could be shared as an example for those commissioning and providing services.



## Contacts

City of York Council, West Offices, Station Rise, York YO1 6GA

### To report a safeguarding concern:

- Contact adult social care, tel: 01904 555111 (office hours) or fax 01904 554055
- Hearing impaired customers can use the text facility 07534 437804
- Out of hours, tel: 01609 780780

### To report a crime:

- In an emergency, tel: 999
- If the person is not in immediate danger, tel: 101

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

**This information can be provided in your own language.**

Informacje te mogą być przekazywane w języku ojczystym.  
Polish

Bu bilgi kendi dilinizde almanız mümkündür.  
Turkish

此信息可以在您自己的语言。  
Chinese (Simplified)

此資訊可以提供您自己的語言。  
Chinese (Traditional)

 **01904 551550**







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**Health and Wellbeing Board**

6 September 2017

Report of the Ageing Well Health and Wellbeing Board Theme Lead

**Progress on the Ageing Well Theme of the Joint Health and Wellbeing Strategy 2017-2022****Summary**

1. This report asks the Health and Wellbeing Board (HWBB) to note the update on progress made against delivery of the ageing well theme of the joint health and wellbeing strategy 2017-2022.

**Background**

2. At the Health and Wellbeing Board meeting (HWBB) in March 2017, the new joint health and wellbeing strategy 2017-2022 was launched. The strategy is based around a life course approach with ageing well as one of the key priorities.

**Context**

3. The ageing well part of the strategy covers the so-called 'third age', roughly from 66 onwards, including the end of life. We know that over the next 15 years the number of people over 65 in York will increase from 36,000 to 46,000 and those aged 75 and over from 7,000 to 26,000.
4. We also know nationally, 1 in 10 older people are suffering from chronic loneliness. When developing the strategy, people told us they particularly wanted us to tackle isolation and loneliness and to ensure that in York, no one ever dies alone. Our top priority within the strategy is to reduce loneliness and isolation for older people.
5. There were other priorities identified in the strategy which are detailed in Annex A. This gives examples of some of the ongoing work in the first year of the five year strategy and the progress made to date in delivering against the theme. An organisational case study is also included at Annex B.

6. An Operational Group of the Voluntary and Community Sector Ageing Well Forum was set up to further explore the strategy; to identify what was working well in the city to meet the priorities, and why, and to identify any gaps, and possible solutions.
7. The group consists of individuals from Older Citizen's Advocacy York (OCAY), York Older People's Assembly (YOPA), Age UK, York Blind and Partially Sighted Society (YBPSS), York Centre for Voluntary Service (CVS) and City of York Council (CYC). This report has been developed by the group, and other representatives from City of York Council.
8. As a starting point, the group believed the most important task was to map the existing groups, boards and services, which provide support for older people. This was to help deliver the strategy, identify gaps, and ensure that appropriate resources flow in the direction of identified new gaps over the course of the strategy - a very important part of this task is to identify where an organisation may already be doing work in a priority area. This work has begun but will be ongoing up to the end of March 2018.
9. The group is also aware of a number of surveys that have been undertaken, the most recent of which is the "York older people's survey" which is the subject of a separate report on this agenda. The group agreed they would like to review all of the surveys to check if there are other needs/gaps which have been identified.

### **Main/Key issues to be considered**

10. The group want to provide HWBB Board Members with;
  - An understanding of the work undertaken so far
  - Demonstrate what is currently being delivered within the city (existing groups, boards and services) which ultimately provide support for older people and can help deliver the strategy
  - Highlight the other priorities which are detailed within the strategy and ask the Board to provide consideration on how they will be supported and delivered; in particular those listed in the 'the board will' section of the joint health and wellbeing strategy.

### **Consultation**

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

### **Options**

12. There are no specific options for the Health and Wellbeing Board; they are asked to note and comment on this report, and consider how the other priorities will be supported and delivered

### **Analysis**

13. Not applicable.

### **Strategic/Operational Plans**

14. As detailed earlier in this report, this report fits with the priorities and actions identified in the joint health and wellbeing strategy.

### **Implications**

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

### **Risk Management**

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

### **Recommendations**

17. The Health and Wellbeing Board are asked to note and comment on the report and consider how best to support and deliver all elements of the joint health and wellbeing strategy.

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

**Contact Details**

**Author:**

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01904 621133

**Chief Officer Responsible for the report:**

Sarah Armstrong  
Chief Executive  
York CVS  
01904 621133

**Report  
Approved**



**Date** 21.08.2017

**Specialist Implications Officer(s)** None

**Wards Affected:**

**All**

**For further information please contact the author of the report**

**Background Papers:**

[Joint health and wellbeing strategy 2017-2022](#)

**Annexes**

**Annex A** – Table of ongoing work: ageing well theme of the joint health and wellbeing strategy 2017-2022

**Annex B** – Organisational Case Study

Priority	Progress/Action Planning already underway
<p data-bbox="136 571 282 651"><b>Top Priority:</b></p> <p data-bbox="114 831 304 1082">Reduce loneliness and isolation for older people</p>	<ul data-bbox="338 292 2074 1369" style="list-style-type: none"> <li data-bbox="338 292 2074 627">• <b>Understand more about poverty and its contribution to loneliness and social isolation:</b> The JRF (Joseph Rowntree Foundation) 'We Can Solve Poverty' document states that; 'Pensioner income poverty has reduced considerably in recent years, yet a substantial number of pensioners still have a low standard of living, especially if they are disabled or in ill health. Poor access to public transport restricts some older people from getting around, reducing their autonomy and increasing exclusion from social networks, sometimes leading to loneliness and isolation. Furthermore, stigma and lack of awareness mean that take-up of state support is often low. A case study is provided at Annex B to this report which further highlights the complexity of this.</li> <li data-bbox="338 639 2074 754">• The operational group has begun to focus on two issues; <b>fuel poverty</b> and <b>transport</b>. This is to understand more about what works well in the city and what more can be done to help reduce social isolation and loneliness.</li> <li data-bbox="338 767 2074 1233">• <b>Fuel poverty:</b> Households are usually considered to be in 'fuel poverty' when they spend more than 10% of their total income to keep their house warm enough for health and comfort. National Energy Action (NEA), which is a fuel poverty charity, suggests that given the time-lag between collection of data and publication of the annual report the current scale of fuel poverty is greatly underestimated. NEA estimates that currently some 4 million (or 18.2%) of English households cannot afford sufficient warmth to maintain a warm and healthy living environment (<a href="http://www.nea.org.uk/government-fuel-poverty-progress-report-2-steps-back">www.nea.org.uk/government-fuel-poverty-progress-report-2-steps-back</a>). In a report developed by City of York Council in 2008, it was estimated that 5976 households, 8.2%, were in fuel poverty in the city. Almost 18% of the total of the people affected were aged 55 and over. The operational group is aware of a number of services which can support people to gain access to information and advice which can help, and is in the process of mapping these so further awareness can be raised of what's available.</li> <li data-bbox="338 1246 2074 1369">• <b>Transport:</b> A group of York organisations, led by the York MS Society and Healthwatch York, is working together to see if it is possible to develop a community transport initiative for the city. There is a lot of interest in the project and a significant need identified by groups across York. The group has</li> </ul>

Priority	Progress/Action Planning already underway
	<p>met twice and is now developing ideas for a paid coordinator. This person will harness the existing enthusiasm to the next stage to engage more organisations, identify models and opportunities and develop a feasibility study, including costings, for what might be possible. The group hope that by working together they will be able to develop a service that helps people get out and reduces isolation across the city.</p> <ul style="list-style-type: none"> <li>• <b>Culture &amp; Wellbeing Consortium:</b> reducing loneliness and social isolation is a principal focus for the Culture &amp; Wellbeing Consortium. The Consortium was established in 2016 in response to the national Cultural Commissioning funded by Arts Council England and managed by National Council for Voluntary Organisations. With a consultant's support the Consortium mapped York's Health and Wellbeing priorities against the cultural sector's strengths and capacity, producing their own Ways to Wellness statement as a result. The overall aim of the Consortium is to overcome the psychological barriers to social and cultural engagement and in turn positively affect the health and wellbeing of older people in York. In 2017 the Consortium bid for and was awarded a City of York Council contract to pilot cultural commissioning. Sample projects are: <ul style="list-style-type: none"> <li>○ Cuppa and a chorus: Age UL working with Converge and the National Centre for Early Music</li> <li>○ Culture on Prescription: the Consortium working with the social prescribing service to enhance the range of available options</li> <li>○ Up for Arts: the Consortium working with BBC Radio York to celebrate older people's participation in the arts and to encourage continuing engagement.</li> </ul> </li> </ul>
<b>Other Priorities:</b>	
Continue work on delayed discharges	<ul style="list-style-type: none"> <li>• The multi-agency Complex Discharge Task and Finish Group (a sub-group of the A&amp;E Delivery Board) oversee a Complex Discharge Programme. The Programme aims to reduce unnecessary delays for patients in hospital and there are a number of projects underway to support this – including the integration of discharge liaison teams, redesign of key discharge processes, integration of intermediate</li> </ul>

Priority	Progress/Action Planning already underway
from hospital	care and reablement teams. The group are using the national 8 High Impact Changes to Reduced Delayed Transfers of Care. We have recently conducted audits of patients in hospital over 7 days (to understand what they are waiting for) and the needs of patients in community inpatient units.
Celebrate the role that older people play and use their talents	<ul style="list-style-type: none"> <li>• <b>Culture &amp; Wellbeing Consortium:</b> The Consortium is planning an application for ‘Celebrating age Funding’ which will put older people in the position of commissioning as well as enjoying the arts and culture.</li> </ul>
Enable people to recover faster	<ul style="list-style-type: none"> <li>• We have re-provided intermediate care services with an increased capacity to provide home based intermediate care. This has allowed an increased number of patients in 2017 to access intermediate care – which provides multi-professional input to support people to remain independent following a crisis.</li> </ul>
Support the vital contribution of York’s carers	<ul style="list-style-type: none"> <li>• City of York Council and the Vale of York CCG currently commission York Carers Centre to deliver a wide range of support services to adult and young carers in the city. The existing contractual arrangements commenced on 31st October 2013 and are due to expire on 31st March 2018. A significant extension of the existing Carers Centre contract was agreed in 2016 to support the creation of a Carers Hub, a highly visible referral point where carers could be offered early-stage assessment and preventative support in order to reduce and delay the need for more complex interventions.</li> <li>• Under the branding of the Carers Hub York Carers Centre has successfully established itself as highly visible, front-door contact point in the city which responds rapidly to carers’ needs. Carers therefore have one clear point of contact; a competent and highly respected provider who is able to offer immediate support - or signpost to an appropriate partner agency.</li> </ul>

Priority	Progress/Action Planning already underway
	<ul style="list-style-type: none"> <li>• The Carers Hub has delivered strongly against the strategic priorities set out in the new operating model for Adult Social Care, particularly the principle of ‘preventing, reducing and delaying the need for ongoing care and support’.</li> <li>• Through a combination of early intervention, proportionate assessment and triage for more complex cases of need the Hub provides a highly responsive, integrated and flexible carers support model - one which has proved effective in sustaining carers in their care giving role and reducing the demand for permanent, long-term care. This in turn has led to measurable cost savings across the health and social care system.</li> <li>• Specific examples of achievements since the establishment of the Carers Hub in May 2016 include the following: <ul style="list-style-type: none"> <li>○ A 10% growth in the number of new registrations with York Carers Centre (i.e.2,844 current registrations compared with 2,584 in May 2016).</li> <li>○ Targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016. (1,095 new referrals have been received against a target of 980).</li> <li>○ 1,119 customer contacts have been provided during extended opening hours (Friday / evening cover) since the contract uplift from May 2016.</li> <li>○ The target for Carers Assessments of Need has been exceeded by 17% (88 completed assessments against a target of 75).</li> <li>○ The waiting list for Carers Assessments in the city has reduced from 90 to 21 since May 2016.</li> <li>○ Carers now have to wait for a maximum of 4 weeks for a carer’s assessment, compared to an average wait of over 8 weeks in May 2016.</li> <li>○ Three permanent outreach hubs for carers have been established in Acomb, New Earswick and</li> </ul> </li> </ul>



Priority	Progress/Action Planning already underway
	<p>Tang Hall with numerous additional pop-up outreach activities and events taking place in other neighbourhoods across the city.</p> <ul style="list-style-type: none"> <li>○ Case studies evidence that a complete breakdown of the care giving role has been avoided for at least 207 households in the 11 month period May 2016 to March 2017 including;</li> <li>○ Prevention in admissions to residential care / reduction in the take up of domiciliary care packages (16% of case studies).</li> <li>○ Prevention of a significant deterioration in carer mental health (59% of case studies).</li> <li>○ Prevention of a significant deterioration in carer physical health (12% of case studies).</li> <li>○ Sustaining carers in employment and alleviating financial hardship (13% of case studies).</li> </ul>
<p>Increase the use of social prescribing</p>	<p><b>‘Ways to Wellbeing’</b> is York’s social prescribing service. It connects people to local community support to make them feel better. Nationally, 20-25% of patients consult their GPs for social problems, e.g. loneliness. This service reduces use of GP appointments for social issues, helping people stay safe and well at home for longer. Over 200 people have accessed the service since it officially began in February 2016 and 75% of people using the Ways to Wellbeing service reported feeling more confident and 80% improved their wellbeing. Recent evaluation has demonstrated that people accessing this service see much less of their GP – appointments on average have reduced by 30%. Funding for this work ended in March 2017 and although the service has continued it has no recurring funding source. Therefore maintaining this service is the first priority, and increasing it is the second priority. Funding applications are in progress at the time of writing this report.</p>
<p>Enable people to die well in their place of choice</p>	<ul style="list-style-type: none"> <li>● Improve communications and standardised care records to work towards seamless care provision from different providers</li> <li>● Stimulate the market further to ensure more flexible and higher skilled home care provision across all localities</li> <li>● Ensure that dying well in someone’s place of choice remains a focus of the transformation agenda</li> </ul>

Priority	Progress/Action Planning already underway
	<ul style="list-style-type: none"> <li>• Continuously act on lessons learnt from concerns raised by patients, their families and other stakeholders</li> <li>• To work across health and social care providers to develop a palliative/end of life care register.</li> </ul> <p>Additionally, the experience of health professionals themselves and service delivery could be improved through changes to the current multi-provider model.</p> <p>Transforming local services will be achieved through the development of local place-based services to implement fully integrated out of hospital care and achieve improved quality of the last year of life for all patients.</p>

### Organisational case study – provided by OCAY (Older Citizens Advocacy York)

Working in a small charity with four part-time staff and a team of up to 18 active volunteer advocates, OCAY works with a current caseload of just over 100 live cases on average at any given point this year (2017), compared with nearly 80 in 2016.

Within these figures there has been an escalation in benefits cases – in particular relating to Personal Independence Payment benefit, Disability Living Allowance and Employment Support Allowance, with the first of these taking the lion's share.

Taking a cursory overview of the data, (covering April 2016 to present) reveals the following number of cases seeking help with benefits:

Ages	Closed cases	Open cases
	Unspecified age – 2	Unspecified age – 6
50-59yrs	12	15
60-69yrs	16	23
70-79yrs	6	10
80-89yrs	1	5

## More information

Prior to 2016 OCAY clients typically needed signposting to City of York Council for a benefits review or needed some straightforward information on what their benefits entitlement might be. Over the last 12 months OCAY have seen an escalation in the number of clients with complex mental and/or physical health needs. These clients have typically been allocated Disability Living Allowance (DLA) 'indefinitely' and now have to undergo Personal Independence Payment (PIP) assessments (designed to review those on DLA).

To qualify for the benefit at standard or enhanced rate clients must be able to evidence the impact of their condition(s) on their day to day living to a sufficient level of detail. Clients have come to OCAY having scored zero when applying on their own behalf. In some press reports it has been claimed that assessors have been under guidance to reject as high a rate as 80% of claimants at first assessment.

There is a process of Mandatory Reconsideration, First Tier Tribunal (appeal) and Second Tier Tribunal (which can only give permission to re-run the appeal). OCAY has experienced a sudden need for intensive training to be developed in-house to equip some of the volunteer advocates to help take on more complex cases and meet the increased need. Typically to prepare a full response to seek an appeal can take up to four hours for one client – and that is only one stage of the process.

The process is overwhelming for clients for many reasons; the terminology used, the use of tribunals (often heard in court rooms), the nature of the assessments sometimes intruding into their private lives with little scope for dignity, the way activities are described, the lack of clarity as to the amount of detail which will make a difference, the short timelines by which forms must be turned around, and so on.

It can take up to 18 months to reach a final decision (from original application to Second Tier Tribunal). During this time benefits are reduced in accordance with the original assessment outcome; clients have to survive on a

bare minimum, significantly increasing their risk of sustained poverty and having a significantly detrimental effect on their emotional and mental health. OCAY have already sat with upwards of half a dozen clients who have told us they wished the world would end and they didn't have to wake up the next day due to the traumatizing nature of this. Figures in the national press in 2017 have been reflecting significantly high levels of successful appeals – as much as 64% of cases according to some reports.

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**Health and Wellbeing Board**6<sup>th</sup> September 2017

Report of the Ageing Well Health and Wellbeing Board Theme Lead

**Introducing Ways to Wellbeing: York's Social Prescribing Service****Summary**

1. This report presents an introduction to 'Ways to Wellbeing'; York's Social Prescribing Service. The Chief Executive from York CVS will present the report using the slides at **Annex A**.

**Background**

2. Ways to Wellbeing is York's social prescribing service. It connects people to local community support to assist them to address their issues / concerns without requiring direct input from statutory agencies. Nationally, 20-25% of patients consult their GPs for social issues, e.g. loneliness. This service reduces use of GP appointments for social issues, helping people stay safe and well at home for longer.
3. The presentation will cover how the service works; evaluation of the service and the next steps for the service.

**Main/Key Issues to be Considered**

4. An evaluation process of the first full year of the service has now been undertaken and the data points to a significant reduction in the demands placed upon GP appointments with usage decreasing by 30% for those people using the service.

**Consultation**

5. No consultation was required to produce this report and presentation. The service routinely uses a short outcomes tool to measure levels of satisfaction for those supported.

### **Options**

6. There are no specific options for the Health and Wellbeing Board to consider; the intention is to use the Better Care Fund (BCF) to maintain the service being provided. The board are asked to note and comment on the presentation.

### **Analysis**

7. Health and Wellbeing Board should consider how this service is enabling them to deliver against the ageing well theme of the joint health and wellbeing strategy which specifically references the wish to increase the use of social prescribing, i.e. linking patients in primary care with sources of support within the community.

### **Strategic/Operational Plans**

8. This report relates to the ageing well theme within the joint health and wellbeing strategy 2017-2022.

### **Implications**

9. There are no known implications associated with the recommendation in this report.

### **Risk Management**

10. There are no risks identified with the recommendation in this report.

### **Recommendations**

11. Health and Wellbeing Board are asked to note and comment on the presentation and report.

Reason: To keep the Health and Wellbeing Board apprised of the Ways to Wellbeing Service.

### **Contact Details**

**Author:** **Chief Officer Responsible for the report:**



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City of York Council

**Report  
Approved**



**Date** 21.08.2017

**Specialist Implications Officer(s)** None

**Wards Affected:**

**All**



**For further information please contact the author of the report  
Background Papers:**

[Joint health and wellbeing strategy 2017-2022](#)

**Annexes**

**Annex A** – presentation slides

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**Introducing... Ways to Wellbeing**

**York's Social  
Prescribing Service**

What is it?

**It's a way to give people a little extra support at a time they need it most**

(It's that simple)

## How does it work?

- ▶ Someone finds us
- ▶ We meet over a cup of tea
- ▶ Find out what life is like for them
- ▶ Come up with an idea
- ▶ Work with others to make it real
- ▶ Try it!
- ▶ Review it
- ▶ Try it again...

## How do we know it works?

- ▶ Over 200 referrals so far
- ▶ Positive feedback
- ▶ Formal evaluation of first three months
- ▶ Reduced hospital admissions and GP appointments
- ▶ 80% people reported greater sense of wellbeing
- ▶ 75% people reported increased confidence
- ▶ Return on investment of £1 for every 50p invested

And...

We have just undertaken an evaluation of the first full year of Ways to Wellbeing delivery, and our data tells us that GP appointment usage has decreased by 30% for patients using the service

## What would have happened to Mr and Mrs Jones without Ways to Wellbeing?

- ▶ Hospital admissions due to falls (and use of ambulance services)
- ▶ Increased GP visits
- ▶ Increased visits from district nurses, physio and OT
- ▶ Accelerated move into residential care?
- ▶ Lack of customer choice



## What would have happened to Rose without Ways to Wellbeing?

- ▶ Increased GP appointments
- ▶ Referral to mental health services
- ▶ Deteriorating mental health
- ▶ **Increased GP contact?**
- ▶ **Falls likelihood and associated hospital admissions?**

## What works?

- ▶ Taking time to get to know someone (not just getting to know their need/their difficulty)
- ▶ Listening with no time limits
- ▶ Trying ONE new thing at a time
- ▶ Going with people to try a new thing for the very first time
- ▶ Taking away barriers like transport - we can provide a taxi or bus fare

## What works?

- ▶ Working with others to find something that works
- ▶ Being consistent
- ▶ Being different and ‘not like the system’
- ▶ Keep trying until we find something that works
- ▶ And if there is a solution we will find it! We never give up!

These are our tools - not revolutionary, but tried and tested, and so far they are working

## What we don't do...

- ▶ Offer in-depth counselling
- ▶ Offer a long term service which creates dependency
- ▶ Offer our solutions
- ▶ Don't turn people away
- ▶ Don't perform miracles!

# What next for social prescribing...

- ▶ Secure funding
- ▶ City wide support
- ▶ Create more local social connections
- ▶ Strengthen communities
- ▶ Support our VCS
- ▶ Grow volunteering
- ▶ Be clear about outcomes
- ▶ **Put York on the map!**

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**Health and Wellbeing Board**  
Report of Assistant Director of Public Health

6<sup>th</sup> September 2017

**Report on York Older People's Survey**

**Summary**

**Background**

1. At the Health and Wellbeing Board (HWBB) meeting on 20 July 2016 a request was made for the Board to support the carrying out of an older people's survey, similar to that carried out in 2008. The Board agreed to this and work commenced through a steering group in October 2016. The steering group consisted of representatives from York Older People's Assembly, Age UK York, Healthwatch York, York CVS, The Police and Crime Commissioner North Yorkshire, The Vale of York Clinical Commissioning Group and City of York Council. Additionally support was also received from the York Blind and Partially Sighted Society.
2. The survey was distributed from 8<sup>th</sup> May – 30<sup>th</sup> June 2017 and data entry and analysis was carried out throughout July and August 2017. The survey was available to complete online and additionally partner agencies distributed 4070 paper copies to their membership lists. We do not know if people received more than one copy of the survey through different routes.
3. There were 912 completed surveys returned; of which 142 were online submissions and 770 paper submissions.
4. This report provides a brief overview of some of the key results emerging from the survey, with recognition that analysis is still ongoing and a full report of all the results will be produced and sent to the HWBB at a later date.

### **Main/Key Issues to be Considered**

5. The survey highlighted that on the whole respondents generally reported having good health. Much of this was due to being physically active and having adequate social contact.
6. In terms of health and what older people felt kept them healthy and independent there was an emphasis on social contact, whether this was through formal groups and activities, or informal contact with family and friends. Practical support for personal care, or with running a home was also important as was support with caring responsibilities. There was an appetite to do more self monitoring of health conditions, which currently only around a quarter of respondents do.
7. The highlight report at Annex A focuses on social isolation as the key priority of the ageing well theme of the joint health and wellbeing strategy. Whilst the majority of respondents had as much social contact as they would like, or adequate social contact, there was just under a quarter who indicated that they were socially isolated. Social isolation was more apparent in the winter as some people avoided going out due to cold weather and dark nights.

### **Consultation**

8. The development of the survey was carried out through a multi agency partnership group.
9. The survey was piloted with a group of older people and a focus group was carried out to ensure the survey covered that issues that older people felt were important to them.

### **Options**

10. There are no specific options for the Health and Wellbeing Board to consider. However they are asked to:
  - a. note the initial results of the survey.
  - b. receive a further report of the survey when full analysis is complete
  - c. consider how recommendations from the survey might be taken forward



### **Strategic/Operational Plans**

11. The Older People's survey was designed to understand the issues older people in York face. Therefore supporting the delivery of the ageing well theme of the joint health and wellbeing strategy as well as influencing the plans of partner agencies working with older people.

### **Implications**

12. There are no risks identified for the following categories: financial, equalities, legal, crime/disorder, information technology, property or other.

