

**Notice of a public meeting of
Health and Wellbeing Board**

To:	Councillors Runciman (Chair), Craghill, Cannon and K Myers
	Dr Nigel Wells (Vice Chair) Chair, NHS Vale of York Clinical Commissioning Group (CCG)
	Sharon Stoltz Director of Public Health, City of York
	Sharon Houlden Corporate Director, Health, Housing & Adult Social Care, City of York Council
	Amanda Hatton Corporate Director, Children, Education & Communities, City of York Council
	Lisa Winward Chief Constable, North Yorkshire Police
	Alison Semmence Chief Executive, York CVS
	Catherine Scott Interim Manager, Healthwatch York
	Gillian Laurence Head of Clinical Strategy (North Yorkshire & the Humber) NHS England

Vacant until April 1	Director of Operations, North Yorkshire & York - Tees, Esk & Wear Valleys NHS Foundation Trust
Mike Proctor	Interim Chief Executive, York Hospital NHS Foundation Trust
Dr Kevin Smith	Executive Director for Primary Care and Population Health, NHS Vale of York Clinical Commissioning Group
Mike Padgham	Chair, Independent Care Group

Date: Wednesday, 13 March 2019

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

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 3 - 12)

To approve and sign the minutes of the last meeting of the Health and Wellbeing Board held on 17 October 2018.

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 Tuesday 12 March**.

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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Residents are welcome to photograph, film or record Councillors and Officers at all meetings open to the press and public. This includes the use of social media reporting, i.e. tweeting. Anyone wishing to film, record or take photos at any public meeting should contact the Democracy Officer (whose contact details are at the foot of this agenda) in advance of the meeting.

The Council's protocol on Webcasting, Filming & Recording of Meetings ensures that these practices are carried out in a manner both respectful to the conduct of the meeting and all those present. It can be viewed at:

http://www.york.gov.uk/download/downloads/id/11406/protocol_f_or_webcasting_filming_and_recording_of_council_meetings_20160809.pdf

4. Report from the Place Based Improvement (Pages 13 - 14) Partnership

The following provides an update to the Health and Wellbeing Board (HWBB) on progress of the PBIP.

5. Care Quality Commission - Local System (Pages 15 - 62) Review Progress Report

This report provides the board with an update on the Care Quality Commission (CQC) progress report on the local system review of York, including a summary of their findings and York's system response.

- 6. Better Care Fund Update** (Pages 63 - 76)
This report on the Better Care Fund provides an update on the progress against national targets, national reporting to NHS England, NHS England planning and guidance, information on a recent co-production event and progress with the Whole System Demand and Capacity Model.

THEMED MEETING: LIVING AND WORKING WELL

- 7. Performance Report: Living & Working Well** (Pages 77 - 88)
This report outlines the current position against a set of indicators in respect of the living and working well theme within the joint health and wellbeing strategy 2017-2022.
- 8. Update on Development of a Healthy Weight Strategy in the City of York** (Pages 89 - 116)
This report updates the Health and Wellbeing Board (HWBB) with progress on the development of a Healthy Weight Strategy for adults and children in the City of York, and invites any comments from the board about the strategy.
- 9. Draft Learning Disabilities Strategy** (Pages 117 - 152)
This report asks the Health and Wellbeing Board to formally ratify the All Age Learning Disabilities Strategy.

OTHER BUSINESS

- 10. Report from the Ageing Well Partnership** (Pages 153 - 162)
This report asks the Health and Wellbeing Board (HWBB) to endorse the recommendation of the Ageing Well Partnership to apply to become a member of the UK Network of Age Friendly Communities.
- 11. Update from the Health and Wellbeing Board Steering Group** (Pages 163 - 190)
This report provides the board with an update on the work that has been undertaken by the Health and Wellbeing Board (HWBB) Steering Group.

12. EU Exit Preparedness

(Pages 191 - 194)

This report is intended to assure the Health and Wellbeing Board (HWBB) that preparations are being made in anticipation of the United Kingdom (UK) leaving the European Union (EU).

13. Urgent Business

Any other business which the Chair considers urgent under the Local Government Act 1972.

Democracy Officer:

Chris Elliott

Telephone No – 01904 553631

Email – christopher.elliott@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting Chris Elliott
christopher.elliott@york.gov.uk

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

This information can be provided in your own language.

我們也用您們的語言提供這個信息 (Cantonese)

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

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

Bu bilgiyi kendi dilinizde almanız mümkündür. (Turkish)

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی میا 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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City of York Council

Committee Minutes

Meeting

Health and Wellbeing Board

Date

17 October 2018

Present

Councillors Runciman (Chair), Cannon,
Craghill and K Myers

Dr Nigel Wells (Chair, NHS Vale of York
Clinical Commissioning Group)

Sharon Stoltz (Director of Public Health, City
of York)

Dr Kevin Smith (Executive Director for
Primary Care and Population Health, NHS
Vale of York Clinical Commissioning Group)

Michael Melvin (Interim Corporate Director of
Health Housing and Adult Social Care, City of
York Council)

Maxine Squire (Interim Corporate Director of
Children, Education and Communities, City of
York Council)

Lisa Winward (Chief Constable, North
Yorkshire Police)

Catherine Scott (Manager, Healthwatch York)

Mike Proctor (Interim Chief Executive, York
Teaching Hospital, NHS Foundation Trust)

Lisa Pickard (Chief Executive, Independent
Care Group)

Jane Hustwit (Chair of York CVS)

Gillian Laurence (Head of Clinical Strategy,
NHS England: North Yorkshire and the
Humber)

Patrick Scott (Locality Director: York and Selby, Tees, Esk and Wear Valleys NHS Foundation Trust)

Apologies

Mike Padgham (Chair, Independent Care Group)

13. 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. None were declared.

14. Minutes

Resolved: That the minutes from the meeting of the Health and Wellbeing Board held on 11 July 2018 be approved and signed by the Chair as a correct record.

15. Public Participation

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

16. Appointments to Health and Wellbeing Board

A report was presented to the board, asking for the confirmation of new appointments to its membership, including some new substitute members.

Resolved: That the Health and Wellbeing Board endorse the appointments as set out in the report.

Reason: In order to ensure that the Health and Wellbeing Board has the full complement of members as set out in its Terms of Reference

17. Report from the Mental Health Partnership

Tim Madgwick, the Chair of the Mental Health Partnership, introduced the report and stated that from early discussion three priority areas had initially been identified. These were:

- Self harm (and in particular, admissions to A&E for self harm)
- Housing and supported accommodation
- Long term prevention

It was also noted that communication between partners and patients would be key in working towards these priorities. He also gave special mention to the excellent work being done on suicide prevention within the Public Health Team and in particular the recent conference that they had organised.

Members of the board discussed Mental Health Crisis Support Services. It was noted that operational issues would continue to be looked at but that the service must be more resilient and sustainable and that this should be reflected in any further resources allocated to services.

Members of the board welcomed the preventative approach and the concordat and discussed the trends and data presented in the report and what this meant for mental health in York. The chair of the partnership highlighted that whilst we have data, the challenge was now to understand what this meant for mental health in York. Officers also highlighted that it was now important to understand what these preventative pathways would look like and what resources needed to be committed. It was noted that system wide co-operation would be key in establishing any community focussed preventative services.

Members discussed IAPT (Improving Access to Psychological Therapies) and the potential challenges around workforce in this area. It was also noted by the Chair of the Clinical Commissioning Group that GP referral behaviour in this area had changed due to the demands on the service and that this would need to be challenged when looking at the service.

Cllr Runciman, the Chair of the board, highlighted that members of the Health and Wellbeing Board were being asked to sign up to the Prevention Concordat for Better Mental Health.