### **Risk Management**

13. There are no risks identified regarding the recommendations below.

### **Recommendations**

14. The Health and Wellbeing Board are asked to:
  - i. note the initial findings from the survey
  - ii. Receive a further report with the full results of the older people's survey.
  - iii. Consider how any recommendations from the survey might be taken forward.

Reason: In order for the survey to have been worthwhile consideration of how any recommendations or findings from the survey are taken forward needs to be considered.

### **Contact Details**

**Authors:** **Chief Officer Responsible for the report:**

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Assistant Director of Public Health

Fiona Phillips on behalf of Sharon Stoltz, Director of Public Health  
City of York Council

Zach Warne  
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City of York Council  
01904 565114

**Report  
Approved**



**Date** 17/08/2017

**Wards Affected:**

**All**



**For further information please contact the author of the report**

**Background Papers:**

None

**Annexes**

**Annex A – Older People’s Survey – Highlight Report**

## **Highlight of Results from Older People's Survey 2017**

The survey was undertaken to gain insight into the issues for older people in York; to identify how older people's attitudes have changed since the previous survey of 2008; and to find out from the older population what they would like to see changed within York.

The Older People's Survey 2017 was available in both paper format and online. 4070 paper copies were distributed by the various groups collaborating on the survey. These were either distributed through the partner agencies' mailing lists, available at reception areas, or handed out during their events. A total of 912 surveys were completed. Of these, 142 were completed online via Survey Monkey and 770 were returned paper versions. The returned surveys yield a 19% answer rate (based on the paper copies returned), which is a slight decrease from the 2008 survey. However, the total survey count increased in both formats, as 2008 had only 638 paper responses (from 3000 distributed) and 87 online.

Additionally, two steering group discussions were conducted with various stakeholder representatives to discuss the initial data findings. These proved very insightful as the meetings helped pinpoint areas worth more initial analysis and provided background information on certain response outcomes to questions.

The figures for each question have been calculated after taking out those respondents that did not answer the question.

The demographics of respondents are as below.

In total, 25% of respondents were male and 62.5% were female. The rest did not provide this data.

**Table 1: Age and sex breakdown of respondents**

	Under 50	50-59	60-69	70-79	80-89	Over 90	Total
Male	0	12	50	66	81	23	232
Female	17	36	124	142	177	74	570
Unspecified	0	2	3	2	9	3	19
<b>Total</b>	17	50	177	210	267	100	821

In terms of relationship status, 49% of respondents were single, widowed or divorced, 41% were married, cohabiting or in a civil partnership, and the rest did not respond. There were more single, widowed or divorced females responding (61%) than there were males (37%).

In terms of the geographic spread of responses, people from every ward across York responded. More surveys were returned from wards with a higher concentration of older people, such as Haxby & Wigginton.

**Table 2: Geographical distribution of respondents by ward**

Copmanthorpe Ward	7
Dringhouses & Woodthorpe Ward	32
Fishergate Ward	58
Fulford & Heslington Ward	29
Guildhall Ward	24

<b>Haxby &amp; Wigginton Ward</b>	71
<b>Heworth Ward</b>	46
<b>Heworth Without Ward</b>	28
<b>Holgate Ward</b>	56
<b>Hull Road Ward</b>	11
<b>Huntington &amp; New Earswick Ward</b>	52
<b>Micklegate Ward</b>	28
<b>Osbaldwick &amp; Derwent Ward</b>	23
<b>Rawcliffe &amp; Clifton Without Ward</b>	31
<b>Rural West York Ward</b>	38
<b>Strensall Ward</b>	16
<b>Westfield Ward</b>	29
<b>Wheldrake Ward</b>	12
<b>unspecified</b>	245

The survey questionnaire was divided into nine sections as follows:

Section 1 – Getting information and advice

Section 2 – Social Life

Section 3 – Your health

Section 4 – Staying healthy and independent

Section 5 – your local community

Section 6 – Transport

Section 7 – Finances

Section 8 – Planning for the future

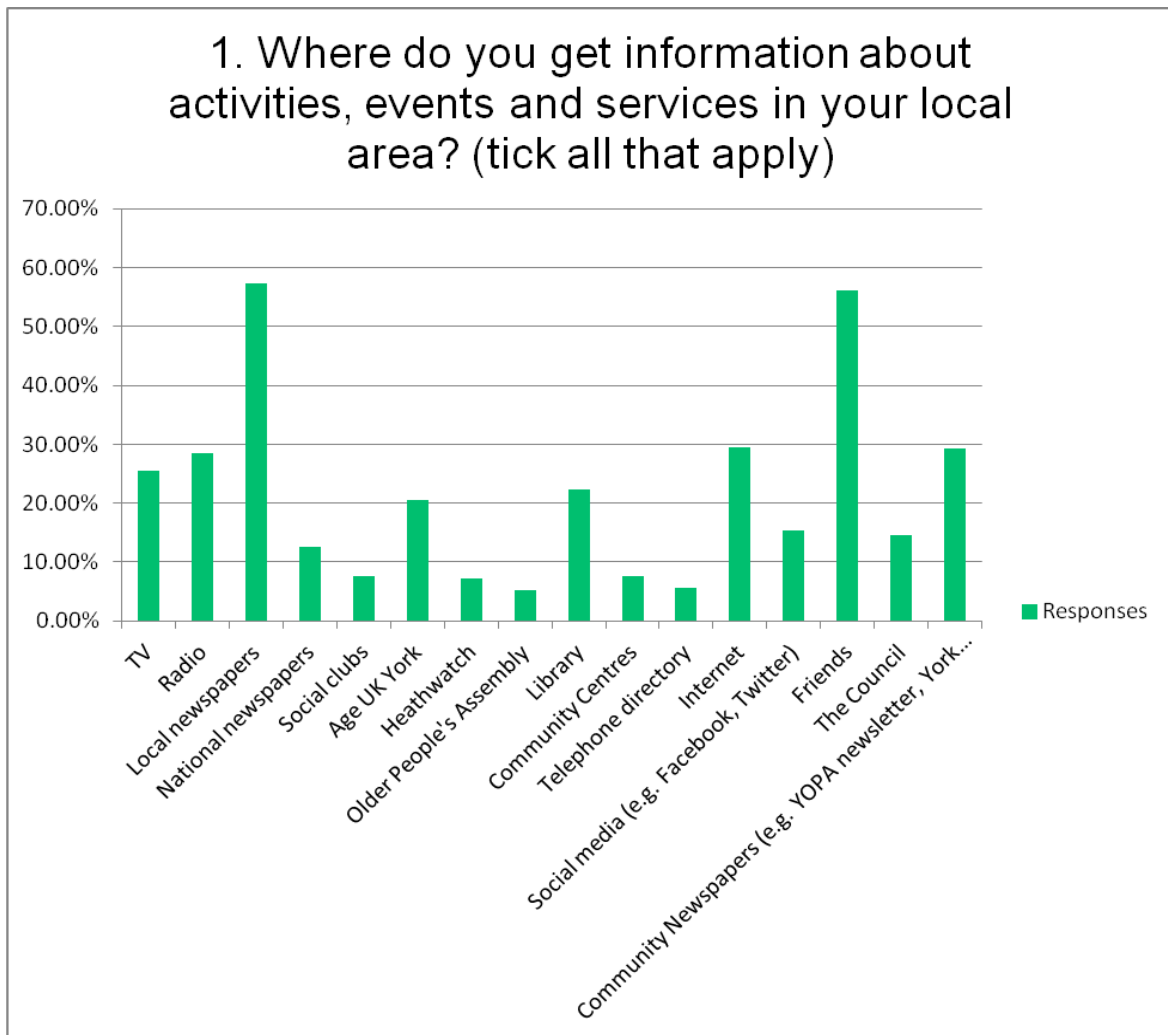
Section 9 – About you (demographics)

A full report will be produced on all sections of the survey, but for the purpose of this meeting this report gives a highlight from each section along with a more detailed look at Section 2 on social life, as reducing social isolation is a key priority within the Joint Health and Wellbeing Strategy.

**Section 1 – Getting information and advice**

**Highlight: Respondents prefer information in printed format, received through the post. This is often through local newspapers, although word of mouth is an important source.**

**Figure 1: Where people get information**



## Section 2 – Social life

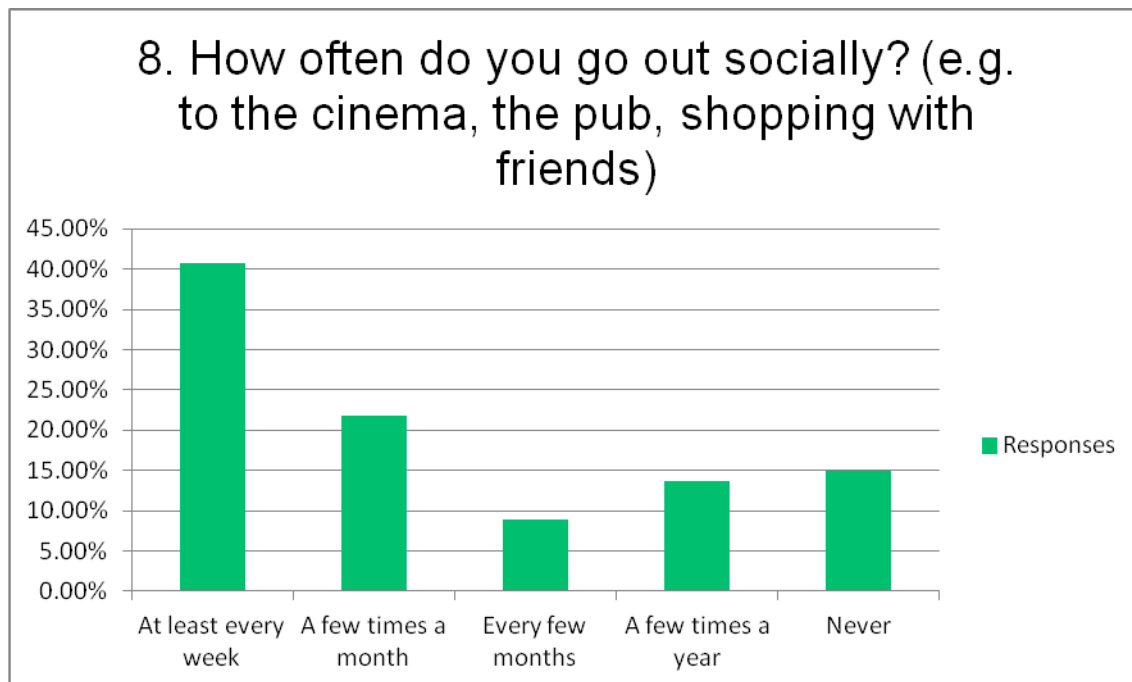
We asked about shopping as an indicator for how much respondents were getting out of the house on a regular basis. The majority of respondents did this weekly or more often. 33% required some kind of assistance to be able to do this. 40% of those requiring assistance relied on family, friends or neighbours to enable them to go shopping. This was either through providing transport for them to get to the shops, helping them in the shop reading labels or pushing a trolley, or helping to unload shopping back at home. Of the 33% that required assistance, 61% were single, widowed or divorced meaning that the additional support needed did not come from a spouse or partner, but from extended family, friends or neighbours. Only 25 respondents said that they did their shopping online.

**Figure 2: Frequency of shopping**



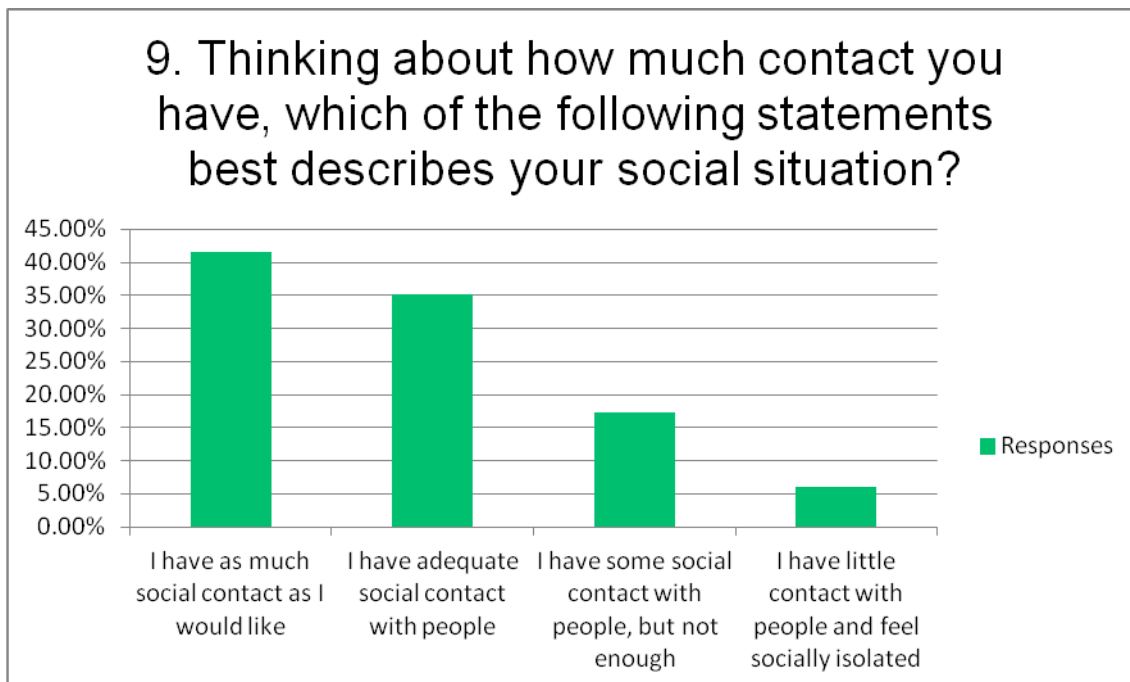
When asked how often respondents went out socially, 40% replied at least every week. In terms of whether people had as much social contact as they would like, the majority replied that they had as much social contact as they would like, or at least adequate social contact.

**Figure 3: Frequency of going out socially**





**Figure 4: How people feel about their level of social contact**



For the 35% of respondents that said that they hardly ever went out socially (either every few months, a few times a year, or never) 63% were female and 70% were over 80 years of age. Of those that hardly ever went out socially, 37% responded that they did not have enough social contact or felt socially isolated.

When asked if there were any social activities that people would like to do 19% provided a comment. The responses were quite varied, but covered opportunities for exercise, arts and cultural activities, social groups etc. Below are some of the comments received:

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

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

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

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

**“Pub quiz at lunch times or early evenings.”**

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

When asked what prevents people from going out or socialising as much as they would like the common barriers were transport, access issues, seating, toilets and money.

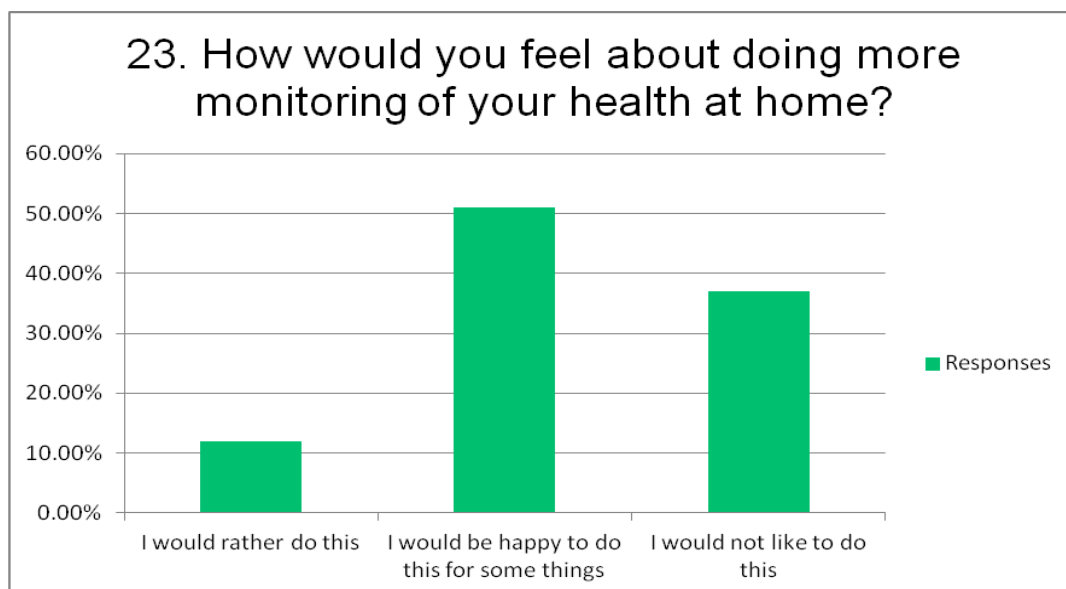
### Section 3 – Your health

#### Highlight: Respondents to the survey were very physically active.

The percentage that reported doing the recommended levels of physical activity in a week (i.e. over 150 minutes per week) was 68%. This is similar to the proportion doing the recommended level of physical activity in the adult population in York (69.8%), which is higher than the England rate of 57%. It is encouraging to see that the trend in high physical activity levels does not appear to drop with age in York as it does in other areas.

There was also willingness for people to do self monitoring of their health at home. Currently 25% of respondents said they already did some form of self monitoring, such as checking blood pressure or blood glucose levels.

**Figure 5: Self monitoring**



### **Section 4 – staying healthy and independent**

We asked people what they thought was important in helping to increase people's independence, helping them to live in their own homes for longer. The key issues appeared to be around social activities and contact with friends and family. This question was asked in the 2008 older people's survey and there is a difference in the results. In 2008 the emphasis was on help having your home adapted, help with personal care and help with the practicalities of running a home.

**Table 3: What keeps people independent responses from 2008 survey and 2017 survey**

Answer Choices	Responses	
	2017	2008
More social activities held in the community	52%	40%
More contact with friends and family	62%	43%
Moving to a new home with care and support linked in	30%	34%
Support for people that care for a relative or friend	52%	60%
Help with the practicalities of running a home	50%	70%
Help with personal care	45%	70%
Access to information on support and services	58%	not asked
Help with having your home adapted	56%	73%

When asked what activities people did to keep them healthy the answers fell into the following categories:

**Table 4: activities that people do to stay healthy**

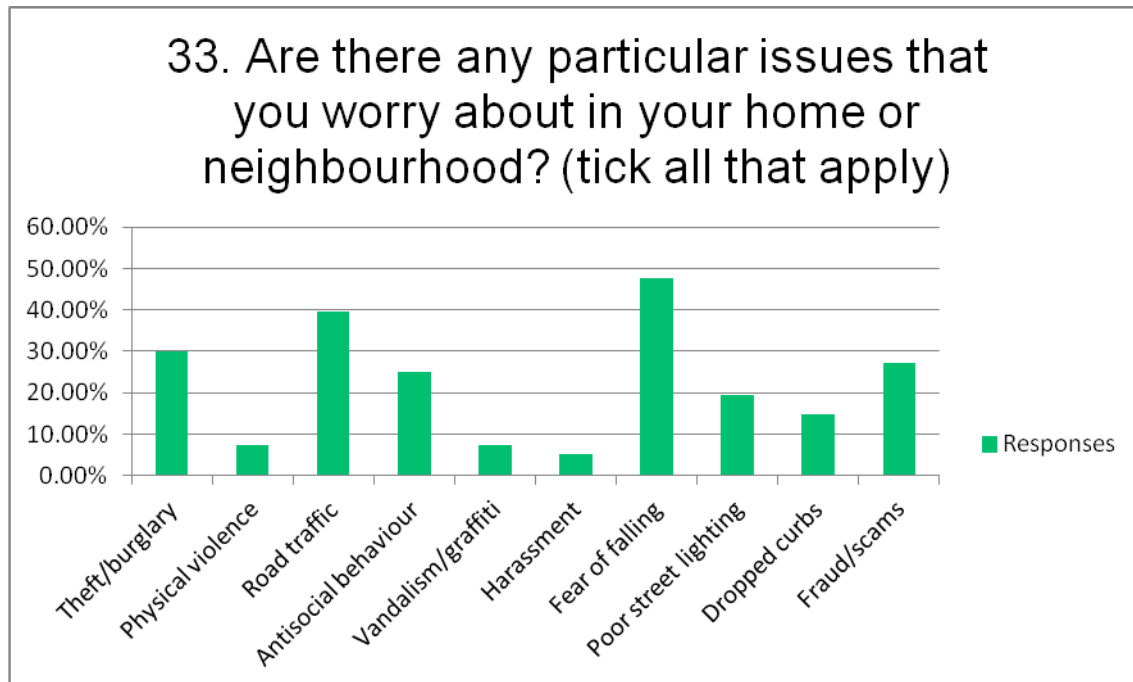
<b>Diet</b>	<b>Eat healthily, diet with fresh fruit and vegetables, include nuts and fruit, eat properly, balanced diet.</b>
<b>Physical Exercise</b>	Gently exercise, keep doing physio exercises, swimming, walking, keep fit classes, cycling, upper body exercises, gardening, dog walking
<b>Mental Exercise</b>	Crosswords, play bridge, keep up with current affairs, sewing and knitting, book club, continuing in employment or volunteering
<b>Outdoor activities</b>	Walking (including dog walking, shopping) and cycling
<b>Indoor activities</b>	Knitting, housework, choir, cooking
<b>Socialising</b>	Keep socially active, looking after grandchildren
<b>Lifestyle</b>	Drinking alcohol to sensible limits, not smoking
<b>Sleep</b>	Sleep well, at least 7 hours sleep.

**Section 5 – Your local community**

**Highlight: 98% of respondents said they feel completely safe or safe most of the time in the area in which they live.**

In terms of the things that people do worry about in their home or their neighbourhood the most common concern is a fear of falling, followed by road traffic.

**Figure 6: What people worry about in their local area**



## Section 6 – Transport

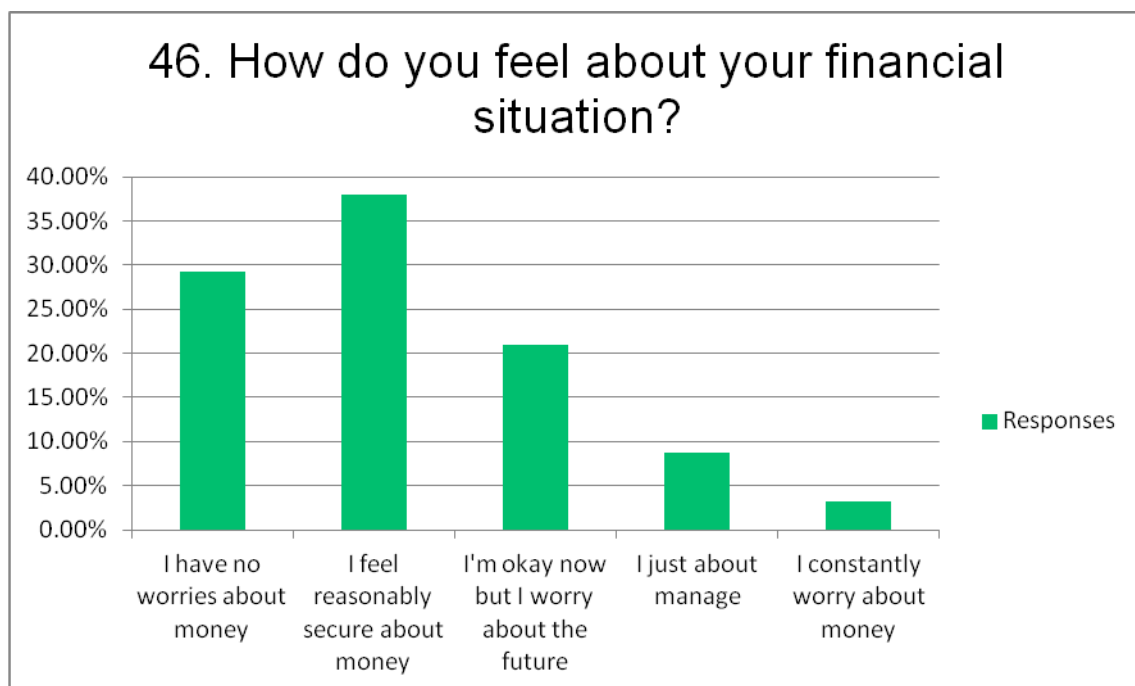
**Highlight: 93% of respondents said they were either very or mostly satisfied with public transport in York.**

When asked about the barriers to getting about in York, the most common responses related to lack of public toilets, seating, condition of pavements, as well as an individuals health condition.

## Section 7 – Finances

**Highlight:** When asked about their financial situation the majority had no worries or were reasonably secure about money. However a significant minority stated that they worried about the future or had current difficulties.