Resolved: That completion of the necessary documentation for sign up to the prevention concordat for better mental health be delegated to the Chair of the Health and Wellbeing Board and the Director of Public Health; and

That a commitment be made by members of the board as both leaders within their own organisations and as leaders across the York health and social care system, to do what is required to transform the mental health of people living in York. Board members were asked to take this back to their individual organisations for action.

Reason: To give the Health and Wellbeing Board oversight of the work of the new Mental Health Partnership.

18. All Age Autism Strategy Update

Officers introduced the update to the All Autism Strategy and highlighted two key issues that are of primary focus:

- Promoting and understanding autism; and
- Improving information for those who are awaiting assessment

Members asked about the literature that is currently available for schools regarding assessments and diagnosis and on what support is available for families whose children may not be diagnosed. Officers informed the Board that work is currently ongoing with CAMHS (Children and Adolescent Mental Health Services) in order to develop literature for schools. It was also noted that there is support available for families with children who are not diagnosed, however this is mostly in the form of signposting to other local services and support based within schools. Officers highlighted that this is a gap in provision but is a difficult area to resolve due to the individual nature of support required by families in this situation.

There was discussion regarding the thresholds used for diagnosis and whether these were correct. Officers informed the board that this is something that is being looked at and should the data continue to imply that the diagnosis is low, further work would be done to interrogate the current thresholds and the screening processes.

Officers also mentioned the need to not lose sight of the aim to build a community approach to tackling issues such as autism and the support that the community can give to families and adults who are diagnosed.

The board also discussed the employment of adults with autism. Officers agreed that this is a key area and currently employment rates are very low. It was noted that there has been work carried out on supported internships and work continues with United Response to improve the levels of employment.

The Chair asked officers to distribute information amongst board members regarding autism awareness training.

Resolved: The Health and Wellbeing Board endorse the All Age Autism Strategy action plan to maintain the progress to meeting need and proactively promoting an autism inclusive city; and

Health and Wellbeing Board members promote autism awareness training to all agency frontline staff within their organisations.

Reason: To keep Health and Wellbeing Board up to date in relation to delivery against the All Age Autism Strategy

19. Refresh of the Local Transformation Plan (Future in Mind)

Officers informed the board that this was the annual refresh of the Local Transformation Plan (Future in Mind). Officers highlighted some of the successes from this year, including the positive feedback from children and staff with regards to the School Wellbeing Service and the improvements to capacity and training within schools on this issue. Officers then outlined the aims for the upcoming year.

The board asked for clarification on the funding allocated to services for the coming year. Officers informed the board of the following commitments:

- £120k recurrent funding in Limetrees (CCG)
- £50k recurrent funding into the autism pathway (TEWV)
- £90k non-recurrent funding into Autism Assessments (CCG)

Officers responded to questioning on the targets for this area and stated that significantly higher staffing levels and further resources would be needed in order to bring waiting times in line with NICE (National Institute for Clinical Excellence) guidelines, however the current funding would allow for

significantly more assessments and an improvement to waiting times.

The board discussed the concern of mental wellbeing in schools and the Interim Corporate Director for Children's Services highlighted the following points:

- That schools were building capacity and understanding in this area
- Changes to assessment within schools' curriculum were having an affect on anxiety levels and brought a new challenge
- That social media was influencing the need for new styles of pastoral care
- That zero tolerance behaviour policies were causing issues with exclusion and mental health generally.

It was confirmed that the plan covered the whole of NHS Vale of York CCG's footprint and that the CCG were accountable to NHS England for the plan on behalf of all organisations represented at the Health and Wellbeing Board.

Resolved: That the Health and Wellbeing Board have commented on the draft Local Transformation Plan and authorise the Chair to endorse the final draft prior to submission to NHS England on 26 October 2018.

Reason: In order that the Health and Wellbeing Board are sighted on the development of the Local Transformation Plan prior to submission to NHS England.

20. Healthwatch York Report: LGBT experiences of health and social care services in York

The Chair noted that this report was to be taken back to board members' individual organisations and responses sent to the Healthwatch York within 20 days.

The Manager of Healthwatch York outlined the report and highlighted under questioning that the most significant recommendation was to encourage sector wide training and education.

It was also noted that the Health and Wellbeing Partnerships Co-ordinator would circulate the details of the LGBT Forum's Training programme to the Board.

Resolved: That the report and recommendations be further considered within the individual organisations represented at the Health and Wellbeing Board

That individual organisations respond to Healthwatch York within 20 working days from the date of the board meeting, acknowledging receipt of the report and detailing any actions that they intend to take.

That the report be referred to the Joint Commissioning Group for consideration of any implications for joint commissioning.

Reason: To keep members of the board up to date regarding the work of Healthwatch York.

21. Better Care Fund Update

The Assistant Director for Joint Commissioning (CYC and NHS Vale of York CCG) was in attendance to present an update on the Better Care Fund (BCF).

The board were informed that a notice has been received from the Department of Public Health of additional funding available through the Improved Better Care Fund to assist with Delayed Transfer of Care (DTOC).

Officers informed the board co-production events for the BCF have been very effective in bringing together services and organisations to discuss and inform the use of BCF allocation. It was also noted that the Care Quality Commission (CQC) have created automated data profiles which was a positive step and an important tool for organisations.

Members of the board noted the significant improvement in patient's length of stay and highlighted issues funding the winter plan. It was also noted that there are staffing issues in both primary and secondary care and that we are currently seeing unprecedented troubles in recruiting to General Practice.

Members also commented on the importance of planning for next winter and using the BCF to help fund preventative measures and services to keep people out of hospital where possible.

Resolved: That the Health and Wellbeing Board noted and commented on this report.

Reason: To keep the Health and Wellbeing Board updated in relation to the BCF

22. Report from the Place Based Improvement Partnership

The Interim Chief Executive of York Teaching Hospital NHS Foundation Trust, gave an update on the Place Based Improvement Partnership (PBIP), informing the board of the reasons for creating PBIP and a brief overview of the report.

It was noted that Cllr Cannon had written to the Chief Executive of CYC asking for the papers of the PBIP to be made available publicly.

Resolved: That this report has been noted.

Reason: To keep the Health and Wellbeing Board up to date with the work of the Place Based Improvement Partnership.

23. Report from the Health and Wellbeing Board Steering Group

The Director of Public Health presented the update from the Health and Wellbeing Board Steering Group.

It was noted that there had been a proposal to create an Ageing Well Partnership for York and the board was asked to ratify the creation of this partnership.

Resolved: That the Health and Wellbeing Board noted this update and agreed to ratify the HWBB Steering Group's decision to establish an Ageing Well Partnership.

Reason: To update the board in relation to the work of the HWBB Steering Group.

24. Safeguarding Adults Annual Report

The Chair informed the Board that the current Chair of the Safeguarding Adults Board would be stepping down due to ill health.

It was noted that the Board would like to thank Kevin McAleese for all of his hard work and wish him well.

It was also noted that the recruitment for a new Chair of this board was well under way and a candidate was expected to be appointed by the end of the month.

Resolved: That the Health and Wellbeing Board has noted the Safeguarding Adult's Board Annual Report.

Reason: To keep the board apprised of the work of the Safeguarding Adult's Board.

25. Annual Report from the Children's Safeguarding Report

The Chair informed the board that the Children's Safeguarding Board was moving to a more centralised system and the creation of a Children's Safeguarding Partnership. It was noted that the Terms of Reference were currently being finalised for this new way of working.

Resolved: That the Health and Wellbeing Board received the Annual Report of the Independent Chair of the Children's Safeguarding Board.

Reason: Communication between boards and an understanding of each board's key messages and priorities enhances collaborative work and optimum outcomes.