**Figure 7: Perceptions of financial situation**



## Section 8 – Planning for the future

**Highlight:** 85% of respondents stated they had made a will.

However, only 17% had made an advanced directive. Although according to Age UK the figure nationally is only 12% having made an advance directive.

***Conclusion and next steps***

The survey yielded a good response and has enabled an insight into the issues facing older people in York. There will be further analysis to look at all of the questions in the survey and to begin looking at whether there are any differences in responses according to some of the demographic factors. A full report will be made available to members of the Health and Wellbeing Board.

When analysis is complete the report will also make some recommendations. This will aim to inform the development of an action plan to deliver the priorities of the Health and Wellbeing Strategy theme for older people as well as any other additional areas that are highlighted as requiring action. The report will be shared widely with partners in order that they can use the results to inform future service provision and priority areas.





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**Health and Wellbeing Board**

6 September 2017

Report of the Chief Executive of York CVS

**Ageing Well Performance Report****Summary**

1. The attached performance summary (Annex A) outlines the current position against a set of indicators in respect of the Ageing Well theme within the Joint Health and Wellbeing Strategy 2017-2022.

**Background**

2. The performance report is designed to provide a simple view of indicators related to the Ageing Well theme. These indicators relate to the key ambitions and objectives. The narrative provides an update on the context of the indicator and the key activities to deliver change in these areas.
3. As a summary of activity, it does not seek to present every indicator or piece of data, but rather provide an accessible starting point to facilitate discussion.

**Main/Key Issues to be Considered**

4. The key updates are included within the Annex.

**Consultation**

5. CVS Ageing Well Forum regularly meets to discuss the ageing well theme in the joint health and wellbeing strategy; they have formed an operational group to oversee this work.
6. The purpose is to ensure older people views are at the heart of the year one operational plan for the theme with the older people's survey results being a key source of evidence for this activity.

### **Options**

7. This paper does not ask the Health and Wellbeing Board for a decision, so no options are included.

### **Analysis**

8. The analysis of performance and the supporting activity is included at Annex A.

### **Strategic/Operational Plans**

9. This report forms part of the performance management arrangements for the Joint Health and Wellbeing Strategy. Reports in respect of the other key themes will come to future meetings.

### **Implications**

10.
  - **Financial** – There are no specific impacts in relation to this report.
  - **Human Resources (HR)** - There are no specific impacts in relation to this report.
  - **Equalities** - There are no specific impacts in relation to this report.
  - **Legal** - There are no specific impacts in relation to this report.
  - **Crime and Disorder** - There are no specific impacts in relation to this report.
  - **Information Technology (IT)** - There are no specific impacts in relation to this report.
  - **Property** - There are no specific impacts in relation to this report.

### **Risk Management**

11. There are no risks identified beyond the performance narrative within the Annex.

## Recommendations

The Health and Wellbeing Board are asked to:

- i. Note the content of the performance report

Reason: to ensure understanding of the progress made against the Health and Wellbeing Strategy.

- ii. Request any further information on specific areas of work

Reason: to ensure board members have the required level of detail.

## Contact Details

### Author:

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Tel No: 01604 553412

### Chief Officer Responsible for the report:

Sarah Armstrong  
Chief Executive, York CVS  
  
Martin Farran  
Corporate Director Health, Housing and  
Adult Social Care  
City of York Council

Report  
Approved



Date 24.08.2017

Wards Affected:

All

For further information please contact the author of the report

## Annexes

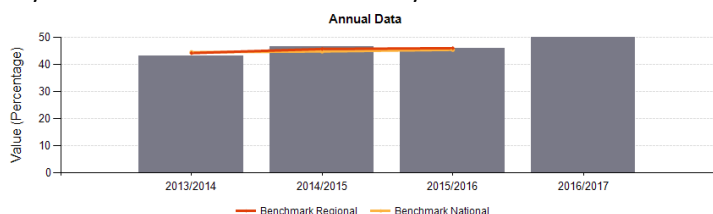
Annex A – Ageing Well Performance Report – September 2017

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We are monitoring progress on:

- more older people telling us they have as much social contact as they would like
- reducing the number of unnecessary admissions to hospital for older people
- reducing the number of delayed discharges from hospital beds
- more older people still being at home 91 days after reablement or rehabilitation
- more volunteering opportunities for older people
- more older people telling us they are happy with the care they receive, and have done the groundwork to prepare for their end of life.

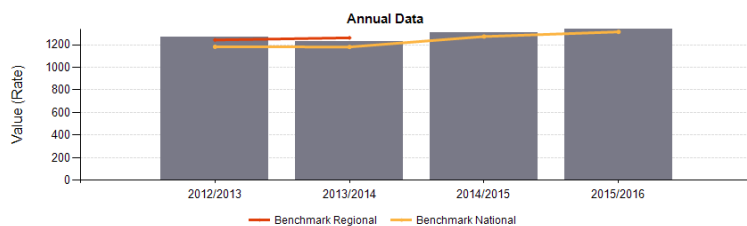
**ASCOF1I1 - Proportion of people who use services who reported that they had as much social contact as they would like**



**Annual Data**

	2014/2015	2015/2016	2016/2017
Proportion of people who use services who reported that they had as much social contact as they would like	46.6	45.8	50
Benchmark - National Data	44.8	45.4	-
Benchmark - Regional Data	45.7	46	-

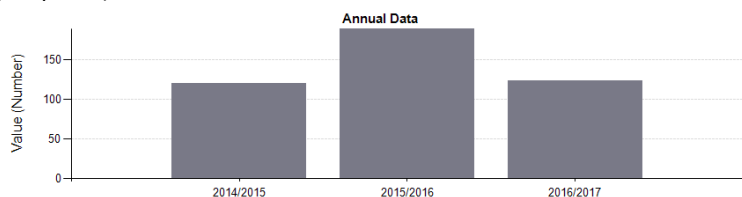
**CCGOIS301 - Emergency admissions for acute conditions that should not usually require hospital admission, per 100,000 registered patients - (VoY CCG)**



**Annual Data**

	2014/2015	2015/2016
Emergency admissions for acute conditions that should not usually require hospital admission, per 100,000 registered patients - (VoY CCG)	1306.6	1336.8
Benchmark - National Data	1273	1314.2

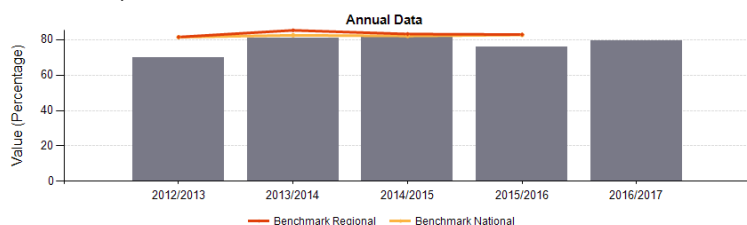
**PVP04 - Total number of Acute delayed discharges (YDH only) - (Snapshot)**



**Annual Data**

	2014/2015	2015/2016	2016/2017
Total number of Acute delayed discharges (YDH only) - (Snapshot)	120	189	124

**ASCOF2B1 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services**

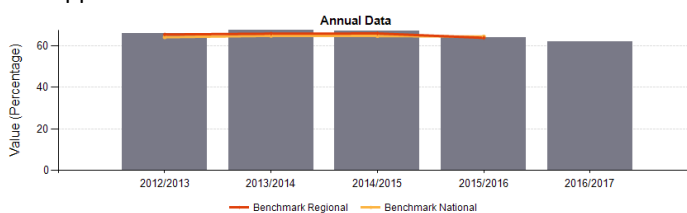


**Annual Data**

	2014/2015	2015/2016	2016/2017
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	81.5	75.7	79.26
Benchmark - National Data	82.1	82.7	-
Benchmark - Regional Data	83.2	82.9	-

More volunteering opportunities for older people – Not collected

**ASCOF3A - Overall satisfaction of people who use services with their care and support**



**Annual Data**

	2014/2015	2015/2016	2016/2017
Overall satisfaction of people who use services with their care and support	67.1	64	62
Benchmark - National Data	64.7	64.4	-
Benchmark - Regional Data	65.9	63.8	-

## Performance narrative and update on actions

### **More older people telling us they have as much social contact as they would like:**

The ASCOF measure (1I1) for 2016-17 shows that 50% of Adult Social Care users surveyed in 2016-17 had as much social contact as they would like. Amongst the Older People surveyed, this increased to 56% amongst those in residential care, but was only 45% amongst Older People in the community. These levels are both higher than those reported in 2015-16 (52% and 37% respectively). The disparity is explained because those in residential care are more likely to have contact with others because of their setting, whereas those in the community are more likely to have to initiate contact with others.

### **Reducing the number of unnecessary admissions to hospital for older people:**

In the year to 31 December 2016, which is the latest data available, there were 1,427 emergency admissions (EAs), per 100,000 registered patients (RPs), to hospital for acute conditions that would not normally require this in the Vale of York CCG area. (A breakdown to the CYC LA area is not possible). This rate has steadily been increasing – in the year to 31 March 2016, it had been 1,337 EAs per 100,000 RPs. The latest data shows that this rate is slightly higher for females (1,476 EAs per 100,000 RPs) than it is for males (1,378 EAs per 100,000 RPs).

### **Reducing the number of delayed discharges from hospital beds:**

There were 22 delayed discharges from York Hospital in the first quarter of 2017-18. This compares with 38 in the corresponding quarter of 2016-17. There has been a major focus in the York health and social care system with reducing delayed transfers of care across both acute and non-acute pathways, with there being a clear downward trend in the amount of time occupied by patients waiting for care packages over the last year; the forthcoming CQC review of the system has provided an impetus for all involved to improve the relevant procedures. The number of days that patients were delayed in YDH awaiting a care package was 35% lower in the first quarter of 2017-18 (1,252) than it was in the corresponding quarter of 2016-17 (1,919); this is for patients of all ages, although older people will make up a sizeable proportion of those.

### **More older people still being at home 91 days after reablement or rehabilitation:**

In 2016-17, the ASCOF measure (2B1) shows that 79.2% of Older People were living at home 91 days after being discharged from hospital, which is an increase from 2015-16 (75.8%). However, this indicator only measures discharges in one quarter (Q3) each year, and it does not take account of people dying within the 91 day period that would otherwise have counted as “successes”; York had a relatively high number of these people in 2016-17 compared to other LAs in Yorkshire and the Humber. Service managers advise that – generally speaking – they feel that this percentage would be higher if it was measured on a year-round basis.

### **More older people telling us they are happy with the care they receive:**

The ASCOF measure (3A) for 2016-17 reported that 62% of Adult Social Care users surveyed in 2016-17 were “extremely” or “very” satisfied with their care and support. Amongst Older People surveyed, 66% of those living in residential care reported these levels of satisfaction, but only 55% of those living in the community did. This represents a decrease from the 2015-16 level for those in residential care (74% said they were “extremely” or “very” satisfied) but an increase on the 2015-16 level for those in the community (52% reported being “extremely” or “very” satisfied with their care). Again, the disparity is likely to arise because of the amount of contact each group has with a service supported by Adult Social Care.



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**Health and Wellbeing Board**  
Report of the Manager; Healthwatch York

6<sup>th</sup> September 2017

## **Developing Co-Production in York**

### **Summary**

1. This report provides the Health and Wellbeing Board with a progress update on developing an approach to co-production that can be used by all partners across the health and social care system in York.

### **Background**

2. At the November 2016 meeting of Health and Wellbeing Board the Board committed to following a co-design and co-production approach for all future major changes to health and social care services (in line with the Social Care Institute of Excellence definition).
3. Co-production is a way of delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours (New Economics Foundation). It can be defined as designing, reshaping or delivering services in equal partnership with the people who use them in order to create better services and outcomes.
4. In order to support members of the Health and Wellbeing Board with this approach, City of York Council agreed to work with Healthwatch York to develop a co-production strategy for the city.
5. Using existing documents and guidance an initial rough draft was produced and in the spirit of co-production preliminary engagement undertaken to collect comments and thoughts from both residents and stakeholders at an early stage.
6. This engagement and awareness raising took place during National Co-Production Week in July 2017 with City of York Council,

Healthwatch York and International Service working together to hold an event entitled People and Places: York goes Global.

7. The event was well attended and comments and suggestions were received at the event via table top discussion and also via a short survey circulated after the event.
8. Table discussions were focussed around a number of questions with the concept of co-production itself being very much supported and a clear message of *'for the people, by the people, because of the people'* at the heart of this.
9. There were a number of comments and concerns raised around the practicalities of services and/or organisations working together; how best to agree common objectives; ensuring that co-production wasn't just a tick box exercise and a strong concern around ensuring everyone had the appropriate support to equally contribute. The event in particular recognised that residents should not merely be perceived as passive recipients of services but as active citizens contributing to new approaches and co-designed services and a challenge to agencies to recognise and celebrate this.
10. This strategic direction would complement York being recognised as 'an asset based place' where we have strong, resourceful and connected people – and are recognised as a hub of place based social action, informed by principles of co-production. This approach and thinking complements the 'People and Place - strength based approaches and collaboration' conference held in May and co-hosted by City of York Council and the National Local Area Coordination Network.
11. Some examples of good practice in the city were also referred to and these included the development of the safe haven which had been identified as a need by service users and developed by service users.
12. Additionally there were a significant number of comments in relation to using accessible language in any document produced.
13. The above are a snapshot of the most common themes emerging from the preliminary engagement. All comments received will now be collated and analysed in a thematic way and used to progress this piece of work through its next stages. Consideration will also be given to good practice used in other areas.



14. Some comments have already been used to rewrite the initial draft co-production document and this second draft is attached at **Annex A** to this report.

### **Main/Key Issues to be Considered**

15. When this piece of work was first started there was an intention to develop a co-production strategy for the city. Having considered the comments received to date and the purpose of any strategy produced (including how a strategy on co-production could be delivered) it would seem more appropriate to develop a set of guiding principles/approach to working as an alternative option based on **Annex A**. These principles could be used by all organisations within the city and could sit alongside and complement the common design principles being developed through the Future Focus work; and the work of the Central Locality Delivery Group.
16. Whilst not yet explored in any detail, a programme of work could be developed to enable the principles to be embedded throughout organisations across the city.

### **Consultation**

17. Preliminary engagement has taken place as described in the paragraphs above.

### **Options**

18. Health and Wellbeing Board are asked to comment on the draft at **Annex A** and agree that this work progresses to a third draft (using the comments already received to shape it) and then to proceed to formal consultation.

Additionally the Board has, at this stage, the following options:

**Option A:** Change the focus of this piece of work and agree to the development of a set of guiding principles for co-production, or;

**Option B:** Proceed as originally intended and develop a co-production strategy for the city

### **Analysis**

19. Having considered the comments received to date from residents and partners it would seem that the best way forward would be to raise awareness and increase understanding about how and why we should be co-producing and co-designing services together. This would be better achieved by developing a set of guiding principles that can then be embedded across numerous organisations in the city rather than producing a strategy.
20. Should **Option A** be approved by the Health and Wellbeing Board work can begin immediately on reviewing **Annex A** to convert this into a set of guiding principles that can then be consulted on. As part of this consultation there would be an opportunity to not only seek views on the document itself but to ask for views on how best to embed the principles across the different organisations in the city.

### **Strategic/Operational Plans**

21. In order to deliver the priorities and commitments in the joint health and wellbeing strategy there is a need to transform the way organisations within the health and social care system work with individuals and each other. The joint health and wellbeing strategy commits to continuing this transformation in a co-productive way.
22. All future strategies and operational plans for the local health and social care system should endeavour to have co-production at their core.

### **Implications**

23. There are no implications associated with the recommendation in this report. However, implications may arise as this piece of work develops.

### **Risk Management**

24. There is a risk that the services provided to our local residents will not be the services they need if service changes aren't carried out using the guiding principles of co-production.

### **Recommendations**

25. The Health and Wellbeing Board are asked to comment on the draft document at **Annex A** and approve **Option A** to change the focus

of this piece of work and agree to the development of a set of guiding principles for co-production.

26. Additionally they are asked to agree that this work progresses to a third draft (using the comments already received to shape it) and to then proceed to formal consultation.

Reason: To keep Health and Wellbeing Board up to date with ongoing work around co-production.

### Contact Details

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**Specialist Implications Officer(s)** None  
*Tel No.*

**Wards Affected:**

**Chief Officer Responsible for the report:**

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

**Report  
Approved**



**Date** 24.08.2017

**All**

**For further information please contact the author of the report  
Background Papers:**

### Annexes

**Annex A:** Draft Approach to Co-Production Document

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## Co-production – The Approach for York

### What is co-production?

*The term co-production refers to a way of working, whereby everybody works together on an equal basis to create a service or come to a decision which works for them all.*

*It is built on the principle that those who use a service are best placed to help design it.*



### What is great about co-production?

- \* Everybody is equal.
- \* The outcomes are meaningful and positive.
- \* People who use your services, carers and families are seen and recognised as assets.
- \* Your service will improve.
- \* It is a fun and productive way of working together.
- \* You have the opportunity to see different perspectives that may differ from your own.

### What is important for co-production?

#### 10 Top tips

1. Co-production must start as an idea that blossoms with everybody involved having an equal voice.
2. Come to the table with a blank agenda and build it with people who use your service, their carers and families.
3. Involve people who use services, carers and their families in all aspects of a service – the planning, development and delivery.
4. In order to achieve meaningful, positive outcomes, everybody involved must have the same vision, from front line staff to management/board members.
5. Start small and build up to bigger projects, letting people lead, not professionals.
6. Acknowledge that a range of skills are needed for co-production.
7. Recruit the right people that support co-production.
8. People who use services, carers and families should be clear about what their expectations are and be fully engaged in the process.
9. People who use services and their carers know what works, so you can't get it right without them.
10. Don't take responsibility for solving every problem—allow the group to find collective solutions.

### How can you support co-production?

- \* Ensure appropriate and adequate resources are available to support co-production (participation fees, expenses, easy read documents and access needs).
- \* Ensure frontline staff have everything they need to for co-production, including time and flexibility.
- \* Ensure no one group or person is more important than anyone else. Everyone can contribute given the right support.
- \* It is important to have good facilitation and listening skills, and to reflect and act upon what is heard.
- \* Acknowledge and respect what people who use services, their carers and families say.
- \* Ensure everything in the co-production process is accessible to everyone taking part.
- \* Before you start the work, decide together how you are going to work and what will make it successful, then stick to it.
- \* Accept that sharing power means taking risks. Take a chance!
- \* Learn to share power. Doing things differently means we can work across a whole range of issues that confront us.
- \* Work with the group to support a clear set of identified values with a collective sense of direction.
- \* Don't use jargon or acronyms, plain English is better for everybody.
- \* Create the expectation that people who use services, carers and families will be involved in every aspect of service planning, design/development and delivery at every level.

## What is co-production?

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours" (New Economics Foundation).

Co-production is defined as designing, reshaping or delivering services in equal partnership with the people who use them in order to create better services and outcomes.

There are 4 key principles of co-production. These are:

- Seeing people as assets
- Recognising the core economy
- Promoting reciprocity
- Building social networks

Social Care Institute of Excellence define these as equality, diversity, accessibility and reciprocity.<sup>i</sup>

## Developing Co-production

### ***People at the heart of getting things done***

Co-production recognises that everyone has an important contribution to make. It recognises that when we value people's lived experience equally alongside professional expertise, this leads to better, shared solutions.

### **Plan**

We can work out what is needed and develop ways to meet gaps with our service users and communities by holding open conversations.

### **Do**

We want to make sure that what we build together includes ways that individuals and communities can contribute to their own support.

### **Review**

We will listen to feedback and comments from those using services to tell us how it's doing. We will involve people directly in monitoring services.

### **Analyse**

Again consultation and feedback from the ground up supports the decisions about any changes that need to be made for the future commission.

## Getting started

We are already delivering lots of work in a co-produced way. Our next steps are to make sure this way of working becomes York's usual way. We need to work together to raise awareness of co-production, and publicise ways to be involved.

## More information

There is lots of useful information available online, particularly through Think Local Act Personal - <http://www.thinklocalactpersonal.org.uk/> and the Social Care Institute of Excellence - <https://www.scie.org.uk/>.

Six principles for engaging people and communities:

<http://www.nationalvoices.org.uk/node/1481>

At the heart of health:

[http://www.nesta.org.uk/sites/default/files/at\\_the\\_heart\\_of\\_health\\_-\\_realising\\_the\\_value\\_of\\_people\\_and\\_communities.pdf](http://www.nesta.org.uk/sites/default/files/at_the_heart_of_health_-_realising_the_value_of_people_and_communities.pdf)

Engaging and empowering communities:

<http://www.thinklocalactpersonal.org.uk/assets/Resources/BCC/EngagingAndEmpoweringfinal.pdf>

NHS Clinical Commissioners

<http://445oon4dhpii7gjvs2jih81q.wpengine.netdna-cdn.com/wp-content/uploads/2015/05/NHSCC-Engaging-the-Public-Final.pdf>

Creating person centred organisations

[http://www.ideaswa.net/upload/editor/files/creating\\_a\\_person-centred\\_organisation\\_helen\\_sanderson.pdf](http://www.ideaswa.net/upload/editor/files/creating_a_person-centred_organisation_helen_sanderson.pdf)

## Key indicators of co-production

- You have identified a problem or a question to explore not an answer to it

- You have a clear mechanism for bringing people together throughout the project, not just at the beginning and the end – engagement is embedded throughout
- Venues are varied and go beyond statutory offices and services
- Initial conversations involve a wide range of stakeholders, including people directly affected by the problem, front line staff, and local bodies with an interest in the work
- There are opportunities to bring more people in as ideas grow
- The discussion is open and transparent, approached with curiosity and a desire to explore
- The scope and expectations are clear
- The work is an equal partnership

<sup>i</sup> <http://personcentredcare.health.org.uk/overview-of-person-centred-care/what-person-centred-care>

<sup>ii</sup> <http://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/defining-coproduction.asp>

<sup>iii</sup> <http://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/principles-of-coproduction.asp>

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**Health and Wellbeing Board**

6 September 2017

Report of the Joint Chair(s) of the York Better Care Fund (BCF) Performance and Delivery Group.

**Status report on the draft plan for 2017/19:****Summary**

1. This report updates the Health and Wellbeing Board (HWBB) on progress in relation to the development of the BCF submission for 2017/19.
2. Also included is a final performance metrics table showing the position against the national and local metrics for 2016/17 (**Appendix 1**)

**Main/Key Issues to be considered****Guidance**

3. All guidance has now been received including: timetable for submission of plans; model narrative templates; planning return template and Key Lines of Enquiry (KLOEs).
4. There remain some queries on some of the assumptions relating to technical definitions for the calculation of metrics which have been flagged to NHS England. In the meantime, plans are being developed based on information received to date.

**Progress to date**

5. A balanced plan has been agreed including the 'source' and 'application' of funds.
6. As a system we have agreed how to use the additional monies made available through the national £2bn social care grant monies.

Strategically, the plan looks to support improved outcomes in health and social care through:

- Early intervention/prevention
  - Using the community assets and resources to support people to maintain their independence
  - Prevent admission to hospital and reduce delayed transfers of care
7. Detailed discussions about what schemes should be included within the BCF over the next two years have taken place within the multi-agency BCF Task Group. A number of sessions have focused on challenging proposed investments to ensure there is compliance with national BCF and iBCF guidance on priority areas for investment.
  8. As a system we have recognised the financial pressure that the individual organisations face which, in turn, impacts us collectively. We have developed a set of investments that maintain existing services as well as looking to new opportunities that contribute to shared strategic plans.
  9. The current draft narrative (attached at **Appendix 2**) is being shared with members during the development phase to allow for consideration before being finalised. This document requires more detail and further review before being considered a complete and full plan. The submission date for the final narrative is 11 September 2017.
  10. Health and Wellbeing Board members are aware of the forthcoming local system review by the Care Quality Commission (CQC). A briefing for partners is attached at **Appendix 3**.

### **Key differences between the 2016/17 and 2017/19 plan**

11. National conditions have been reduced to the following four:
  - That a BCF Plan, including the minimum of the pooled fund specified in the Better Care Fund allocations, should be signed off by the HWB itself, and by the constituent local authorities and CCGs, and with involvement of local partners
  - A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum

contribution to the fund in 2017/18 and 2018/19, in line with inflation

- That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement
- Implementation of the High Impact Change Model for Managing Transfers of Care

12. Local metrics have been removed as a requirement for national reporting. At a local level, the performance dashboard will continue to include local metrics on falls and will be extended to provide more detail on the impact of the schemes within the system. This is in line with the Board's agreement for on-going quarterly monitoring at the May meeting.
13. Locally, there is no risk share in place for any portion of the fund in 2017/19.

### Local funding contributions

14. Overall, the pooled fund has increased in line with improved Better Care Fund allocations. The CCG minimum allocation has been maintained alongside Care Act monies. The total agreed funding contributions are set out below:

<b>Funding Contribution</b>	<b>15/16 Actual</b>	<b>16/17 Actual</b>	<b>17/18 Proposed</b>	<b>18/19 Proposed</b>
LA Minimum (DFG)	0.951	1.003	1.101	1.101
LA Additional (iBCF and iBCF supplementary funding)	0.000	0.000	2.847	3.735
CCG Minimum (includes reablement and carers breaks)	3.354	3.412	3.473	3.539
Care Act	0.444	0.454	0.454	0.454
CCG Additional	7.378	7.334	7.473	7.624
<b>Total pooled fund (£M)</b>	<b>12.127</b>	<b>12.203</b>	<b>15.348</b>	<b>16.551</b>

## Local plan development/high level scheme

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

Step 1 – Existing schemes maintained (following high level review)

Step 2 – Full year effect (FYE)/recurrent commitment costs applied

Step 3 – Risk share costs absorbed

Step 4 – Inflation/growth applied if applicable

Step 5 – System wide schemes identified and added

Step 6 – Additional new schemes agreed and added

16. This methodology supports the following investment profile:

Investment Profile	16/17 Actual	17/18 Proposed	18/19 Proposed
Existing schemes maintained	12.203	12.203	15.348
FYE/Recurrent commitments	0.000	723	658
Risk share costs absorbed	0.000	1.227	0.000
Inflation/growth applied	0.000	104	126
System wide schemes	0.000	667	0.000
Additional new schemes	0.000	424*	571**
<b>Total pooled fund (£M)</b>	<b>12.203</b>	<b>15.348</b>	<b>16.551</b>

\*£424K includes £152K potentially available following detailed review in 2017/18 of schemes

\*\*£571K includes FYE of £152K potentially available following detailed review in 2017/18 of schemes

17. A more detailed investment schedule is provided within the BCF narrative plan.

## **Next Steps**

18. Completion of the narrative plan and detailed planning return template for submission by 11 September 2017.
19. Sign off of the final narrative plan, via delegated authority, by the Chair and Vice-Chair in conjunction with senior officers at the CCG and City of York Council - as agreed at HWBB meeting of 17 May 2017.
20. Consideration and response to feedback from NHS England from submitted plan in line with national timescales.
21. Progression of Section 75 to support the jointly agreed plan by 30 November 2017.

## **Consultation**

22. The issues summarised in this report have been subject to discussion and agreement involving a wide range of partner organisations within York and North Yorkshire.

## **Options**

23. There are no options provided in this report.

## **Strategic/Operational Plans**

24. The BCF plan is part of wider strategic plans of all partner organisations, including the CCG and CYC and should not be considered in isolation.

## **Implications**

25. One of the key challenges facing partners is our stated desire to progress shared initiatives and grow the level of pooled resource whilst managing the on-going system pressure.

## Risk Management

26. The BCF is part of a wider set of risks as the system moves towards implementation of strategic plans.
27. A revised risk log will be developed as part of the final narrative and will be monitored via the BCF Task Group.

## Recommendations

28. The Health and Wellbeing Board are asked to note the issues set out in this report:

Reason: HWBB oversight of BCF

## Contact Details

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### Chief Officer Responsible for the report:

Phil Mettam  
Accountable Officer  
Vale of York CCG  
01904 555870

Report  
Approved



Date 24.08.2017

Wards Affected:

All

## Background Papers:

None

## Annexes

- Annex 1 – 2016/17 performance dashboard  
Annex 2 – BCF 2017/19 narrative  
Annex 3 – Partner briefing - local system review by the Care Quality Commission

**Glossary**

BCF – Better Care Fund

CHC – Continuing Health Care

CCG – NHS Vale of York Clinical Commissioning Group

CYC – City of York Council

DFG – Disabled Facilities Grant HWB – Health and Wellbeing Board

NEA – Non-Elective Admissions

TEWV – Tees, Esk & Wear Valleys NHS Foundation Trust

YFT – York Teaching Hospital NHS Foundation Trust

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## 2016/17 Performance Metrics Table

\*Data taken from BCF Task Group Dashboard as of 31 March 2017

Metric type	Metric description	Target	Q1 position	Q2 position	Q3 position	Q4 position	Year End Position	Performance
National:	Reduction in non-elective admissions (General & Acute)	20,781	5,530	5,639	5,739	5,731	22,639	Deteriorating/ Missed target
*Local metric (outwith routine reporting framework)	Reduction in non-elective admissions (General & Acute) *National data adjusted for Ambulatory Care Recording issues	20,781	5,063	5,220	5,317	5,319	20,919	Static/ Missed target
National:	Delayed Transfers of Care: Number of bed days per 100,000 of population	9,837	2,497	2,889	3,117	2,032	10,535	Deteriorating/ Missed target
National:	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population	657.8	189	184	143	153.6	669.6	Improving/ Missed target
National:	Number of permanent admissions to residential & nursing care homes for older people (65+)	238	70	68	53	57	248	Static/ Missed target

## 2016/17 Performance Metrics Table

\*Data taken from BCF Task Group Dashboard as of 31 March 2017

National:	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	0.758	NO DATA	NO DATA	NO DATA	0.793	NO DATA	Improving/ Above target
Local:	Injuries due to falls in people aged 65 and over per 100,000 population	2,454.7	591	641.6	588.4	665.6	248.6	Static/ Missed target
Local:	Injuries due to falls in people aged 65 and over (actuals)	922	222	241	221	250	934	Static/ Missed target
Local:	Overall satisfaction of people who use services with their care and support	0.664	NO DATA	NO DATA	NO DATA	0.62	NO DATA	Deteriorating/ Missed target

**Integration and Better Care Fund****Narrative Plan Template 2017/19*****Better Care Support Team***

Area	<b>York</b>
Constituent Health and Wellbeing Boards	<b>York Health and Wellbeing Board</b>
Constituent CCGs	<b>Vale of York CCG</b>

<b>Action/ amendment</b>	<b>Who By</b>	<b>Date</b>
Blank template updated with VOY details/existing narratives	Elaine Wyllie	21/8/17
Updated template with info from CYC colleagues	Elaine Wyllie	28/8/17
Updated template with further revisions from CYC colleagues	Elaine Wyllie	30/8/17

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## Introduction / Foreword

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

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

- ✓ York Integrated Care Team
- ✓ Reablement services
- ✓ Integrated place based commissioning
- ✓ Local area co-ordination
- ✓ Focus on well-being
- ✓ More self-care, self-management

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

- A long standing challenging financial picture across the commissioner and provider base
- A high level of reliance on hospital based services by the public
- An acute trust provider that has historically delivered good performance but is now facing significant financial challenge and deteriorating performance
- A high level of self-funders using care home services
- A vibrant retail and tourism sector which impacts on the available workforce
- An articulate and well-informed population who demand access to statutory services

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

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

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

**Our local vision and approach for health and social care integration?**

Our local vision is embodied within the Joint Health and Wellbeing Strategy which has been reviewed and updated for the period 2017 to 2022 [\[insert hyperlink to the document off CYC website\]](#). The review has taken into account the views of local residents, intelligence from the Joint Strategic Needs Analysis (JSNA); local plans and wider system plans.

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

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

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

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

The vision for the Humber, Coast and Vale Sustainability & Transformation Plan

(STP) [\[insert hyperlink to relevant document\]](#) reflects similar themes to that of the local HWB strategy: To be seen as a health and care system that has the will and the ability to help people 'start well, live well and age well'. To achieve the STP vision we aim to move our health and care system from one which relies on care delivered in hospitals and institutions to one which helps people and communities proactively care for themselves. The STP plan focuses on the wider determinants of health in our footprint, with all public services working together to support people to take more responsibility for their own health.

The wider system (STP) approach is to develop new models of care across the constituent population, supported by strategic commissioning across the acute health system. This builds on the ideas put forward in the Five Year Forward View and best-practice national and international examples of whole population management and outcomes-based commissioning for health and social care.

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

**Table 1: Four Themes for Health & Wellbeing in York 2017- 2022**

### **Moving towards fuller integration by 2020**

A priority for the York footprint is to deliver improved outcomes for the population

within the context of the demographic, cost and demand pressures faced by the health and social care system. There is recognition that these pressures, together with the financial context of the statutory agencies requires a whole system approach to transformation and the development of a single medium term financial strategy (MTFS) for the system. The York HWB operates in the context of significant community assets supported by a strong and vibrant third sector presence.

**How will our local vision be achieved?**

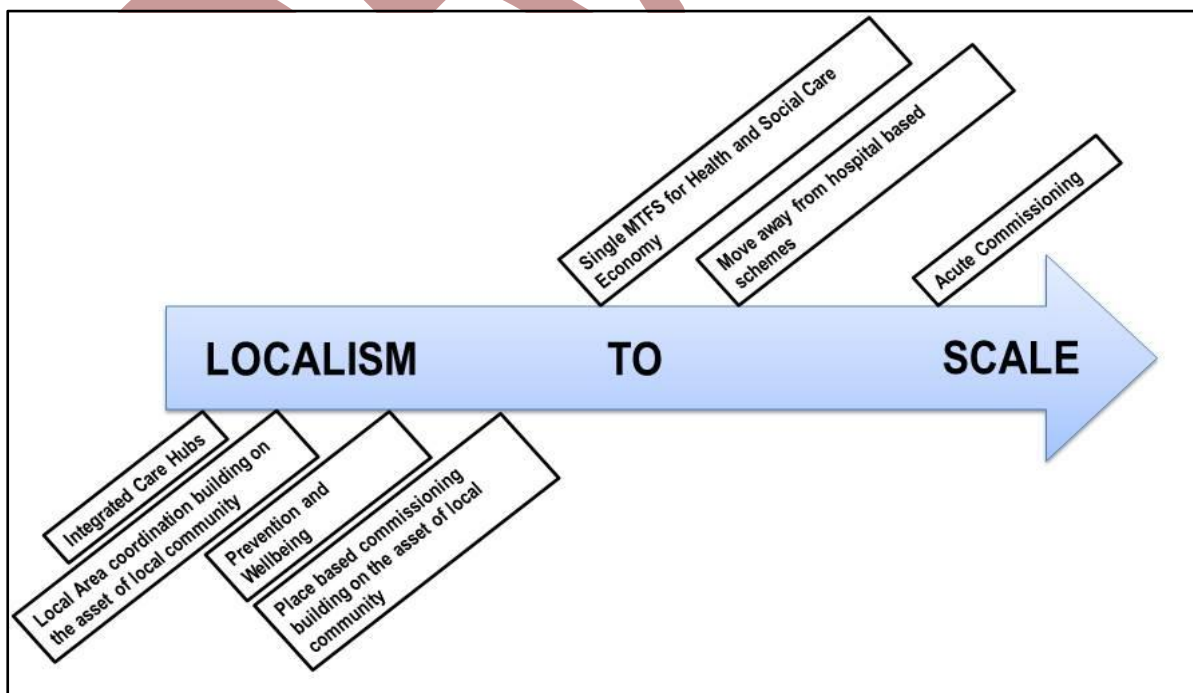
***System first, organisation second***

The Better Care Fund continues to influence how we join-up health and social care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

However we cannot rely on the BCF on its own to resolve some of the complex pressures facing our joint health and care system. A whole system approach is needed if we are to deliver our vision for 2020. The most fundamental change facing the system requires a shift away from statutory agencies meeting needs through the provision of services and medical interventions, towards working with individuals and communities to support self-help and self-care. This will require all agencies to shift the focus of commissioning activity upstream towards early intervention and prevention.

***Combining the benefits of scale and localism***

We want to use the resources available to us in the most effective manner possible. This means that we will use our assets at scale or locally, depending upon the outcomes we are trying to achieve. Graphic1 sets out the approach we will take across this continuum for different aspects of health and social care.



**Graphic 1: Localism to Scale**



***Prevention through self-care and self -management***

**Insert text**

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### Background and context to the plan

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

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

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

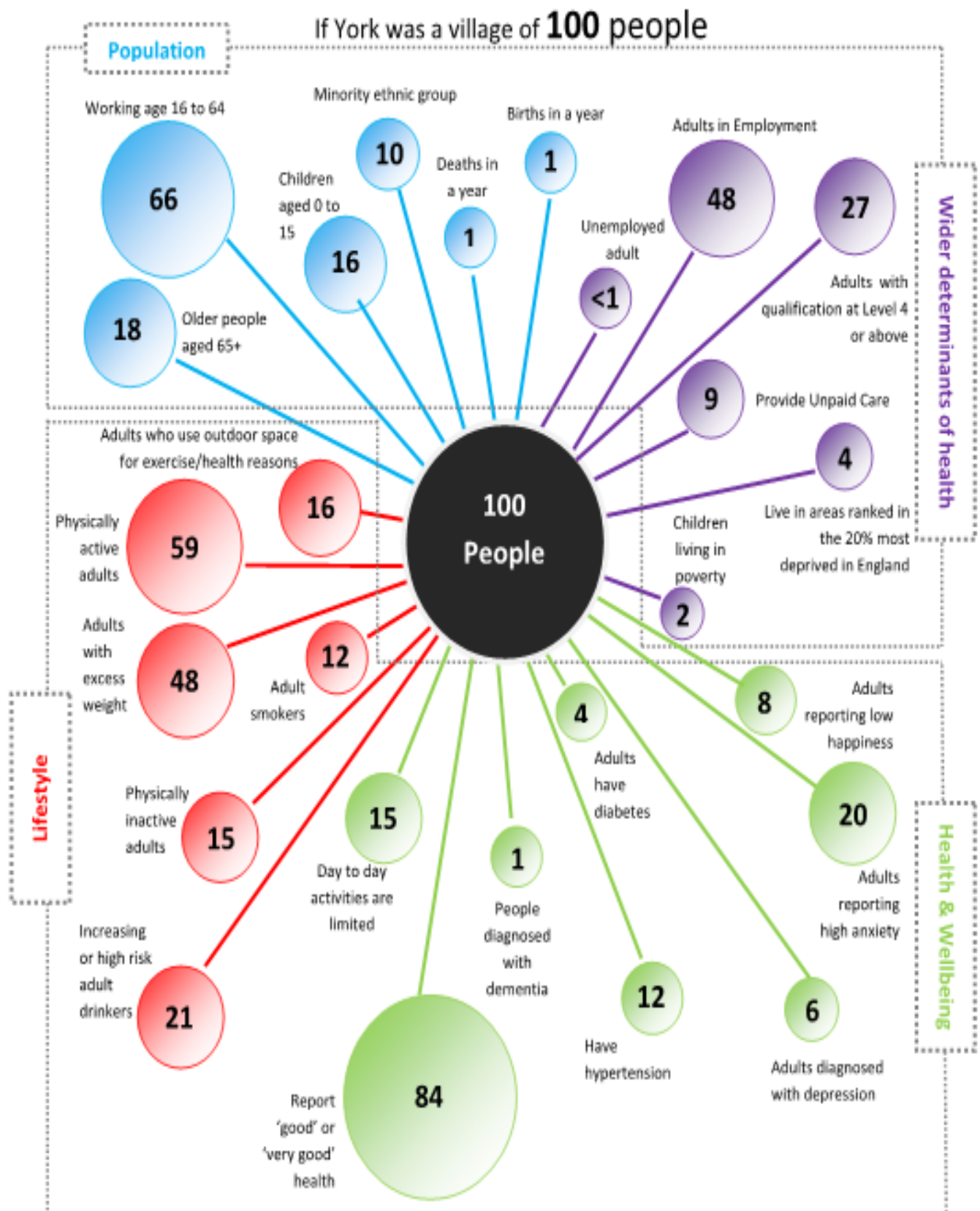
The city has become more culturally and religiously diverse with a Black and Minority Ethnic (BME) population of 9.8% (non-White British) compared to 4.9% in 2001. If we look at 'York in a nutshell' (see Graphic 2) we can illustrate what the composition of York would be like if it was a village of 100 people based on available data. (October 2016). **[insert ref: Page 5 of HWB Strategy]**

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

Despite this picture the following challenges remain:

- a) **Health inequalities exist** and there are communities for whom health and wellbeing fall short of those enjoyed by the majority. The difference in life expectancy between the most and least deprived is 7.7 years for women and 5 years for men.
- b) **People who experience mental ill health are still not consistently getting the services they need.** A new mental health/dementia strategy is in draft stage to steer the development of services that meet people's needs going forward. This strategy will recognize the need for physical and mental health services to be more closely aligned than they are currently.
- c) **A high level of reliance on hospital based services by the public.** The 26 GP practices that deliver primary care in the locality have been assessed as 'good' and there has been a focus on integrated care solutions wrapped around primary care models of delivery.

Graphic 2: 'York in a nutshell'



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

- d) An **acute trust provider that has historically delivered good performance but is facing significant financial challenge and deteriorating performance**. The development of the accountable care system, underpinned by the Accountable Care Partnership Board, is demonstrable progress towards integrated commissioning arrangements and joint delivery models across health and social care partners.
- e) **Significant financial challenges faced by both the CCG and the council**. The focus on early intervention and prevention is a helpful driver for aligning CCG and CYC financial plans. The role of public health is pivotal in this regard, alongside the opportunity gained from developing existing forums within the third and voluntary sector.

### **BCF - Local Context**

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

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

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

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

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

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

Although challenging, this context provides a significant opportunity for agencies to

tap into the assets that exist with the local population and wider community. York has a demonstrable history of community benevolence with over 1000 voluntary sector agencies operating across the population.

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## **Integration: Progress to date**

A Joint Commissioning Strategy was approved by the York HWB in January 2017 [CHECK DATE and INSERT HYPERLINK TO DOCUMENT] This is a high level strategy which sets out why and how we will work together in the period to 2020 to commission health and social care services for children, young people and adults. It is designed to provide a framework within which specific strands of joint commissioning work will take place, including the schemes linked to the BCF.

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

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

The first annual joint commissioning plan, currently in development to align with the usual business planning cycle, will set out priorities for joint commissioning work, with specific plans for the actions to be taken to deliver the plan. Identifying key actions, agreeing individual lead commissioning responsibilities, engaging with providers and the community, and setting timescales for action in relation to these strands of work is the immediate focus for the Head of Joint Commissioning.

### **Key outcomes include:**

- The integration of community based health and care services and delivery through local care hubs including mental health care support
- The development of integrated assessments and care plans for vulnerable adults
- A single pathway and pooled budget for reablement and intermediate care
- Integrated personal budgets for health and social care, to promote choice and personalisation
- Development of a single integrated pathway for Continuing Health Care
- Creation of a pooled budget and joint commissioning arrangements for mental health and learning disabilities
- Agreement on, and implementation of, an approach to incrementally shift funding towards early intervention and prevention

Governance and leadership arrangements in place to support the development of joint commissioning can be found in Appendix x.

Joint delivery of services or wider partnerships to date can be evidenced by:

- Archways - relocation of social work teams to a shared facility with community service staff is proving beneficial and increasing integration at service delivery level
- Prevention Partnership – Although early days, a forum to bring third sector providers together has been established which will allow commissioners and providers to develop ways to further increase partnerships, look at new ways of working across partners and identifying further opportunities to develop the community assets available in York
- Integrated teams – the York Integrated Team, funded from the BCF initially as a pilot across one GP practice population, has now been rolled out to cover the full population registered with GP practices within the City. This service works directly with practices and A & E to support case management of those at high risk of readmission in order to reduce non-elective admissions and speed up discharge.

#### **How has the BCF helped with integration?**

It is important to recognize that the BCF plan/funding is one slice of the wider health and social care system and, as such, a direct correlation between a

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

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

During 2017/19 the BCF plan figures prominently in the wider integration agenda underpinned by robust governance arrangements to support delivery. A high level review of current governance arrangements across the system has been undertaken, which has resulted in a clear understanding of the partnership arrangements that are in place to support the different levels of system change required. Commissioners are clear that the HWB is statutorily responsible for oversight of the BCF with a need to manage any resource effectively through shared commissioning and programme management functions. This is a shared strategic intent and is being progressed at pace to support delivery in-year.

The BCF Performance and Delivery Group was established in 2016 and remains in place as the 'engine room' for the BCF plan. Other groups are a critical part of the wider system such as the Complex Care Discharge Group which sits within the A &

E Delivery Board architecture and the Central Locality Delivery Group. The connections between these groups are described in more detail in Section XXX.

Regular reports on progress in relation to metrics and performance have been provided to the HWB over the last year with agreement by the Board in May 2017 to extend the performance dashboard to include greater detail on the impact of schemes within the wider system for 2017/19. Table XXX sets out the final year end performance for 2016/17 which shows that the majority of the indicators did not achieve the target set in the plan showing that further improvement is required.

Metric type	Metric description	Target	Q1 position	Q2 position	Q3 position	Q4 position	Year End Position	Performance
National:	Reduction in non-elective admissions (General & Acute)	20,781	5,530	5,639	5,739	5,731	22,639	Deteriorating/ Missed target
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Local:	Overall satisfaction of people who use services with their care and support	0.664	NO DATA	NO DATA	NO DATA	0.62	NO DATA	Deteriorating/ Missed target



**Table XXX: Summary of 2016/17 Performance Metrics**

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## Evidence base and local priorities to support plan for integration

The changes in demographics in York means that the Council has to take a proactive approach and has already started a process to re-design their operating model focusing on prevention, reducing and delaying the need to access statutory care and support provision. The Council is focused on meeting locally identified need by listening to the voice of local people and providing the means by which local groups can develop and flourish. Demographics show that there are 2,700 older people in York with dementia, this is set to grow to around 3,500 in the next 10 years, across York 14,000 live alone, this is set to grow to 16,000 by 2027 and there are an estimated 2,500 people over 65 providing 20 hours or more unpaid care each week. By 2025, it is estimated that that this level of care provided by older people will increase by 16%. These are just some of the challenges that the social care market faces in York.

The Council is currently revising their Market Position **Statement [INSERT HYPERLINK TO CURRENT MPS]** but there are a number of key messages emerging;

- There is an ongoing and continued pressure on providers to recruit and retain paid carers in a “full employment city”
- The Council’s commitment to maximising independence to prevent, reduce and delay access to care services
- That information and advice provision needs to be well developed to meet the cities aspirations of promoting independence, choice and control
- That we need with partners to greater understand the needs of self-funders which present a challenge to the City in terms of numbers and service requirements
- That York has a strong established process for monitoring the quality of service provision and supporting providers that may be struggling

From a health and wellbeing perspective we know that:

- York has a higher rate of emergency hospital admissions for intentional self-harm than the national average
- 3.8% of York’s population live in areas that are among the most deprived in the country. Childhood obesity affects more children in our most deprived wards. There are also poorer health and wellbeing outcomes for certain vulnerable groups, e.g. the gypsy and Roma community and the lesbian, gay, bisexual and transsexual (LGBT) population.

As a system we have recognised the financial pressure that faces individual organisations which, in turn, impacts us collectively. For 17/19 we believe we have developed a set of investments that maintain existing services as well as looking to new opportunities that contribute to shared strategic plans.

## Evaluation of 16/17 schemes

16/17 schemes were evaluated using agreed metrics and key performance indicators against their individual aims that reflect the focus on reduction of non-elective admissions in accordance with the Better Care Fund grant determination for 16/17.

### Challenges

- Recruitment and Retention of staff across the care sector in a city which has full employment
- High costs of care due to local economy
- Increased needs of customers resulting in higher average levels of care packages
- The care home market is 70% self-funded leaving the local area with an underdeveloped and under-stimulated provision of care homes

### Successes

Reablement – The service has been recently re-commissioned and a revised specification developed. This will include a pathway for people to be assessed at home following a stay in hospital facilitating discharge and supporting the reduction of delayed transfers of care. The service currently provides around 400 hours of direct care to customers, this will increase to a maximum of 612 hours during the next two years which will enhance capacity and will be achieved through the development of an integrated approach via the “One Team” and a revised, challenging specification.

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

York Integrated Care Team - Analysis of the York Integrated Care Team scheme is positive and shows that: **[CHECK DATA ]**

NEA are down by 2.1%, admissions are holding static and where patients are admitted their excess bed days have decreased by 25%

Reduction in York Acute Delayed Transfers of Care from 2016 to 2017(

Reduction in the numbers of people entering Residential Care –

A 10% growth in the number of new registrations with Carers Services

Targets for the number of new referrals into the Hub have been exceeded by 12% since May 2016.

The target for Carers Assessments of Need has been exceeded by 17%

Case studies show that a complete breakdown of the care giving role has been avoided for at least 207 households in the 11 month period May 2016 to March 2017.

Approximately 19,000 equipment deliveries in 2016/17 with 98.5% delivered within 5 working days.

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## Overview of funding contributions

An assessment of the investments in 2016/17 has been used to inform the funding plan and detailed list of schemes for 2017/19 (see Table 1.4). The 2017/19 BCF plan has been jointly agreed by partners, including the level of maintenance for social care, funding for reablement and carers breaks as set out in summary in Table 1.3.

Funding Contribution	15/16 Actual	16/17 Actual	17/18 Proposed	18/19 Proposed
LA Minimum (DFG)	0.951	1.003	1.101	1.101
LA Additional (iBCF and iBCF supplementary funding)	0.000	0.000	2.847	3.735
CCG Minimum (includes reablement and carers breaks)	3.354	3.412	3.473	3.539
Care Act	0.444	0.454	0.454	0.454
CCG Additional	7.378	7.334	7.473	7.624
<b>Total pooled fund (£M)</b>	<b>12.127</b>	<b>12.203</b>	<b>15.348</b>	<b>16.551</b>

**Table 1.3: 2017/19 Funding Plan**

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

- Step 1 – Existing schemes maintained (following high level review)
- Step 2 – Full year effect (FYE)/recurrent commitment costs applied
- Step 3 – Risk share costs absorbed
- Step 4 – Inflation/growth applied if applicable
- Step 5 – System wide schemes identified and added
- Step 6 – Additional new schemes agreed and added

This methodology supports the following investment profile: **[CHECK FIGURES]**

Investment Profile	16/17 Actual	17/18 Proposed	18/19 Proposed
Existing schemes maintained	12.203	12.159	15.196
FYE/Recurrent commitments	0.000	723	658
Risk share costs absorbed	0.000	1.227	0.000
Inflation/growth applied	0.000	104	126
System wide	0.000	863*	0.000
Additional new schemes	0.000	272	571**
<b>Total pooled fund (£M)</b>	<b>12.203</b>	<b>15.348</b>	<b>16.551</b>

\*£863K includes £152K potentially available following detailed review in 2017/18 of schemes

\*\*£571K includes funding potentially available following detailed review in 2017/18 of schemes

**Table 1.4: 2017/19 Investment Profile**

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

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

A summary of the services funded in 2016/17 and proposed for 2017/19 is given in Table XYZ. :[CHECK FIGURES]

Scheme	2016/17 current	2017/18 plan	2018/19 plan
Disabled Facilities Grant	1,003	1,101	1,199
Care packages (demographic change impact)	2,174	3,115	3,208
Contribution to social work post	137	138	139
Carers support	655	655	655
Care Act implementation	454	454	454
Community facilitators	40	40	40
Reablement services (Human Support Group contract)	1,099	1,099	1,099
Step up/step down beds (inc dementia)	300	303	312
Telecare and Falls lifting	192	192	192
Community equipment	180	180	180
Home adaptations	75	75	75
York Integrated Care Hub	625	750	758
Urgent Care Practitioners	569	526	526
Hospice at Home	170	173	176
Street Triage	150	150	150
Out of hospital services (commissioned by CCG)+	4,380	5,262	5,408
Arc Light – A Bed Ahead	0	81	83
Age UK – Escorted Transport	0	91	93
Fulford Nursing Home beds & OT support (6 months funding pending review)	0	152	0
Rapid Assessment & Treatment Service extended hours and social worker	0	207	207
Priory Outreach	0	180	182
Increased reablement capacity (7 months in 17/18)	0	97	168
Self support champions (4 months in 17/18)	0	33	98
Social prescribing/ways to wellbeing (8 months in 17/18)	0	101	152
Expanded handypersons service (4 months in 17/18)	0	10	30
Information and advice (4 months in 17/18)	0	16	49
Alcohol prevention (5 months in 17/18)	0	15	47
7 day working: multi-agency project	0	0	300
Uncommitted/contingency funds*	0	152	571
<b>Total</b>	<b>12.203</b>	<b>15.348</b>	<b>16.551</b>

+includes: specialist nursing, integrated community teams, community therapies, community equipment & wheelchair services)

\*Uncommitted funds includes £152K (2017/18) and £571K (2018/19) potentially available following detailed review in 2017/18 of schemes

**Table XYZ: Summary of 2017/19 schemes**

**Risks**

Risks to delivery include:

Main market /delivery risk and current market position – include likelihood vs severity/impact

Financial risk – approach to mitigation of risks, including risk shares – use risk approach from 16/17

**[INSERT RISK LOG AS AN APPENDIX]**

There is no risk share in place for 2017/19.

Target setting for 2017/19 has considered wider whole system impacts and a risk impact analysis has been undertaken to try to identify unintended consequences of any actions.

**National Conditions**

The York BCF is based on shared system outcomes overseen by the York HWB within the wider context of the Vale of York population from a CCG perspective.

The York HWB is a statutory committee of CYC and is chaired by the elected member with a responsibility for health and social care. The Board meets bi-monthly and, along with its wider health and wellbeing duties and exists to consider and make recommendations to the Council's Executive and the CCG on the use of BCF funding based upon jointly agreed plans. The Board covers the City of York Council population boundary and has a membership covering a broad range of partners as set out in **Table 3.1**.

<b>HWB Partner Agencies</b>	
City of York Council	York Council for Voluntary Services
NHS Vale of York CCG	Healthwatch York
York Teaching Hospital NHS Foundation Trust	Independent Care Group
Tees, Est & Wear Valleys NHS Foundation Trust	North Yorkshire Police
NHS England	

**Table 3.1: HWB and ACS/ Central Locality Partners**

The York HWB has received regular updates on the BCF Plan throughout 2016/17 and, at the May meeting agreed to delegate authority to the Chair and Vice Chair of the Board **[INSERT HYPERLINK TO MAY MINUTES]** to act as signatories to the plan should the submission timetable fall outwith the Board meeting cycle. A draft version of the BCF narrative was considered by the HWB on 6 September 2017 in advance of the final submission by 11 September 2017.

### Implementation of Care Act

This element of the BCF supports activities and services resulting from new statutory duties imposed on local authorities by the Care Act 2014. Key services provided through this scheme include Care Act Advocacy Services, online counselling support, financial assessment/personal accounts and information/advice services. The outcomes we are expecting include services which intervene at an earlier stage, improvement in the wellbeing of the population, provision of information and advice, advocacy support, increased numbers of carers assessments and customers being reviewed in an appropriate and timely manner.

Key performance measures include the number of financial assessments completed, number of carers accessing online support, the number of people with personal accounts and that undertaking self- assessment.

### Managing Transfers of Care

**[Add narrative once National Metrics section complete]**

### Overview of funding contributions

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Risk share costs absorbed	0.000	1.227	0.000
Inflation/growth applied	0.000	104	126
System wide schemes	0.000	667	0.000
Additional new schemes	0.000	424*	571**
<b>Total pooled fund (£M)</b>	<b>12.203</b>	<b>15.348</b>	<b>16.551</b>

\*£424K includes £152K potentially available following detailed review in 2017/18 of schemes

\*\*£571K includes FYE of £152K potentially available following detailed review in 2017/18 of schemes

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Non- Elective Admission Plan	5,439	5,429	5,579	5,435	4,720	4,711	4,841	4,716	21,882	18,989

### Admissions to residential care homes

Reduced admissions to care homes will be achieved through the protection of domiciliary care, alongside an enhanced and better integrated reablement offer. These schemes are closely linked to the development of more extra care housing as an alternative to residential care and the transformation of assessment and care management services to ensure people are able to access this.

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	683.1	633.6	638.4	616.4
	Numerator	253	238	243	238
	Denominator	37,037	37,561	38,067	38,611

### Reablement

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

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

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	75.7%	75.8%	86.0%	86.0%
	Numerator	106	138	43	43
	Denominator	140	182	50	50

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Delayed transfers of care

		16-17 Actuals				17-18 plans				18-19 plans				Comments
		Q1 16/ 17	Q2 16/ 17	Q3 16/ 17	Q4 16/ 17	Q1 17/ 18	Q2 17/ 18	Q3 17/ 18	Q4 17/ 18	Q1 18/ 19	Q2 18/ 19	Q3 18/ 19	Q4 18/ 19	
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	14 54. 4	16 82. 7	18 15. 5	11 73. 6	10 94. 4	12 11. 1	10 95. 0	99 1.8	99 1.8	99 1.8	99 1.8	98 6.4	
	Numerator (total)	2,4 97	2,8 89	3,1 17	2,0 32	1,8 95	2,0 97	1,8 96	1,7 29	1,7 29	1,7 29	1,7 29	1,7 29	
	Denominator	17 1,6 84	17 1,6 84	17 1,6 84	17 3,1 49	17 3,1 49	17 3,1 49	17 3,1 49	17 4,3 27	17 4,3 27	17 4,3 27	17 4,3 27	17 5,2 81	

High Impact Change Model – Self Assessment **[ADD NARRATIVE]**

Impact Change	Where are you now	Actions to address challenges
1) Early Discharge Planning	<p>Elective:</p> <p>a) <b>Plans not established:</b> <i>Early discharge planning in the community for elective admissions is not yet in place.</i></p> <p>Emergency/unscheduled:</p> <p>b) <b>Plans in place:</b> <i>Plans in place to develop discharge planning in A&amp;E for emergency admissions</i></p>	<ul style="list-style-type: none"> <li>• Pre assessment focus is on the anaesthetic risk assessment of patients having surgery (POPs Model for elderly). There is no proactive management of potential complex discharge management, there is a strong drive at pre assessment to ensure no day case patients are admitted for social reasons and the onus is on the patients to identify support. Pre assessment can occur on the day of or day before surgery and not all patients are pre-assessed. Patients being referred in should have this discussion with the primary care.</li> <li>• SAFER , bundle includes EDD set within 48 hours <ul style="list-style-type: none"> <li>- RATS identify/assess patients on admission to ED and aim to turn get them home from ED. York have a social worker attached and have links to York ICT team to support discharge. EDD not set in ED</li> <li>- AAU /AMU/B –EDD set for todays and tomorrows discharges</li> </ul> </li> </ul>
2) Systems to monitor patient flow	<p>a) <b>Not yet established:</b> <i>No relationship between demand and capacity</i></p> <p>b) <b>Not yet established:</b> <i>Capacity available not related to current demand</i></p> <p>c) <b>Plans in place:</b> <i>Analysis of causes of bottlenecks underway and practice changes being designed</i></p> <p>d) <b>Plans in place:</b> <i>Analysis of admissions variation on going with capacity increase plans being developed</i></p> <p>e) <b>Plans in place:</b> <i>Staff training in place to ensure understanding</i></p>	<ul style="list-style-type: none"> <li>• Discharge levelling and golden patient work implemented across both Acute sites</li> <li>• Capacity and demand work required for community teams</li> <li>• Support has been requested from NHSI for demand analysis across the system.</li> <li>• Stranded patient reviews planned 17 August to identify delays /escalation</li> <li>• SAFER/ Stranded patient escalation</li> </ul>

	of the need to increase senior clinical capacity	
<b>3) Multi-disciplinary, multi-agency discharge teams including voluntary and community sector</b>	<p>a) <b>Plans in place:</b> <i>Discussion on going to create integrated health and ASC teams</i></p> <p>b) <b>Plans in place:</b> <i>No daily multidisciplinary team meeting in place</i></p> <p>c) <b>Not yet Established:</b> Continuing Healthcare assessments carried out in hospital and taking "too" long</p>	<ul style="list-style-type: none"> <li>• Integrated Complex Discharge planning project and the one team</li> <li>• Board rounds SAFER in acute and community units ASC team and community DLT attend the weekly Community MDTs. Integrated complex discharge planning model</li> <li>• Pathway 3 yet to be established for discharge to assess</li> </ul>
<b>4) Home First Discharge to Assess</b>	<p>a) <b>Plans in place:</b> <i>Nursing Capacity in community being created to do complex assessments in the community.</i></p> <p>b) <b>Established :</b> People usually only enter a care/nursing home when their needs cannot be met through care at</p> <p>c) <b>Not yet Established:</b> People wait in hospital to be assessed by care homes</p>	<ul style="list-style-type: none"> <li>• Expansion of Scarborough CRT has increased capacity in Scarborough pathway 1. York pathway 1 has been supported by CRT however the One team integration will develop pathway 1 to be supported by intermediate care and reablement. Complex discharge to identify pathway capacity.</li> <li>• CYC numbers show that there is a reduction in the number of people entering care/nursing homes</li> <li>• There is currently no evidence to support the current time to assess, local audit would need to be developed</li> </ul>
<b>5) Seven day services</b>	<p>a) <b>Not yet Established:</b> <i>Discharge and social care teams assess and organise care during office hours five days a week</i></p> <p>b) <b>Not yet Established:</b> <i>OOH'S emergency teams provide non office hours and weekend support</i></p> <p>c) <b>Not yet Established:</b> Care Services only assess and start new care Monday- Friday</p> <p>d) <b>Plans in place:</b></p>	<ul style="list-style-type: none"> <li>• CRT and RATS 7 day service 8-8pm. SW attached to RATS does not cover the full hours</li> <li>• Care Services will restart existing care but not new POC. Wards can request the restart of existing POC within 2 weeks of admission.</li> <li>• Pharmacy, diagnostic and transport available evenings and weekends Age UK home from hospital operate 7 days a week and into the evening. New patient transport contract due to commence April 2018</li> </ul>

	<i>Hospital Departments have plans in Place to open in the evening and weekends</i>	
<b>6) Trusted Assessors</b>	<p>a) <b>Not yet Established:</b> Assessments done separately by health and social care</p> <p>b) <b>Not yet Established:</b> Multiple assessments requested from different professionals</p> <p>c) <b>Not yet Established:</b> Care providers insist on assessing for the service or home</p>	<ul style="list-style-type: none"> <li>• One Team does have plans to develop trusted assessment but these are not yet in place. This forms the 2<sup>nd</sup> phase priority for the team who will be analysing and developing the internal referral processes between the teams and the training of the workforce.</li> <li>• Care home providers still come into assess although there some occasions when assessment is accepted for example fast track patients. CYC SW assessments accepted by care provider. Work to be developed through care home project.</li> </ul>
<b>7) Focus on choice</b>	<p>a) <b>Plans in place:</b> Draft pre-admission leaflet and information being prepared</p> <p>b) <b>Plans in place:</b> Choice protocol being written or updated to reduce seven days</p> <p>c) <b>Not yet Established:</b> <i>No Voluntary sector provision in place to support self funders</i></p>	<ul style="list-style-type: none"> <li>• Admission and discharge leaflet "Planning your Discharge from Hospital" available, no reliable process to ensure every patient receives. Plans in place with DLO to build a sustainable process add to the complex discharge project Workstream 3</li> <li>• Joint Protocol to be reviewed as part of the Complex discharge project Workstream 3</li> <li>• No plans in place to involve voluntary sector we have an example where CYC social work team provide this support for self funders.</li> </ul>
<b>8) Enhancing health in care homes</b>	<p>a) <b>Plans in place:</b> CCG and ASC commissioners working with care home providers to identify need.</p> <p>b) <b>Plans in place:</b> Specific high referring care homes identified and plans in place to address</p> <p>c) <b>Established:</b> Quality and safeguarding plans in place to support care homes</p>	<ul style="list-style-type: none"> <li>• Care Home project- Lead nurse for quality and safety appointed to work with care homes.</li> <li>• Care Home project: High referring homes known and plans in place with the care home project to work with these areas</li> <li>• The CQC inspections- the data shows that we do not currently have any inadequate homes in our area and we are actually above the national average for ratings.</li> <li>• Local authority homes have improvement plans in place.</li> </ul>

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## Care Quality Commission Local System Review of York - Briefing for Partners

### 1. Introduction / Purpose of Report

- Inform partner organisations about the forthcoming review
- Provide assurance on the joint work being done to prepare
- Ensure partners are aware of opportunities / requirements to be involved in the review
- To highlight the role of systems leadership in relation to securing better outcomes for local people through joined up approaches and integrated services

### 2. Background to the Review / Strategic Context

- 2.1 The Better Care Fund (BCF) was established to support improvement in outcomes for people using services and local communities by promoting integration and transformation of health and social care. It focuses on out of hospital care to prevent admissions to and reduce the impact of delayed transfers of care.
- 2.2 In the budget 2017 the government announced an additional £2 billion nationally, paid directly to councils – the improved Better Care Fund (iBCF). The aims of the fund are:
- Meet adult social care needs
  - Reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
  - Ensure that the local social care provider market is supported
- 2.3 Following the Spring Budget announcement of additional funding for adult social care, the Department of Health and Department for Communities and Local Government commissioned the Care Quality Commission (CQC) to undertake a programme of targeted reviews of local authority areas. The purpose of the reviews is to ascertain how people move through the health and social care system with a focus on the interfaces, with particular reference to Delayed Transfers of Care (DTC).
- 2.4 The Local System Reviews are taking place first in areas that have been identified as challenged according to 6 key metrics in relation to “*user access and flow (including high numbers of delayed transfers of care)*”.
- 2.5 These metrics are summarised in Table 1, York’s performance is summarised in Table 2. However, it should be noted that this does not reflect an up to date, accurate position for York.

- 2.6 The Better Care Fund plan must be submitted by 11<sup>th</sup> September 2017, and following the national assurance process, plans must be finalised and approved by 30<sup>th</sup> November.
- 2.7 All areas have also been required to respond to national targets for the reductions of Delayed Transfers of Care. The national commitment is to achieve no more than 3.5% of occupied bed days being used by a patient who is ready to go home but remaining in hospital.
- 2.8 The reviews will highlight examples of good practice and make recommendations where improvements are needed.
- 2.9 The Care Quality Commission will publish a local report at a local summit for partners as part of their support offer.
- 2.10 The Care Quality Commission will also publish an interim national report in November, and a final national report at the end of the programme of reviews.

### **3. Scope of the Local System Review**

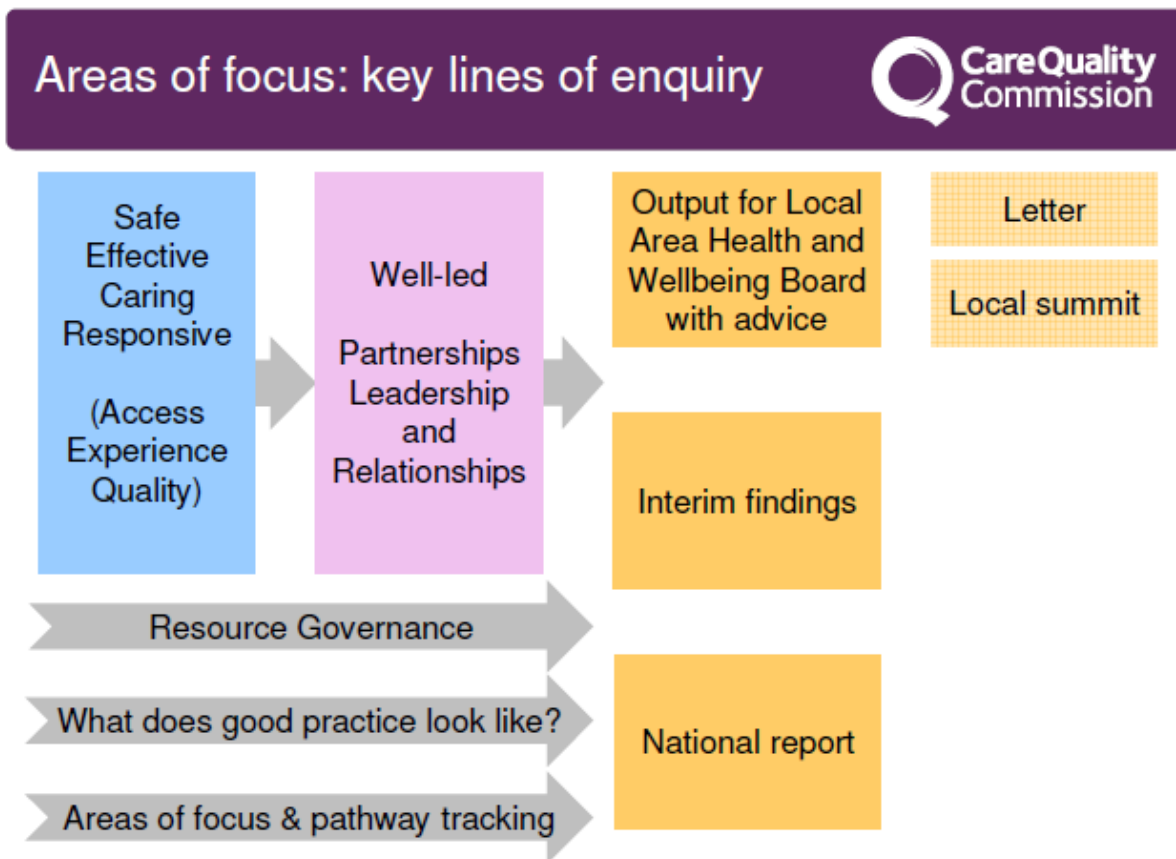
- 3.1 The review is of the whole system, not individual organisations. It will seek to answer the question: “How well do people move through the health and social care system, with a particular focus on the interface between the two, and what improvements could be made?”
- 3.2 The review will focus on older people with complex needs and co-morbidities who become delayed in hospital. It includes dementia, but does not focus on working age adult mental health delays.
- 3.3 An initial cohort of twelve council areas was identified, with a total of forty now being planned over the next year.
- 3.4 Reviews will not result in a rating, but will highlight good practice and articulate recommendations.

### **4 Methodology**

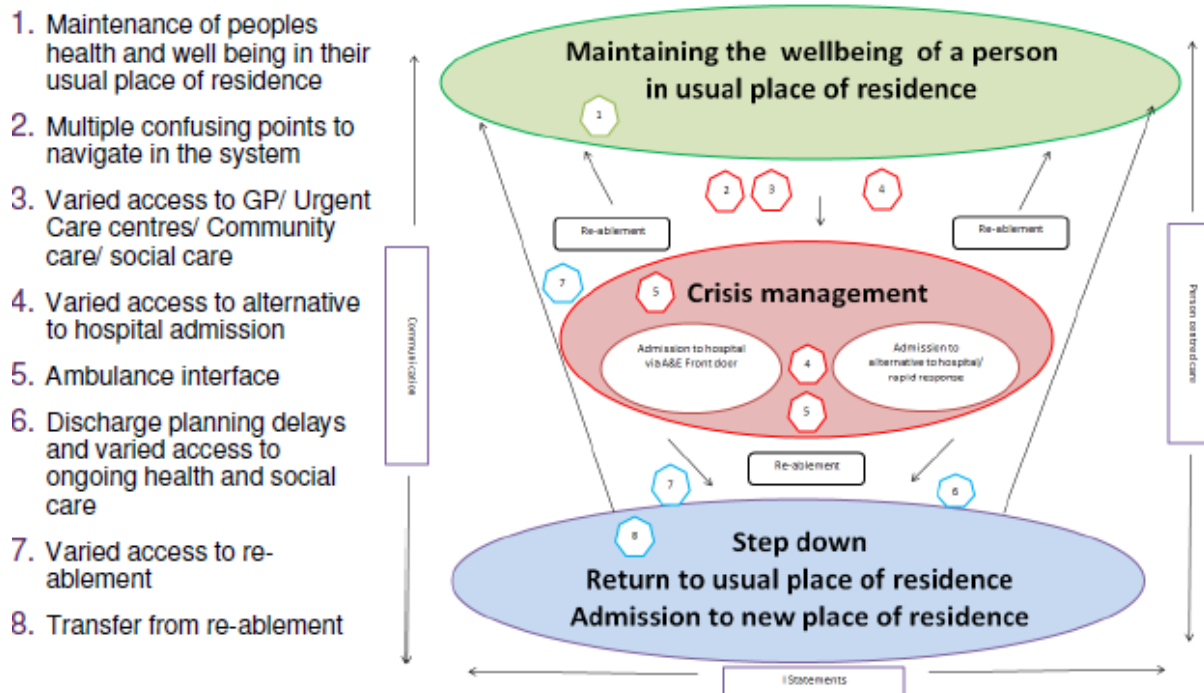
- 4.1 The CQC has published key Lines Of enquiry (KLOEs) and will map all existing evidence from inspections and other available sources against these prior to their visit.
- 4.2 Each area must submit a System Overview Information Return (SOIR) in advance of the review. This will offer a self assessment and allow York to provide information on the work we are already doing to address the challenges we face. It will also allow York to make our case in relation to the financial pressures on our system and the external factors affecting our health and social care economy.

- 4.3 The review will include a “Relational Audit” and case tracking (6 case studies).
- 4.4 CQC will hold preliminary interviews and focus groups as well as consult Scrutiny and Healthwatch prior to their on site week, which takes place in York from 30<sup>th</sup> October to 3<sup>rd</sup> November. Initial feedback will be provided on 3<sup>rd</sup> November.
- 4.5 The review will culminate in a report and a Local Summit with a tailored improvement support offer for each area.

CQC illustrations:



## Pressure points



1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care/ social care
4. Varied access to alternative to hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to re-ablement
8. Transfer from re-ablement

## 5 Local preparation and response

- 5.1 System leaders in York are committed to ensuring that this review is welcomed as a positive opportunity to promote the great developments that are taking place here to reduce dependence on services and foster individual and community resilience. We also welcome the review as an invaluable insight into further improvements which could be made to join up our health and social care system around those people who need it.
- 5.2 The local response is being co-ordinated by the CYC and VOYCCG Head of Joint Commissioning on behalf of the whole system.
- 5.3 A multi agency working group has been established.
- 5.4 Partners are contributing evidence ahead of the CQC timetable in order to fully understand our performance and key issues, and to shape a shared narrative for the System Overview Information Return.

## 6 Opportunities to contribute

- 6.1 The multi agency working group is planning a schedule of briefings and updates for stakeholders to ensure local people are informed about the review.

6.2 The Relational Audit will be disseminated through existing networks to ensure as wide a response as possible, in line with CQC intentions.

6.3 CQC will be inviting groups and individuals to contribute evidence to the review through events, focus groups and interviews.

**7 Timetable**

7.1 CQC expects to formally initiate the review of York by letter during the week commencing 11<sup>th</sup> September 2017.

7.2 The System Overview Information return must be submitted by 16<sup>th</sup> October 2017.

7.3 The CQC review team will be on site in York for the week commencing 30<sup>th</sup> October 2017.

7.4 It is expected that the report will be published at the Local Summit during the week commencing 11<sup>th</sup> December 2017.

CQC illustrative timetable:

**System review end to end**

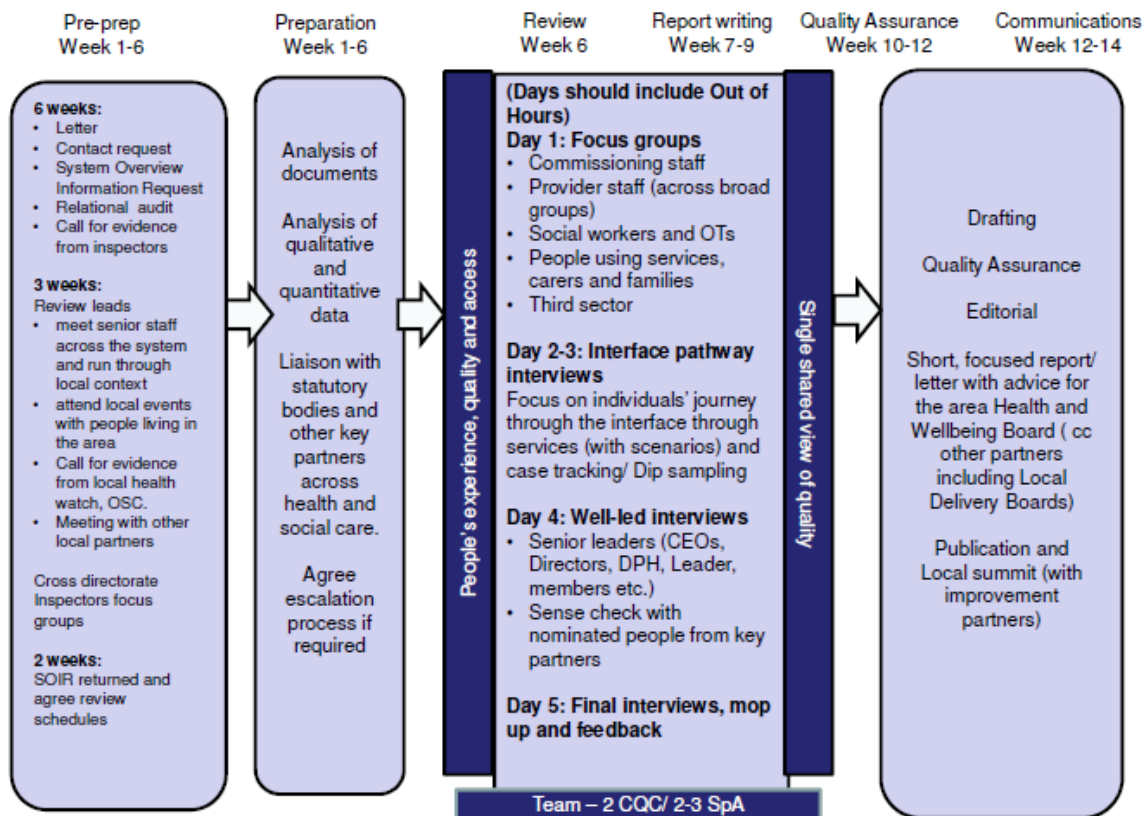


Table 1: 6 key performance metrics on which the review is based

ID	Indicators	What this indicates about the system	Full definition
1	Emergency Admissions (65+) per 100,000 65+ population	Can indicate how good collaboration across the health and care system is to support good management of long term conditions	(Emergency admissions for those with identified age (65+) resident in a local authority) divided by; (Local authority population 65+/100,000)
2	90th percentile of length of stay for emergency admissions (65+)	Longer lengths of stay can indicate poor patient flow out of hospital and hence downstream blockages	The 90th percentile length of stay following emergency admission.  e.g. 10% of patients within a local area have a length of stay longer than X days.
3	TOTAL Delayed Days per day per 100,000 18+ population	This indicates how effective the interface is between health and social care and joint working of local partners	Average number of monthly delayed days (ALL) per day Divided by; (Local authority population 18+/100,000)
4	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	This captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement. Reablement services lead to improved outcomes and value for money across the health and social care sectors.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
5	Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services		The proportion of older people aged 65 and over offered reablement services following discharge from hospital.
6	Proportion of discharges (following emergency admissions) which occur at the weekend	This can indicate successful, joint 24/7 working leading to good flow of people through the system and across the interface between health and social care	Percentage of discharges (following emergency admission) at the weekend

Table 2

Summary of performance

The table below shows the rank of the systems under review compared to their 15 statistically similar nearest neighbours for each of the indicators.

Local Authority	Emergency Admissions (65+) per 100,000 of 65+ population	90th percentile of length of stay for emergency admissions (65+)	Total Delayed Days per 100,000 18+ population	Proportion of older people (65+) who were still at home 91 days after discharge	Proportion of older people (65+) who are discharged from hospital who receive reablement/ rehabilitation services	Proportion of discharges (following emergency admissions) which occur at the weekend
Birmingham	16	5	14	13	5	9
Bracknell Forest	8	13	13	16	9	8
Coventry	16	14	15	10	15	3
East Sussex	4	16	14	1	14	14
Halton	9	16	15	15	6	10
Hartlepool	10	13	14	7	9	13
Manchester	16	10	11	16	6	8
Oxfordshire	9	1	16	9	8	4
Plymouth	3	7	16	8	5	14
Stoke-on-Trent	15	7	16	12	16	9
Trafford	14	15	16	1	10	6
York	12	8	11	15	12	15

Pippa Corner

Head of Joint Commissioning Programme, City of York Council and NHS Vale of York CCG

August 2017

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## Health and Wellbeing Board

6 September 2017

Report of the Strategic Lead – Communications & Engagement,  
Humber, Coast and Vale STP

## Update on the Humber Coast and Vale Sustainability and Transformation Partnership (STP)

### Summary

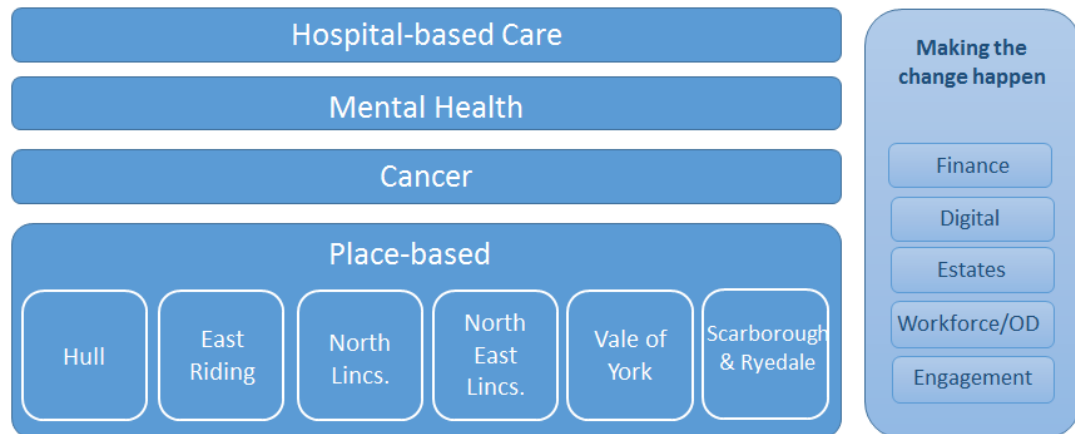
1. This report provides an update on the work of the Humber, Coast and Vale Sustainability and Transformation Partnership (STP).

### Background

2. Since April 2016, leaders from health and care organisations across the region, together with our vibrant voluntary sector, have been working together to establish the Humber, Coast and Vale Sustainability and Transformation Partnership (STP). It is a partnership of nearly 30 different organisations including NHS Trusts, Social Enterprise Companies, Local Councils and Health Commissioners covering a wide area with a diverse mix of rural, urban and sub-urban communities (see **Annex A**).
3. An overarching vision and draft set of proposals were submitted to NHS England in October 2016. This set out the shared vision for our local health and care system of enabling everyone in our area to start well, live well and age well.
4. To achieve the vision we are working hard to create a health and care system that supports everyone's health and wellbeing and that is there to help when people need it. Our proposed future system will begin with people and be built around their needs rather than being built around organisations, processes or pathways. It will focus on promoting better health wherever possible by connecting people, places and services and delivering genuinely integrated

care. We want to become a health improving system rather than an ill-health treating system.

5. We are working with all the partner organisations on a complex programme of change to provide better, more joined-up health and care services that focus on keeping people well. Details of current STP programmes, including key aims and objectives, are set out in **Annex B**.



### Update on Place-based Plans

6. In each of our communities we are working with local councils to integrate health and social care services and to improve the health of our local people by supporting them to access better housing, better jobs and to live healthier lives. In addition to modelling the wider determinants of health, local plans focus on:
  - **prevention** (keeping people well);
  - **supported self-care** (helping people to manage their health conditions at or close to home);
  - **integrated commissioning and provision** of local health and care services (so that services are joined up and flexible enough to meet different people's needs).

7. Improving and joining up care outside of hospital settings is central to delivering the changes that are required in our health and care system.
8. Work is ongoing in each of our 'places' to make progress on integrating the commissioning functions of Clinical Commissioning Groups (CCGs) and Local Authorities. This is following different models in each area but with the same core aims of providing better, more joined-up care and reducing unnecessary duplication. Work is also underway to integrate the provision of services outside of hospital settings, working with GPs, community service providers and the voluntary and community sector.

### **Progress on integrated commissioning**

9. Integrated commissioning is about bringing together the collective buying power of health organisations and local councils in a particular area, to develop a more coherent strategy for health and care provision in an area and avoid duplication of effort. It is about spending the money once to achieve the best outcomes for the health of local people by working together with local councils to align the funding for health and social care.
10. Recent developments in progressing integrated commissioning include the creation of a single management structure across the Local Council and Clinical Commissioning Group in North East Lincolnshire. From 1st August 2017, North East Lincolnshire Council's Chief Executive, Rob Walsh took on the new role; heading up a single leadership team which will service both statutory organisations and strengthen their ability to deliver the best possible outcomes for the community they serve.
11. In a parallel development, Hull CCG and Hull City Council have taken steps to integrate the CCG's budget with Hull City Council's budget for adult social care, public health and children's services. The organisations are now working together to plan future spending on public health, adult social care and children's services from the perspective of an integrated financial plan and single process of prioritisation. Commissioning decisions will be made by a newly established integrated commissioning board and committee in common. Both organisations will retain their existing statutory responsibilities and decisions will be ratified via each organisation's existing governance structures.

12. Within the Vale of York, an Accountable Care System (ACS) Partnership Board has been established, in addition to three locality sub-boards (North, South and Central) to reflect the complex geography of the Vale of York. The three localities within the Vale of York ACS are being further developed to support the formation of Locality Delivery Plans for each area.

### **Progress on integrated provision**

13. Similarly, in each of our six places we are working towards the establishment of integrated provision of out of hospital care. The organisational forms for delivering joined up care and the journey toward establishing integrated provision will be different in each of our six places. Nevertheless, the basic outcome will be the same: a simpler, more effective system for local people to receive local health and care services.
14. Our intention is to develop placed-based service models that are integrated, mutually supportive and maximise the benefits of us working as a system, to manage population health and deliver better outcomes for the people in the Humber, Coast and Vale.

### **Update on STP-wide programmes**

15. In addition to transformation work in each of the six places in Humber, Coast and Vale, the partnership is working together on a number of programmes to develop plans on an STP-wide basis. This cross-cutting work is focused on hospital-based services, cancer care and mental health provision. These programmes will be supported by a number of other programmes of work across the STP to help us make the change happen. These enabler workstreams include: workforce and organisational development, digital technology, estates, and communications and engagement.

### **Hospital Services Review**

16. As part of the STP-wide hospital workstream, we have begun a review of acute hospital service provision in the Humber, Coast and Vale area. The purpose of this review is to achieve improvements in the quality of services available in our local hospitals and ensure that we are providing services that are operationally and financially sustainable service that can be funded and safely staffed in the medium and longer term.

17. The review will consider current and projected future needs for hospital services, taking into account local plans to improve and extend the types of care and treatment that are available outside of hospital settings. The purpose of the review is to provide an evidence-based assessment of current and future need for hospital-based services and use that evidence-based understanding of future need to plan future hospital services.
18. A transparent and inclusive approach will be adopted at all stages of the process. We will implement a rigorous process to creating and refining future scenarios that includes a variety of opportunities for patients, the public, staff and other stakeholders to contribute and will adopt an evidence-based approach.

### **Communications and Engagement**

19. We have developed a comprehensive communications and engagement strategy as well as a number of additional forums to ensure effective engagement and involvement of all partners in developing the work of the STP. This includes the introduction/development of the following groups:
  - Provider Collaborative – Chaired by Michele Moran, Chief Executive of Humber NHS Foundation Trust, the forum now meets on a regular basis to consider how provider organisations can work collectively on key priority areas such as workforce.
  - Lay members and non-executive director's (NED) forum – NEDs and CCG lay members have agreed to establish a regular forum to advise the STP programmes and plans and to carry out a skills audit of lay members and non-executives from across the organisations to ensure we are utilising the skills and experience they offer the system.
  - Staff-Side Forum – a regular meeting with trade union representatives has been established to maintain regular contact and enable discussion of issues raised by the staff side representatives.
  - Local Authority Forum – this meeting provides an opportunity for Health and Wellbeing Board Chairs, other local government representatives and CCG leads to meet together

to discuss the work of the partnership and share learning across the area.

### **Next Steps – Accountable Care Systems**

20. The 'Next Steps to the Five Year Forward View', which was published by NHS England in March 2017, launched the concept of Accountable Care Systems (ACSs). The first eight Accountable Care Systems (ACSs) in eight STP or sub-STP areas across England were announced in July 2017. These areas are currently working towards the implementation of a new model for Accountable Care in their area, which bring together local NHS organisations, in partnership with social care services and the voluntary sector.
21. The first group of designated ACSs have agreed with national leaders to deliver fast track improvements set out in Next Steps on the Five Year Forward View, including taking the strain off A&E, investing in general practice making it easier to get a GP appointment, and improving access to high quality cancer and mental health services.
22. These areas will also lead the way in taking more control over funding available to support transformation programmes, matched by accountability for improving the health and wellbeing of the populations they cover. NHS national bodies will provide these areas with more freedom to make decisions over how the health system in their area operates.
23. Early discussions are taking place within Humber, Coast and Vale in relation to the concept of Accountable Care Systems and what the potential models might be for developing an Accountable Care System(s) for Humber, Coast and Vale.

### **Consultation**

24. Details of consultation and engagement activity in relation to the Humber, Coast and Vale STP are provided on the STP website: [www.humbercoastandvale.org.uk](http://www.humbercoastandvale.org.uk)

## **Options**

25. This report is for information.

## **Analysis**

26. This report is for information.

## **Strategic/Operational Plans**

27. Sustainability and Transformation Partnerships are the key mechanism for delivery of the NHS Five Year Forward View and the wider integration of health and social care. The key strategic aim of the Humber, Coast and Vale STP – to help everyone in our communities to start well, live well and age well – reflects the core themes of the Joint Health and Wellbeing Strategy for the City of York.

## **Implications**

28. This report is for information.

## **Recommendations**

29. The Health and Wellbeing Board are asked to note the contents of the report and to continue to contribute to the work of the partnership via existing mechanisms:

Reason: To ensure the Health and Wellbeing Board are apprised of the Humber, Coast and Vale Sustainability and Transformation Partnership

## **Contact Details**

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**Report  
Approved**



**Date** 22.08.2017

Julie Warren  
Locality Director  
NHS England

**Report  
Approved**



22.08.2017

**Wards Affected:**

**All**



**For further information please contact the author of the report**

### **Background papers**

Humber, Coast and Vale STP Outline Strategy, October 2016  
Submission: [http://humbercoastandvale.org.uk/wp-content/uploads/2016/12/HCV-October-Submission\\_v.3.1-updated.pdf](http://humbercoastandvale.org.uk/wp-content/uploads/2016/12/HCV-October-Submission_v.3.1-updated.pdf)

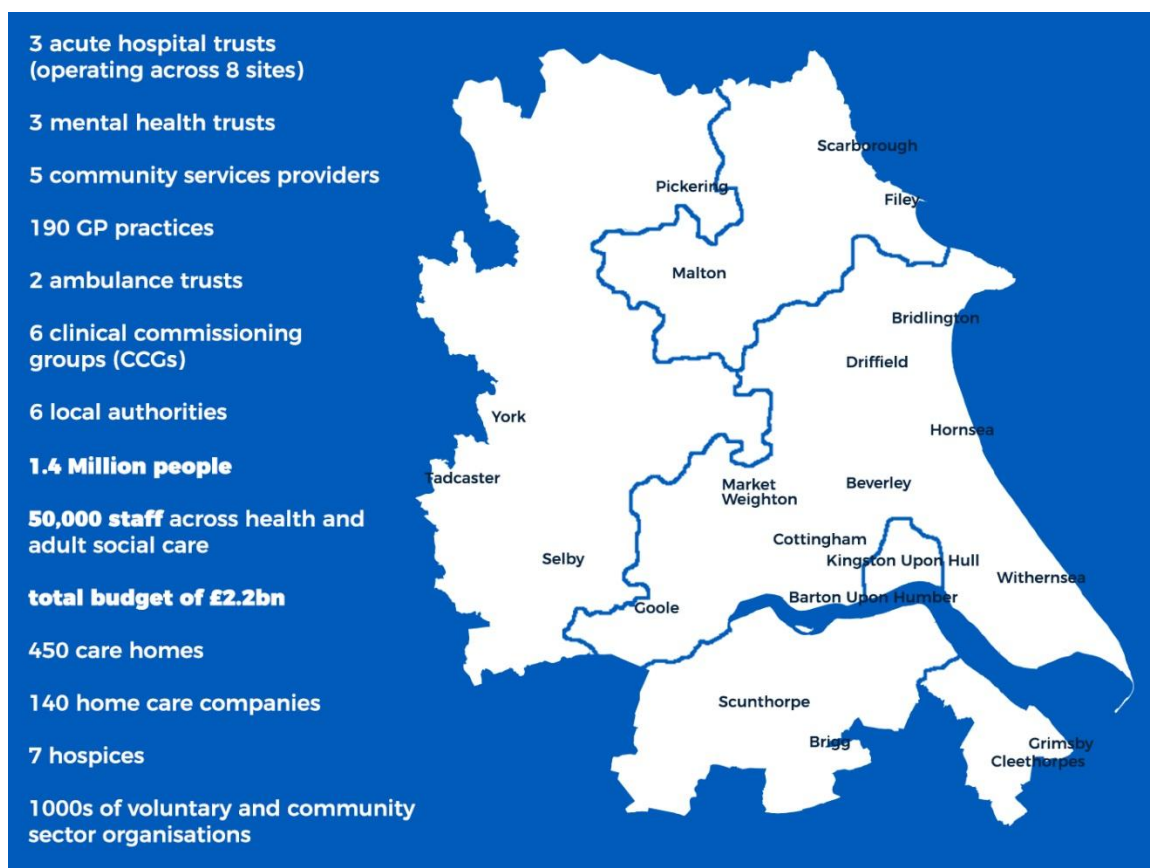
### **Annexes**

Annex A – About Humber, Coast and Vale

Annex B – Humber, Coast and Vale Programmes



## Annex A – Humber, Coast and Vale



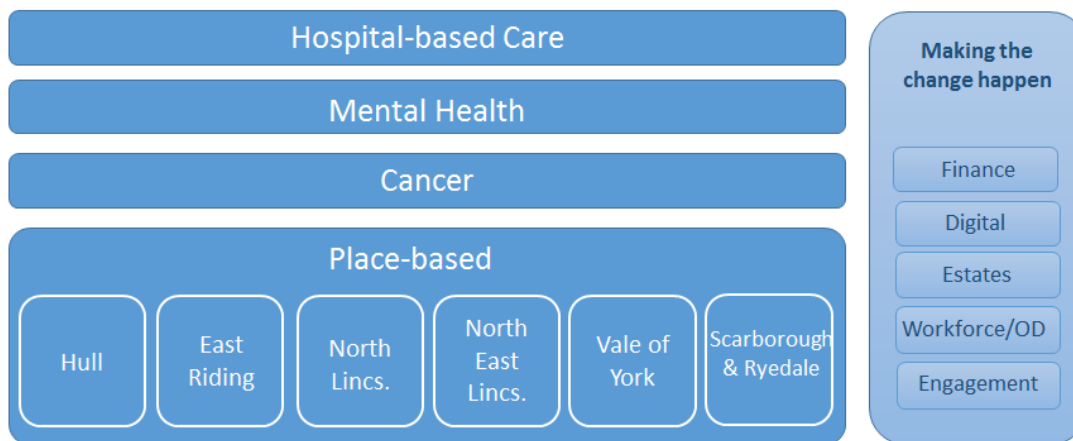
The Humber, Coast and Vale Sustainability and Transformation Partnership (STP) is a collaboration of nearly 30 different organisations across a geographical area of more than 1500 square mile, serving a population of 1.4 million people. The Humber, Coast and Vale STP Partnership Board is made up of NHS Commissioners, Providers and Local Authorities. These are:

- East Riding of Yorkshire CCG
- Hull CCG
- North Lincolnshire CCG
- North East Lincolnshire CCG
- Scarborough and Ryedale CCG
- Vale of York CCG
- Northern Lincolnshire and Goole NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Humber NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- City Health Care Partnerships CIC
- Navigo
- Focus
- Care Plus Group
- Yorkshire Ambulance Service NHS Trust
- East Midlands Ambulance Service NHS Trust
- City of York Council
- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- North Yorkshire County Council

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Annex B – Humber, Coast and Vale Programmes

Our programmes



Place-based



**Integrated Commissioning**

- Collaboration with Local Authorities
- Aligned budgets
- Commissioning for outcomes and population health management

**Integrated Provision**

- Improved access to GPs and other primary care
- Increased range of out of hospital services
- Improved access and ease of use – joined-up care

**Prevention, Self Care and Staying Well**

- Prevention at scale
- Healthy communities
- Healthy workplaces
- Supported self care

**Wider Determinants**

- Housing
- Employment
- Education

**Better Use of IT and Public Estate**

- Shared electronic records
- New ways to access and provide services
- Shared use of accommodation



# Hospital-based care



<p><b>Overall Hospital Configuration</b></p> <ul style="list-style-type: none"> <li>• Elective services</li> <li>• Emergency medical services</li> <li>• Emergency surgical services</li> <li>• Paediatric services</li> <li>• Shift of services to non-hospital settings</li> </ul>	<p><b>Sustainable Specialised Services</b></p> <ul style="list-style-type: none"> <li>• Clinical networks for Cancer, Major Trauma, Vascular and Critical Care</li> <li>• Service reviews: Rehabilitation , Neonatal Intensive Care, specialised Paediatrics and Orthopaedics</li> </ul>	
<p><b>Maternity Care</b></p> <ul style="list-style-type: none"> <li>• Improve local maternity systems to reduce stillbirth and neonatal death rates and improve perinatal mental health</li> </ul>	<p><b>Clinical Support Services</b></p> <ul style="list-style-type: none"> <li>• Radiology</li> <li>• Pathology</li> <li>• Pharmacy</li> </ul>	<p><b>Shared Non-Clinical Services</b></p> <ul style="list-style-type: none"> <li>• Standardise what we do and share functions to provide better and more efficient services</li> </ul>



# Cancer



<p><b>Increased Awareness and Early Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Improving lifestyle choices and raising awareness</li> <li>• Screening and active case finding</li> <li>• Diagnosing vague symptoms</li> <li>• <u>gFIT</u> for symptomatic patients</li> </ul>	<p><b>Smarter Use of Diagnostics</b></p> <ul style="list-style-type: none"> <li>• Diagnostic capacity and demand – system review</li> <li>• Networked model of Radiology and Pathology</li> <li>• Developing the diagnostic workforce</li> </ul>
<p><b>Optimal Treatment</b></p> <ul style="list-style-type: none"> <li>• Standardised and optimised pathway for lung cancer</li> <li>• High value pathway reviews – Prostate, Colorectal and Breast</li> <li>• Chemotherapy services review</li> </ul>	<p><b>Consistent Cancer Recovery</b></p> <ul style="list-style-type: none"> <li>• Personalised cancer follow up</li> <li>• Better support for people after treatment</li> </ul>



# Mental health



## Eliminating out of area placements for all age adults

- No one will be admitted to an inpatient bed outside the HCV footprint, where appropriate for their individual care.
- Develop stronger partnerships with housing providers to provide support and housing to reduce delayed discharges.
- Increase the employment and stable housing rates for people living with mental ill-health.

## Perinatal Mental Health Services

- All women, where appropriate will receive access to evidence-based, specialist perinatal mental health treatment.

## Access to crisis and liaison services

- Increase capacity of crisis resolution and home treatment teams so more people have access to 24/7 crisis care response and intensive home treatment.

## Health and Justice for adults, children and young people

- Improve mental health outcomes for the Health and Justice patient population of all ages.
- Contribute to the reduction in incidents of self harm and suicide among this group.

## Community Mental Health

- Reduction in length of stay in hospital through appropriate support in community settings.

## Older People and Dementia

- Improved early diagnosis and intervention for people with dementia.
- Increase in diagnosis rate to ensure that people can access appropriate post-diagnostic support.
- Better management of complex patients.



# Making the change happen

To address shortages of staff we will expand clinical training and develop new roles. We are already developing two training programmes:

- Support Staff at scale
- Advanced Practice at scale.

**Transformed Workforce**

We will use the buildings we have to support delivery of our priorities.

We will make best use of **all** public estate in our areas to enable the provision of joined-up care.

**Estate Strategy**

We will make that all of our plans are shaped through engagement with our stakeholders including:

- Public
- Patients
- Staff
- Other stakeholders

**Communication and Engagement**

We will utilise technology to:

- Give patients access to more information to help manage their own health;
- Create a single electronic care record so patients should only be asked things once.

**IT Strategy**



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**Health and Wellbeing Board**  
Report of the Vale of York CCG

6 September 2017

**Future in Mind Local Transformation Plan (LTP) refresh 2017**

**Summary**

1. The report provides an overview of the work to implement the LTP and sets out the themes for inclusion in the 2017 refresh. The Health and Well Being Board is asked to:
  - a. Note the report and direction for the Local Transformation Plan in 2017/18
  - b. Delegate authority to the Chair of the Board to approve the LTP for submission to NHS England on 31 October 2017.

**Background**

2. *Future in Mind* described the vision and steps to transform the way in which services support children and young people's emotional and mental health. The LTP sets out locally how to achieve step change within the CCG area, working across partners and stakeholders. The Vale of York CCG LTP published in 2015 and refreshed in 2016 was prepared in consultation with a wide range of stakeholders including children and young people and written in close collaboration with City of York and North Yorkshire County Council colleagues. The plan outlined both NHS –mandated and local priority themes:
  - a. Community eating disorder service across North Yorkshire and York (NHS mandated).
  - b. Development of 'Children and Young People's IAPT' principles: these focus on workforce development, service transformation and patient experience (NHS mandated).
  - c. Promotion, prevention and early intervention (local priority).

- d. Easier access to support.
  - e. Support for the most vulnerable.
3. The funded schemes under the LTP are:
- a. Community eating disorder service: a single service across North Yorkshire and York to provide specialist support to meet national delivery targets by 2020. In 2016/17 Tees Esk and Wear Valleys NHS Trust (TEWV) report there were 65 referrals into service within Vale of York. Staff are continuing training to deliver to the national waiting time standards.
  - b. City of York school well-being service, jointly funded by health and schools: each school cluster has a dedicated well-being worker to advise and support staff, and undertake work with individual and groups of pupils. In the first 6 months, over 260 pupils were referred to the well-being workers for advice or support, and the work with school staff has resulted in schools reporting higher levels of confidence in responding to pupils with apparent emotional and mental health needs. The service is overseen by the Strategic Partnership for Emotional and Mental Health (SPEMH) and is regarded as an example of best practice in early intervention.
  - c. North Yorkshire County Council school well-being service: delivered by Compass, a third sector provider, from September 2017 there will be 8 workers across the county, offering advice, training and support to school staff, but not undertaking work directly with pupils.
4. The re-tendered Vale of York CCG mental health contract commenced in October 2015 and included service developments that are key to delivery of the LTP: the single point of access is now operational, and the crisis response offer has now been extended through funding from the New Models of Care programme to offer extended hours of operation and develop intensive home support to prevent admissions and provide some step down treatment after discharge from an inpatient unit. The extended service commenced in June 2017 and there is some anecdotal evidence from York Hospital that the numbers of admissions to Ward 17 from A&E has reduced.



5. The SPEMH is the delivery board for emotional and mental health and has a key role in determining and reviewing the progress of the LTP.
6. There are now national targets and performance indicators for children and young people's mental health services (CYPMH); these cover levels of access to services, and waiting times for eating disorders and psychosis services. Local performance monitoring is now focused on reducing waiting times for all parts of the CYPMH service. The first quarter report for access waiting times for CYPMH general admissions shows that 65% of full assessments (2<sup>nd</sup> appointment) were undertaken within 9 weeks of referral at the end of June, up from 52% in April. Members will be updated regarding the June position at the meeting.

### **Preparing the LTP refresh for 2017/18**

7. Attached at Annex 1 is the assurance return for 2016/17 to NHS England, which details the work across the CCG area for CYPMH.
8. At Annex 2 is the detailed feedback from NHS England from the 2016 LTP refresh, which provides assurance that there is positive progress towards meeting the aspirations of the LTP, and also highlights areas for further work in 2017/18 and beyond. The feedback is across the four North Yorkshire CCGs, thus some comments are not directly applicable to City of York
9. Work is in hand to review and plan for 2017/18 and beyond. NHS England has issued detailed guidance for the LTP (at Annex 3): we are working with colleagues across all agencies to ensure that specific information required is included in the LTP
10. The LTP must incorporate both national and local priorities. National guidance is currently focused on:
  - a. Early intervention, particularly in schools
  - b. Workforce development to provide up to 10,000 additional staff nationally (it is not clear how this is to be funded)
  - c. Integrated commissioning and delivery structures
11. In setting local priorities for detailed planning, discussions with colleagues, feedback from children, families and providers indicate a focus on systems issues which have potential to significantly

impact on the outcomes and experience for children and young people:

- a. Transitions in and between services: this is an area of real concern for young people and families, and the whole system needs to ensure it manages care and communication to ensure the best outcomes and experience.
  - b. Vulnerable groups of children and young people: those in contact with the youth justice system, children looked after, those with complex needs all need a specific offer of support, and the structures of care and support should be assured to be robust.
  - c. Increasing the awareness of and availability of early support including mentoring, peer support and counselling; these types of intervention reduce necessity and pressure to refer to Limetrees or other specialist services.
  - d. Reducing waiting times further.
  - e. Workforce development plan.
  - f. Commissioning intentions up to and beyond 2020 to examine the scope for greater integration of services, and broadening the base of support for children and young people.
12. The timetable for the LTP is as follows:
- a. Publication on or by 31 October 2017: the Health and Well being Board must approve the Plan, hence the recommendation that the Chair have delegated authority to sign the Plan.
  - b. Discuss the draft LTP at the Health and Well-Being Board Development meeting on 6 October, to allow for informal consultation prior to finalising the LTP.
  - c. Discuss the themes and outline at the SPEMH on 19 September 2017.

### **Consultation**

13. Discussions are in hand with partners and stakeholders across a range including police, TEWV, YOT, colleges, third sector,

Healthwatch, and public health. These will inform more detailed planning.

### **Options**

14. Not applicable.

### **Analysis**

15. Not applicable.

### **Strategic/Operational Plans**

16. The York Health and Well Being Strategy includes mental health and well being as a key theme, with a top priority to spot early signs of mental illness or distress, and actions include improving services for children and young people.
17. The Vale of York CCG Strategic Plan includes as an objective “high quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area”. The key programmes for mental health delivery include access, early involvement and crisis avoidance for children and young people’s mental health services.

### **Implications**

- **Financial:** there are no implications
- **Human Resources (HR):** there are no implications
- **Equalities:** there are no implications
- **Legal:** there are no implications
- **Crime and Disorder:** there are no implications
- **Information Technology (IT):** there are no implications
- **Property:** there are no implications
- **Other :** none known

### **Risk Management**

18. Not applicable.

**Recommendations**

- 19. The Health and Well-being Board to asked to
  - a. Note the report and direction for the Local Transformation Plan in 2017/18
  - b. Delegate authority to the Chair of the Board to approve the final LTP

**Contact Details**

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**Chief Officer Responsible for the report:**

*Michelle Carrington  
Executive Nurse  
Vale of York CCG*

**Report Approved**

**Date** *Insert Date*

*Chief Officer's name  
Title*

**Report Approved**

**Date** *Insert Date*

**Wards Affected:** *List wards affected or tick box to indicate all [most reports presented to the Health and Wellbeing Board will affect all wards in the city – however there may be times that only a specific area is affected and this should be made clear]* **All**

**For further information please contact the author of the report**  
**Background Papers:**

***All relevant background papers must be listed here. A 'background paper' is any document which, in the Chief Officer's opinion, discloses any facts on which the report is based and which has been relied on to a material extent in preparing the report***

*Either the actual background paper or a link to the background paper should be provided.*

## **Annexes**

1. Assurance report to NHS England April 2017
2. Feedback report from NHS England for LTP 2016
3. NHS England guidance for the LTP 2017

## **Glossary**

***A separate document must be attached to each report which clearly lists in alphabetical order any abbreviations used within the report and its associated annexes.***

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## Annex 1

### NHS VALE OF YORK CCG – QUARTER 4 PROGRESS REPORT FUTURE IN MIND TRANSFORMATION PLAN

#### 1. Overall progress

The CCG has published the updated Local Transformation Plan with baseline data.

[www.valeofyorkccg.nhs.uk/publications-plans-and-policies-1/](http://www.valeofyorkccg.nhs.uk/publications-plans-and-policies-1/)

Regular reports are made to Health and Well-being Boards and Children's Trust Boards. A report was made to NYCCC CTB in March 2017



Children's\_Trust\_Boar  
d\_Agenda\_22nd\_Marc



SEMH Strategic cross  
service implementatio

#### Strategic Direction

The CCG continues to work closely with local authority colleagues at City of York Council, North Yorkshire County Council and other stakeholders on children and young people's emotional and mental health. The review of the 49 FiM recommendations in Q4 has highlighted areas to commence planning for the refresh of the LTP in October 2017: a more detailed analysis across a range of partners is under way.



Q4 FiM return final  
SEF (VOY) 27 April.do

The North Yorkshire County Council SEMH steering group continues to meet and includes representation from NYCC and a wide range of stakeholders. The revised governance structure continues to ensure that actions in relation to progress of Future in Mind are reported upwards. A key action from this group is to further develop the implementation plan with CCG actions and key milestones aligned to the updated Transformation Plan. One sub group has already been established, called the Emotional Health and Wellbeing Delivery Group, and they will lead on delivery and implementation.



Draft SEMH update  
CTB March 8v2.pptx



SEMH Terms of  
Reference.docx

The Strategic Partnership for Emotional and Mental Health (SPEMH) is now working through small thematic groups developing action plans across its thematic areas in City of

## Annex 1

York. There are five thematic sub groups to reflect the themes in Future in Mind, and their work will inform the Local Transformation Plan refresh in October 2017.



Minutes February  
2017.docx

### **Collaborative commissioning with NHS England**

The CCG has worked on a collaborative commissioning plan with NHSE: this sets out the arrangements between health and NHSE to develop collaborative and seamless services for those children and young people needing either inpatient care or more specialist care, for example in forensic units. The draft plan has been shared with NHSE. Through the Local Transformation Plans and the collaborative Commissioning Plan, all opportunities for collaborative commissioning are being explored. Sharing good practice and collaborative approaches will be the foundation of the Commissioning Plans in the Y&H Specialised Commissioning Hub



YH Joint  
Commissioning Plan T

### **New Models of Care: intensive intervention and crisis support**

CCGs are working closely with the provider trust, TEWV on the pilot for New Models of Care, encompassing crisis support and intensive home treatment, whilst vanguard funding has been received to pump prime the crisis team. This project is establishing a model based on planned and unplanned pathways of care, with the crisis team 'holding' urgent cases until and after assessment and decisions regarding care and treatment. The current crisis support team based in York District Hospital ED between 13.00 and 21.00 will be incorporated into the new services, providing a significantly enhanced scheme of support for children and young people. The service will work daily 7am-12midnight, 7 days/week. The project is will go live in June 2017. Recruitment to posts in York is complete. Staff are in training and the project will go live in June 2017. Closer links have been made with T4 service at Mill Lodge in York (16 bed general adolescent unit). The new service manager will become a member of both the SPEMH and SEMH steering groups.



Business case T4  
NMC.docx



## Annex 1

### 2. Scheme progress to date

The CCG continues to fund through Future in Mind the Children and Young People Community Eating Disorders Service (CEDS) and School Wellbeing Projects. All projects are joint funding with either North Yorkshire County Council and North Yorkshire CCGs

#### 1. The School Wellbeing Project in City of York

The School Wellbeing Project in York was fully implemented in September 2016; in addition to the funding allocated through FiM monies, the CCG has invested additional funding of £14,430 from NHSE CYP additional mental health allocation. There are six wellbeing workers covering the six school clusters in York providing advice and training on mental health and wellbeing, and offering group work and 1:1 support. The project group meets bi-monthly (next meeting is 4 May 2017), and monitoring data is now being received.



SWS Activity report  
.xlsx



SWS Evaluation  
framework.docx



School Wellbeing  
Service - Project upda

#### 2. North Yorkshire School Mental Health Project

The procurement for the School Mental Health Project for North Yorkshire is completed and mobilisation of the service has commenced and planned to go live in May 2017.

There will be one Wellbeing Worker for each local authority district, therefore one in the Selby area and one in Hambleton District, which includes Easingwold. Comprehensive training sessions have been run in schools for staff to consider the issues of emotional well-being and stigma.

The provider, Compass, offer a web portal that provides links to appropriate websites for advice and support for children, parents/carers and professionals, and offer downloadable self help tools and apps. Initial website is now active with links to appropriate websites

<http://www.compass-uk.org/northyorkshirehealthandwellbeingproject/>



Compass - North  
Yorkshire School Ment

## Annex 1

### 3. Eating Disorders service

The CAMHS service, commissioned through Tees Esk and Wear Valley NHS Trust has completed the recruitment of additional posts for the service, with the exception of the Consultant Psychiatrist post in York which remains to be filled (0.4 WTE). The service is operational Monday-Friday 5 days a week, 9am-5pm; there are presently 45 CYP on the caseload. The service is delivered in the community through a hub and spoke model, working in partnership with locality based CAMHS teams. The hubs are based in Harrogate and York. There are 45 CYP on the caseload across NYY. Appointments are booked to meet the new waiting time standards. The operational policy is in place and progress continues to be made against consistency of care delivered. Training is planned for the service which includes 'Guided self-help' and 'Meal support for young people and their families'.

KPIs have been agreed for 2017/18 and beyond and will be monitored through Quality and Performance meetings. TEWV staff have been trained on the national programme and also appointed as trainers on the programme.



FINAL NY\_VOY  
PERFORMANCE REQ.X

The CAHMS service is currently reviewing the service and providing in Q2 an Action Plan to the CCGs on the readiness to apply for membership to the Quality Assurance Network.

### 4. Progress on other local priorities

1. **Single Point of Access** for CAMHS in York and Selby is now operational and an open day was run for stakeholders in March. All new referrals come through SPA and will receive at least 30 minute phone call with a clinician on duty, who will decide on the appropriateness of a full assessment or signposting to other services.

Formal monitoring through the CAMHS KPIs will start on 1 April 2017, whilst staff report the SPA has been well used, with the effect that a more consistent service is developing across the area as staff develop a common approach towards referrals handling. When the crisis service comes online in June 2017, there will be a positive effect on capacity in clinics. The close working between well being workers and CAMHS is developing a clearer pathway for referrals.

## Annex 1



Minutes February  
2017.docx

### 2. **The SDIP agreed with TEWV** is monitored at CMB



Integrated SDIP Vale  
o York - February 2017.docx



TEWV CMB Minutes  
20 03 17\_v1.doc.docx

### 3. **The Waiting List initiative** funded ADHD assessments for 23 young people to reduce waiting times, as numbers have increased significantly and waiting times have also increased; a capacity and demand plan is under preparation by TEWV to set out approaches to managing the workload for ADHD, CAMHS and autism. TEWV has now agreed with NHS England a timetable for waiting time data for 2016/17 to support the waiting lists initiative, this will be available at the end of May 2017. KPIs agreed for 2017/18 will measure as standard the time between referral and treatment.



York CCG CAMHS  
implementation Plan v1.docx

### 4. **Policing and Crime Act 2017: mental health provisions.** The mental health provisions within this act are designed to improve outcomes for people experiencing a mental health crisis by helping to ensure that they get the most appropriate support and care, promptly. For example, this means for children and young people under 18 years old, prohibiting the use of police cells as places of safety. S136 reporting forms part of the TEWV Quality & Performance monthly meeting and any breaches would be investigated as a priority

### 5. **The CQUIN for transitions** has been monitored.

This shows a high level of underperformance across the whole area including York, and has highlighted some issues such as the appropriate pathway for those young people referred at age 17, for whom there may not be time to develop a transition plan. The matter will be closely monitored at Q4 and decisions taken regarding future work to

## Annex 1

achieve compliance with the CQUIN targets.



CQUIN Q3  
Transitions.docx

6. **Early intervention in psychosis:** this continues to be monitored as part of the suite of KPIs. The CCG has noted the recent deep dive on EIP and will address the issues highlighted as they affect young people under 18



Copy of Copy of EIP  
Deep Dive Output Forr

7. **Yorkshire and the Humber Child Sexual Assault Assessment Services (CSAAS) 2017/18.** NHS England have confirmed that the contractual arrangements for this service, which has been co-commissioned with the North Yorkshire Police and Crime Commissioner and is delivered by York Teaching Hospital NHS Foundation Trust. The service will continue to be delivered from the Acorn Unit within York Hospital and will work closely with police, local authority staff and CAMHS for those children who are, or are suspected to be victims of sexual assault/suspected to be victims of sexual assault. The service operates Monday to Friday 9-5. CYP requiring assessment at weekends or bank holidays will be seen by Mountain Healthcare Ltd in West Yorkshire or Sheffield Hospital in South Yorkshire.



YatH CSAAS Service  
Overview 2017-18 - A1

### 8. **Peri-natal mental health (PNMH)**

Recent scoping exercises have highlighted a gap in specialist perinatal mental services across North Yorkshire and York. Following on from the unsuccessful bid to NHSE for specialist PMH services, a North Yorkshire and York perinatal mental health sub-group has been established (sitting under the North Yorkshire and York Maternity network). The purpose of this group is to drive forward this area of work and prepare for the application for further funding from NHSE in wave 2 (expected July 2017).

## Annex 1



ACTIONS from PNMH  
sub-group (12 April 2016)

9. **Service Development Improvement Plan:** this is agreed with TEWV and continues to be monitored.



Integrated SDIP Vale  
of York - February 2016

### 10. Crisis Care Concordat (all age crisis response)

This project is led by Tees Esk and Wear Valley (TEWV) with input from across partner agencies. An action plan has been developed from the partnership-wide improvement 'superflow' week held in March 2016.

TEWV undertook a month long pilot to test the proposed triage and assessment process and tools began on 1 November 2016 in the Scarborough and Ryedale locality. Joint work is ongoing to develop and agree a single crisis service specification



CCC Delivery Group  
Minutes 3 March 2017

### 11. Forward planning

The TEWV New Models of care pilot programme for delivery of crisis support and intensive home treatment will be pursued to ensure more children and young people receive the right level of care closer to home.

The monitoring of the two School Wellbeing Projects will continue. The monitoring of Eating Disorders Service and CAMHS targets and delivery will be through Quality and Performance meetings and CMB as well as the respective local authority partnerships.

We will be developing the City of York SPEMH and North Yorkshire County Council SEMH Board through action plans to align local priorities with Future in Mind and meet national targets through the IAF.

Projects and workstreams for the coming period include:

## Annex 1

- Monitoring the Well being worker projects
- Monitoring CEDS and CAMHS performance through CMB and Q and P committees
- Monitoring of EIP access standards through Q and P and CMB, noting the deep dive report in March 2017
- Monitoring national and IAF targets for CAMHS
- Working with the Peri-Natal Mental Health group
- Working with TEWV on the New Models of Care pilot project
- Develop and implement the Partners in Practice (NYCC) integrated support pathway across health education and care for children often known to troubled families and sometimes known to the youth justice service.
- Workforce development plan to ensure increased knowledge of mental health issues in children and young people.
- Develop with providers and local authority colleagues engagement arrangements for children and young people.
- Develop a pilot project in COY with NSPCC for counselling for children and young people to support emotional and mental health
- Develop the FIRST extension project (COY) in conjunction with NYCC and East Riding Council for a regional development and delivery model, new build facilities and redevelopment of intensive short breaks provision
- Working on development of a project (COY) for regional commissioning for low incidence high support needs SEND, with NYCC and NATSIP/Seashells Charities

## Annex 2

### Regional Assurance of CYP MH Refreshed Local Transformation Plans North Region

**Hambleton, Richmondshire and Whitby CCG  
Harrogate and Rural District CCG  
Scarborough and Ryedale CCG  
Vale of York CCG**

#### **Overall Feedback**

The plan clearly demonstrates a good understanding of local need and sets out proposed ways of addressing these. There is clearly a tremendous amount of collaborative working across the 4 CCGs with all the various other partners including LAs and providers, work needs to be carried out to improve links with the voluntary sector.

Some achievements have already been made and there are clearly other improvements in the offing. However, the plan needs to demonstrate a much more detailed action plan setting out key KPIs and outcome measures for delivery. The plan also needs to evidence better risk management mechanisms.

Whilst there has been some good examples of multi-agency and stakeholder engagement, this could be improved by better involvement of parents and carers and taking forward plans for use of digital technology. The plan also needs to strengthen proposals on how to support vulnerable groups particularly those in the youth justice system and to consider other support to LAC children over and above the life coach model.

There are some good examples of shared learning from pilots and even looking further afield, this needs to be built upon to avoid inequity of access across such a large geography.

	KLOE	Rating	Feedback
<b>1</b>	<b>Transparency and governance</b>		<b>1 Transparency and governance</b>
A	Will the LTP be both refreshed and republished by the deadline of 31 October 2016 and is it included in the STP?	<b>Green</b>	Refreshed and re-published and working to align with the 3 STPs in the area
B	Does the LTP include a baseline (15/16), including figures for: <ul style="list-style-type: none"> <li>- finance;</li> <li>- staffing (WTE, skill mix, capabilities);</li> <li>- activity (e.g. referral made/accepted; initial and follow-on contacts attended; waiting times; CYP in treatment)</li> </ul>	<b>Green</b>	Contained in appendices, could be improved by adding info re skill mix
C	Is the refreshed LTP the result of engagement with a wide variety of relevant organisations, including children, young people and their parents/carers, youth justice and schools & colleges? Does it evidence their participation in: <ul style="list-style-type: none"> <li>- Governance</li> <li>- Needs assessment</li> <li>- Service planning</li> <li>- Service delivery and evaluation</li> <li>- Treatment and supervision</li> </ul>	<b>Amber</b>	There has definitely been some engagement with CYP and a range of organisations, some of which is innovative e.g: going to rock events, visiting youth clubs and children being involved in question setting for procurement of school service. However, no direct engagement with youth justice referred to and the plan itself identifies the need to improve engagement with parents and carers and using digital technology.
D	Has the LTP been signed off by the Health and Wellbeing Board and other relevant partners, such as specialist commissioning, local authorities etc.?	<b>Green</b>	Signed off by both H and WBs if the governance arrangements set out in section 5 have been followed then sign off by others can be implied
E	Are there clear and effective multi-agency governance board arrangements in place with senior level oversight for planning and delivery?	<b>Green</b>	Described and illustrated in section 5
F	Does the plan clearly identify areas of effective provision alongside current challenges and priorities?	<b>Green</b>	Yes, section 4 reviews progress examples of good practice include enhanced eating disorder service, the SPA and school wellbeing project, recognises barriers and has reviewed actions. Highlights areas for improvement such as autism, self-harm and recognises the need for equality of access which is a challenge across such a



			big geography but new initiatives in different localities such as school projects are learning from existing projects and all will benefit from pilots eg: telephone links to CAMHS, online assessment tool and NSPCC bespoke counselling service.
G	Are there clear mechanisms and KPIs to track progress?	Amber/red	Whilst there are clear reporting structures the plan does not set out any specific KPIs to report against and action plans for the implementation of this plan are yet to be developed.
H	Is the refreshed LTP published on local websites for the CCG, local authority and other partners? Is it in accessible format, with all key investment and performance information from all commissioners and providers within the area?	Green	Yes published and includes data
<b>2</b>	<b>Understanding local need</b>		<b>2 Understanding local need</b>
A	Has the plan been designed and built around the needs of CYP and their families?	Green	Plan articulates local need and describes how service improvements look to meet those needs i.e.: earl intervention and advice to meet gaps, focus on self-harm, SPA and self-referral etc.
B	Does the plan evidence a strong understanding of local needs and meet those needs identified in the published Joint Strategic Needs Assessment (JSNA)?	Green	Yes, outlined in section 6 which also cites other sources of data such as CHEIMAT, child health profiles, growing up in Yorkshire survey
C	Does the plan make explicit how health inequalities are being addressed?	Amber	Identifies particular groups of vulnerable young people, examples of good practice such as life coaches, refers to transforming care for LD and autism but doesn't state specifically what is being done, refers to transition but doesn't say what is being done specifically, makes links with EHCP and improved health input to plans but makes no mention of work with children in the youth justice system
D	Does the plan contain up-to-date information about the local level of need and the implications for local services?	Green	Yes
<b>3</b>	<b>LTP ambition 2016-2020</b>		<b>3 LTP ambition 2016-2020</b>
A	Does the LTP identify a system-wide breadth of transformation of all relevant partners, including the local authority, third sector, youth justice and schools & colleges?	Amber	There is clearly work with health, social care and schools but due to geography recognises work still to be done with voluntary sector, needs to improve engagement of parents and carers and evidence work with youth justice
B	Does the plan have a vision as to how delivery will be different in 2020? (is there a visions, and how differs)	Green	Articulated in section 1
C	Does the plan address the whole system of care including:	Green	All identified throughout h the plan

	early prevention and early intervention, early help provision with local authorities, routine care, crisis care and intensive interventions, groups with extra vulnerability, inpatient care, specialist disorders		
<b>4</b>	<b>Workforce</b>		<b>4 Workforce</b>
A	Does the LTP include a multi-agency workforce plan?	<b>Red</b>	However the plan does recognise the need to develop such a plan
B	Does the plan identify the additional staff required by 2020 and include plans to recruit new staff and train existing staff to deliver the LTP's ambition?	<b>Red</b>	Not in total but does give some examples of where additional staff training may be required
C	Does the plan detail the required work and engagement with key organisations, including schools and colleges and detail how the plans will increase capacity and capability of the wider system?	<b>Red</b>	No, but recognises the need to do so and to set up a workstream to look at this
<b>5</b>	<b>Collaborative commissioning</b>		<b>5 Collaborative commissioning</b>
A	Does the LTP include details about creating joint plans to develop a local integrated pathway for CYP requiring beds that includes plans to support crisis, admission prevention and support appropriate and safe discharge?	<b>Green</b>	Yes in section 8.6 and 8.7
B	Does the LTP include details about creating joint plans to ensure join up with Health and justice Commissioners to develop local integrated pathways,(including transitioning in or out of secure settings, SARCs and liaison & diversion) A good joint plan will identify: the aim; the pathways concerned; the partners involved with a joint commitment to deliver; a project plan including planning structures; resources (including resource transfer); time scale; benefits and outcomes and; risk assessment and potential barriers.	<b>Red</b>	No specific joint plans for pathways for this group although they will benefit from the life coach pilot in North Yorkshire
<b>6</b>	<b>CYP IAPT</b>		<b>6 CYP IAPT</b>
A	Does the LTP evidence full membership and participation in CYP IAPT and its principles? These principles include: - collaboration and participation; - evidence-based practice; - routine outcome monitoring with improved supervision?	<b>Green</b>	Yes section 8.2
B	If not a CYP IAPT member, is there a clear commitment to join a CYP IAPT learning collaborative?	<b>Green</b>	Yes

C	Is there a commitment to support the participation of staff from all agencies in CYP IAPT training, including salary support?	green	Yes for CAMHS staff but doesn't mention staff from other agencies
<b>7</b>	<b>Eating disorders</b>		<b>7 Eating disorders</b>
A	Does the LTP identify current baseline performance against the new Eating Disorder access and waiting time standards ahead of measurement beginning from 2017/18?	Green	The new service will be recording against new data requirement as from October 2016
B	Does the plan clearly state which CCGs are partnering up in the eating disorder cluster?	Green	Yes
<b>8</b>	<b>Data</b>		<b>8 Data</b>
A	Does the LTP identify the requirement for all NHS-commissioned services, including non-NHS providers to flow data for key national metrics in the MH Services Data Set? (MHSDS)	Amber/red	Refers to MHSDS but doesn't state requirement for who is to report into it
<b>9</b>	<b>Urgent and emergency care (crisis) mental health for CYP</b>		<b>9 Urgent and emergency care (crisis) mental health for CYP</b>
A	Does the LTP identify an agreed plan and its implementation to expand provision for CYP in crisis care and the need for a 24/7 crisis service?	Amber	Acknowledges the need for a plan but yet to be delivered – refers to improved OOH support but does not specify 24/7 but has received money for a community intensive home support service
<b>10</b>	<b>Early Intervention in Psychosis (EIP)</b>		<b>10 Early Intervention in Psychosis (EIP)</b>
A	Does the LTP identify an EIP service delivering a full age-range service, including all CYP, experiencing first episode in psychosis and that all referrals are offered NICE-recommended treatment (from both internal and external sources)?	Green	Yes section 4.8, already in place and meeting national targets monitored monthly
B	If so, does this include the full pathway for all CYP, including those who present to the specialist CYP MH service?	Amber/green	Not specified but implicit
<b>11</b>	<b>Impact and outcomes</b>		<b>11 Impact and outcomes</b>
A	The LTP is a five-year plan of transformation. Do you have: - a roadmap to achieve the LTP vision, including trajectories which include clear year on year targets for improving access and capacity to evidence based interventions?	Amber	Clear direction of travel but needs a more specific implementation plan with objectives and timed milestones

B	The LTP is a five-year plan of transformation. Do you have: - examples of projects which are innovative and key enablers for transformation?	<b>Green</b>	Some examples of innovation – school projects, life coach model, children involved in procurement questions.
C	The LTP is a five-year plan of transformation. Do you have: - examples of how commissioning for outcomes is taking place?	<b>Red</b>	Not specifically referred to although identifies the need to improve data collection so as to better monitor outcomes. Clearly some services have been commissioned to improve outcomes but the plan needs to specify how these will be monitored, reported and acted upon
<b>12</b>	<b>Other comments</b>		<b>12 Other comments</b>
A	Does the plan highlight key risks to delivery, controls and mitigating actions? Workforce , procurement of new services not being successful or delayed	<b>Red</b>	Other than referring to difficulties presented by huge geography there is no specific reference to the management of risk or mitigation
B	Does the plan highlight or prompt the use of innovation particularly in relation to the use of social media and apps that can be shared as 'best practice'	<b>Amber</b>	Recognises the importance of using digital means of engagement and support but yet to be implemented. Has some good ideas on way forward eg: website development, involving CYP in how to go about, promotion of websites and apps and even training of staff
C	Does the plan state how the progress with delivery will be reported encouraging the transparency in relation to spend and demonstration of outcomes	<b>Amber</b>	Robust governance arrangements but needs to have clear implantation action plan with KPIs and outcomes and improved baseline data
D	Does the plan fit in with the STP and other local CYP LTPs; (CCGs are requested to provide a paragraph on alignment)	<b>Green</b>	Yes so far as possible the plan fits in with STPS but they are aligned to 3 different STP footprints. The 4 CCGs are already working together on this plan and sharing commissioning intentions for future years.
E	Does the plan show how funding will be allocated throughout the years of the plan. If risks does it highlight this within the plan?	<b>Red</b>	No – acknowledgement that further work to be done on finance planning

<b>Will the LTP be both refreshed <i>and</i> republished by the deadline of 31 October 2017 with checked URLs</b>
<b>Is the LTP appropriately referenced in the STP? Does the plan align with the STP and other local CYP LTPs (CCGs are requested to provide a paragraph on alignment)</b>
<b>If the plan is not refreshed by the deadline - has the CCG confirmed that a progress position statement on the refresh is on their website</b>
<b>Does the LTP include a baseline (15/16) actual for 2016-17 and planned trajectories which include:</b> - finance (including identification of, at least, the additional investment flowing from this LTP's share of Budget allocations and performance to date) - staffing (WTE, skill mix, capabilities); - activity (e.g. referral made/accepted; initial and follow-on contacts attended; waiting times; CYP in treatment) with clear year on year targets and performance to date for improving access and capacity to evidence based interventions
<b>Does the refreshed LTP clearly evidence engagement with a wide variety of relevant organisations, including children, young people and their parents/carers from a range of diverse backgrounds including groups and communities with a heightened vulnerability to developing a MH problem and aligned to key findings of the JSNA, youth justice and schools &amp; colleges? Does it evidence their participation in:</b>
- governance
- needs assessment
- service planning
- service delivery and evaluation
- treatment and supervision
<b>Has the LTP been signed off by the Health and Wellbeing Board and other relevant partners, such as specialist commissioning, local authorities including Directors of Children's Services and local safeguarding children's boards, Children's Partnership arrangements and local participation groups for CYP and parents/carers ?</b>
<b>Are there clear and effective multi-agency governance board arrangements in place with senior level oversight for planning and delivery and with a clear statement of roles, responsibilities and expected outputs?</b>
<b>Does the plan clearly evidence outcomes of existing services including achievements and challenges, alongside a coherent statement of strategic priorities, areas where further development is needed and future commissioning focus?</b>
<b>Are there clear mechanisms and KPIs to track progress, that are shown over the plans period? i.e.. show yr1, 2, 3 etc.</b>
<b>Is the refreshed LTP published on local websites for the CCG, local authority and other partners? Is it in accessible format for children and young people, parents, carers those with a learning disability and those from sectors and services beyond health, with all key investment and performance information from all commissioners and providers within the area?</b>
<b>Does it include specific plans to improve local services?</b>
<b><u>2. Understanding Local Need</u></b>
<b>Is there clear evidence that the plan was designed and built around the needs of all CYP and families locally who may have or develop a MH problem, with particular attention to groups and communities with a known heightened prevalence of MH problems?</b>
<b>Does the plan evidence a strong understanding of local needs and meet those needs identified in the published Joint Strategic Needs Assessment (JSNA)?</b>
<b>Does the plan make explicit how health inequalities are being addressed?</b>
<b>Does the plan contain up-to-date information about the local level of need and the implications for local services, including where gaps exist and plans to address this?</b>
<b><u>3. LTP Ambition 2017-2020</u></b>
<b>Does the LTP identify a system-wide breadth of transformation of all relevant partners, including NHS England specialist commissioning, the local authority, third sector, youth justice and schools &amp; colleges, primary care and relevant community groups ?</b>
<b>Does the plan have a vision as to how delivery will be different in 2020 and how this will be evidenced ?</b>
<b>Does the LTP align with the deliverables set out in the 5YFV for Mental Health ?</b>
<b>Does the plan address the whole system of care including:</b>

- early prevention and early intervention including universal setting, schools and primary care
- early help provision with local authorities
- routine care
- crisis care and intensive interventions
- identifying needs, care and support for groups with particular needs and who may require alternative intervention types or settings or further outreach services, such as those who have experienced trauma or abuse, looked after children, children with learning disabilities, isolated communities, groups with historically poor access to mental health services, those at risk of entering the justice system. This is not an exhaustive list and will vary from one area to another.
- inpatient care?
- specialist care e.g. eating disorders

**Does the LTP include sustainability plans going forward beyond 2020/21 ?**

**Where New Models of Care are been tested - is there a commitment to continue to invest LTP monies beyond the pilot?**

#### **4. Workforce**

**Does the LTP include a multi-agency workforce plan?**

**Does the workforce plan identify the additional staff required by 2020 and include plans to recruit new staff and train existing staff to deliver the LTP's ambition?**

**Does the workforce plan include CPD and continued participation in CYP IAPT training programmes**

**Does the plan include additional workforce requirements where provision of CYP 24/7 crisis care is not already in place ?**

**Does the workforce plan detail the required work and engagement with key organisations, including schools and colleges and detail how the plans will increase capacity and capability of the wider system?**

#### **5. Collaborative and Place Based Commissioning**

**Does the LTP include joint place based plans (between CCGs and specialised commissioning) to: develop a local seamless in-patient CYP MHS pathway across appropriate footprint - demonstrating the interdependency of the growth of community services aligned with recommissioning inpatient beds, including plans to support crisis, admission prevention and support appropriate and safe discharge?**

**Is the role of the STP reflected in joint place plans?**

**Is there evidence of clear leadership and implementation groups in place to oversee progress of place based plans?**

**Does the LTP detail how it is ensuring that there is full pathway consideration for children and young people in contact with Health and Justice directly commissioned services? This should include during their stay in secure settings, transition in and out of secure settings, and in and out of community services, whether continuing in children and young people services or moving into adult services.**

#### **6. CYP Improving Access to Psychological Therapies (CYP IAPT)**

**Does the LTP evidence full membership and participation in CYP IAPT and its principles? These principles include:**

- collaboration and participation
- evidence-based practice
- routine outcome monitoring with improved supervision

**If not a CYP IAPT member, are there plans in place to join a CYP IAPT learning collaborative?**

**Is there a commitment to support the participation of staff from all agencies in CYP IAPT training, including salary support? Does it include staff who are in other sectors than health ?**

**Is there sustainability plans for CYP IAPT learning collaboratives in preparation for central funding coming to an end ?**

#### **7. Eating Disorders**

**Does the LTP identify current baseline performance against the new Eating Disorder access and waiting time standards ahead of measurement beginning from 2017/18?**

**Does the plan clearly state which CCGs are partnering up in the eating disorder cluster?**

Where in place, is the community eating disorder service (CEDS) in line with the model recommended in NHS England's commissioning guidance?

Is the CEDS signed up to a national quality improvement programme?

## 8. Data

Does the LTP set out baseline and incremental increase in number of CYP accessing care, number of existing staff being trained and numbers of new staff recruited to deliver EB interventions? - is there evidence of progress against set trajectories ?

Does the LTP identify the requirement for all NHS-commissioned (and jointly commissioned) services, including non-NHS providers to flow data for key national metrics in the MH Services Data Set? MHSDS) Does it set out the extent and completeness of MHSDS submissions for all NHS-funded services across the area, and where there are gaps set out a plan of action to improve that data quality?

Is there evidence of the use of local/regional data reporting template(s) to enhance local data?

## 9. Urgent & Emergency (Crisis) Mental Health Care for CYP

Does the LTP identify an agreed costed plan with clear milestones, timelines for implementation and investment commitment to provide a dedicated 24/7 urgent and emergency mental health service for CYP and their families

Is there evidence of progress of planning and implementation of urgent and emergency mental health care for CYP with locally agreed KPIs, access and waiting time ambitions and the involvement of CYP and families including monitoring their experience and outcomes ?

## 10. Integration

Does the LTP include local delivery of the Transition CQUIN and include numbers of expected transitions from CYPMHS and year on year improvements in metrics?

Does the LTP include evidence of extended provision across schools, primary care, early help or specialist social care? Does it evidence a clear and actionable plan to provide a targeted service offer that reaches vulnerable groups (i.e. those with a heightened vulnerability to developing a MH problem or those with historically poor access to MH services or particular issues accessing MH services, be it cultural, communication-based, etc.)

Does the LTP include work underway with Adult MHS to link to liaison psychiatry ?

## 11. Early Intervention in Psychosis (EIP)

Does the LTP identify an EIP service delivering a full age-range service, including all CYP, experiencing first episode in psychosis and that all referrals are offered NICE-recommended treatment (from both internal and external sources)?

If so, does this include the full pathway for all CYP, including those who present to the specialist CYP MH service? Is there a commitment to specifically monitor CYP access?

## 12. Impact and Outcomes

The LTP is a five-year plan of transformation. Do you have:

- a transformation road map
- examples of projects which are innovative and key enablers for transformation;
- examples of how commissioning for outcomes is taking place?

## 13. Other Comments

Does the plan highlight key risks to delivery, controls and mitigating actions? Workforce, procurement of new services not being successful or delayed?

Does the plan highlight or prompt the use of innovation particularly in relation to the use of social media and apps that can be shared as 'best practice'?

Does the plan state how the progress with delivery will be reported encouraging the transparency in relation to spend and demonstration of outcomes?

Does the plan show how funding will be allocated throughout the years of the plan ?

If there are risks does it highlight this within the plan?

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## Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 6<sup>th</sup> September 2017 - West Offices

Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
<b>Governance</b>			
Substitute Appointments to the Health and Wellbeing Board	<u>City of York Council</u> Angela Bielby Tracy Wallis		<ul style="list-style-type: none"> <li>To appoint two additional substitutes for board members</li> </ul>
<b>Theme: Ageing Well (lead HWBB Member: Sarah Armstrong)</b>			
Adults Safeguarding Report	<u>Independent Chair</u> Kevin McAleese		<ul style="list-style-type: none"> <li>To receive the annual report of the Adults Safeguarding Board</li> </ul>
Progress against the Ageing Well theme of the Joint Health and Wellbeing Strategy	<u>York CVS</u> Sarah Armstrong		<ul style="list-style-type: none"> <li>To receive a progress update on the Ageing Well theme of the joint health and wellbeing strategy</li> </ul>
Ways to Wellbeing	<u>York CVS</u> Sarah Armstrong		<ul style="list-style-type: none"> <li>To receive a presentation on Ways to Wellbeing</li> </ul>
Older People's Survey	<u>City of York Council</u> Fiona Phillips		<ul style="list-style-type: none"> <li>To receive the initial analysis and evaluation of the older people's survey</li> </ul>
Performance Management	<u>York CVS</u> Sarah Armstrong	<u>City of York Council</u> Michael Melvin	<ul style="list-style-type: none"> <li>To receive a performance and monitoring update in relation to the ageing well theme of the joint health and wellbeing strategy</li> </ul>
<b>Other Business</b>			
Co-Production Strategy	<u>Healthwatch York</u> Siân Balsom	<u>City of York Council</u> Joe Micheli	<ul style="list-style-type: none"> <li>To receive the draft co-production strategy</li> </ul>
Better Care Fund Update	<u>NHS Vale of York Clinical Commissioning Group</u>		<ul style="list-style-type: none"> <li>To receive an update on the Better Care Fund (BCF) and the 2017/19 BCF submission</li> </ul>

## Health and Wellbeing Board – Meeting Work Programme 2017/18

### Wednesday 6<sup>th</sup> September 2017 - West Offices

Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
	Elaine Wyllie <u>City of York Council</u> Tom Cray		
Humber Coast and Vale Sustainability & Transformation Partnership (STP)	<u>NHS England</u> Julie Warren	<u>STP Office</u> Linsay Cunningham	<ul style="list-style-type: none"> <li>• To receive an update on the Humber, Coast &amp; Vale Sustainability &amp; Transformation Partnership</li> </ul>
Future in Mind	<u>NHS Vale of York Clinical Commissioning Group</u> Susan De Val	<u>City of York Council</u> Jon Stonehouse Eoin Rush	<ul style="list-style-type: none"> <li>• To receive the draft transformation plan in relation to Future in Mind</li> </ul>

## Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 8 <sup>th</sup> November 2017 - West Offices			
Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
<b>Theme: Mental Health (lead HWBB Members: Martin Farran and Phil Mettam)</b>			
Mental Health Strategy for York	<u>City of York Council</u> Martin Farran  <u>NHS Vale of York Clinical Commissioning Group</u> Phil Mettam		<ul style="list-style-type: none"> <li>To receive a progress update on developing a mental health strategy for York</li> </ul>
Progress against the Mental Health theme of the Joint Health and Wellbeing Strategy	<u>City of York Council</u> Martin Farran  <u>NHS Vale of York Clinical Commissioning Group</u> Phil Mettam		<ul style="list-style-type: none"> <li>To receive a progress update on the mental health theme of the Joint Health and Wellbeing Strategy</li> </ul>
Performance Management	<u>City of York Council</u> Martin Farran  <u>NHS Vale of York Clinical</u>		<ul style="list-style-type: none"> <li>To receive a performance and monitoring update in relation to the mental health theme of the Joint Health and Wellbeing Strategy</li> </ul>

## Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 8 <sup>th</sup> November 2017 - West Offices			
Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
	<u>Commissioning Group</u> Phil Mettam		
<b>Other Business</b>			
Better Care Fund Update (tbc)	<u>NHS Vale of York Clinical Commissioning Group</u> Elaine Wyllie  <u>City of York Council</u> Tom Cray		<ul style="list-style-type: none"> <li>• To receive an update on the Better Care Fund</li> <li>• To include the work programme for the joint commissioning strategy</li> </ul>
Update from the HWBB Steering Group	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>• Update from the HWBB Steering Group</li> </ul>
Annual Report of the Children's Safeguarding Board	<u>Independent Chair</u> Simon Westwood		<ul style="list-style-type: none"> <li>• To receive the annual report of the Children's Safeguarding Board</li> </ul>

## Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 24 <sup>th</sup> January 2018 - West Offices			
Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
<b>Theme: Living &amp; Working Well (lead HWBB Member: Sharon Stoltz)</b>			
Progress against the Living & Working Well theme of the Joint Health and Wellbeing Strategy	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>To receive a progress update on the Living &amp; Working Well theme of the Joint Health and Wellbeing Strategy</li> </ul>
Performance Management	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>To receive a performance and monitoring update in relation to the Living &amp; Working Well theme of the Joint Health and Wellbeing Strategy</li> </ul>
Healthy Weight/Active Lives Strategy	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>To receive a draft Healthy Weight/Active Lives Strategy for consideration</li> </ul>
Alcohol Strategy for York	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>TBC</li> </ul>
<b>Other Business</b>			
Better Care Fund Update (tbc)	<u>NHS Vale of York Clinical Commissioning Group</u> Elaine Wyllie  <u>City of York Council</u> Tom Cray		<ul style="list-style-type: none"> <li>To receive an update on the Better Care Fund</li> </ul>
Update from the HWBB	<u>City of York Council</u>		<ul style="list-style-type: none"> <li>Update from the HWBB Steering Group</li> </ul>

## Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 24 <sup>th</sup> January 2018 - West Offices			
Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
Steering Group	Sharon Stoltz		

Wednesday 7 March 2018 - West Offices			
Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
<b>Theme: All themes: Reducing Health Inequalities – content of agenda tbc</b>			
TBC: Reducing Health Inequalities through Cultural Commissioning	Tbc	Tbc	<ul style="list-style-type: none"> <li>Tbc</li> </ul>
<b>Other Business</b>			
Update from the HWBB Steering Group	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>Update from the HWBB Steering Group</li> </ul>
Pharmaceutical Needs Assessment (PNA)	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>To receive a new PNA for the city covering the period 2018-21</li> </ul>

## Health and Wellbeing Board – Meeting Work Programme 2017/18

Wednesday 9 May 2018 - West Offices			
Item/Topic	Lead Organisation & Officer	Other Contributing Organisations & Participants	Scope
<b>Theme: Wrap up Meeting – content of agenda to be confirmed</b>			
Performance Management	<u>TBC</u>		<ul style="list-style-type: none"> <li>To receive a performance and monitoring update in relation to the Joint Health and Wellbeing Strategy</li> </ul>
<b>Other Business</b>			
Update from the HWBB Steering Group	<u>City of York Council</u> Sharon Stoltz		<ul style="list-style-type: none"> <li>Update from the HWBB Steering Group</li> </ul>

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