26. Director of Public Health for City of York: Annual Report

The Chair highlighted to the Board that the Director of Public Health's annual report was in the form of a video that was included in the agenda details.

27. Briefing Note: Care Quality Commission Follow Up Review

The Chair Highlighted that this was acknowledgement of the positive news that the CQC would be returning to carry out a

follow up review of York's joint working arrangements and relationships and was scheduled for November.

Cllr C Runciman, Chair

[The meeting started at 16:35 and finished at 18:40.



Health and Wellbeing Board

13 March 2019

Report of the Place Based Improvement Partnership**Update on progress of the York Health and Care Place Based Improvement Partnership (PBIP)****Summary**

1. The following provides an update to the Health and Wellbeing Board (HWBB) on progress of the PBIP.

Background

2. An update report of actions to date was provided to the Health and Wellbeing Board on the 17th October 2018. The Partnership meets on a quarterly basis and since the last update the Partnership have met on the 7th November 2018 and the 15th January 2019 and the next meeting is scheduled for the 11th March 2019.

Actions to Date

3. The meeting on the 7th November 2018 heavily focussed on the preparations of the CQC review and the contributions to the slide pack presentation to be presented to the CQC. In addition, to the preparation the Partnership, under the Capital and Estates workstream, had a presentation and update on Bootham and the business plan development underway across Public Sector providers, e.g. CCG, NHS Hospital Trust and CYC, as part of the One Public Estates Programme. Mental health accommodation was also discussed and agreed the need to consider a more detailed approach of benefits and costs.
4. Under the Workforce workstream Mike Proctor presented a paper on staff resourcing in domiciliary care. All agreed to support Mike Proctor and to commission next steps of the study. The Hospital Trust will resource the study.
5. In January there was a main discussion regarding the CQC report and findings to be published on the 16th January 2019.

6. The Partnership agreed there was a need for the Place Based Improvement Partnership to drive forward at pace the workstreams that have been established to improve outcomes in the health and care system in York. The workstreams – capital and estates, workforce, digital and joint commissioning – are strategically linked into the work that is taking place on a wider footprint by the Humber, Coast and Vale Sustainability and Transformation Partnership. The PBIP has appointed joint partner sponsors to collaborate on this work.
7. The PBIP also endorsed a Primary Care Network model for York. This model will bring together a range of health and social care professionals to work together to provide enhanced personalised and preventative care that is tailored to the needs of the local community. Partners agreed to work together to move forward with the implementation of this model.
8. PBIP partners attended a HWBB workshop on 25 January 2019 to consider the Care Quality Commission follow-up review that had taken place in November 2018.
9. At the workshop it was noted that the PBIP was committed to engaging in organisational development as a system partnership to support further improvement in relationships, resulting in a 'Team York' identity.
10. It was also agreed that a Memorandum of Understanding would be developed to embed the commitment to place-based working across organisations and to create clear lines of accountability across the health and social care sector in York.

The York Health and Care Place Based Partnership

Chair – Mary Weastell, Chief Executive, City of York Council

*Officer Author – Will Boardman, (Interim support for the Partnership)
Head of Corporate Strategy and City Partnerships, City of York
Council*

Glossary

HWBB – Health and Wellbeing Board

PBIP- York Health and Care Place Based Improvement Partnership



Health and Wellbeing Board

13 March 2019

Report of the Assistant Director – Joint Commissioning
(City of York Council and NHS Vale of York Clinical Commissioning
Group)

Care Quality Commission – Local System Review progress report**Summary**

1. This report provides the board with an update on the Care Quality Commission (CQC) progress report on the local system review of York.
2. It includes a summary of their findings and York's system response.

Background

3. The background information has been previously reported to the Health and Wellbeing Board (HWBB), and therefore is summarised here.
4. The Care Quality Commission (CQC) was commissioned by government to review twenty local systems during 2017 -18, focusing on how local services work together to support older people at the interface of health and social care.
5. The local system is defined by the Health and Wellbeing Board area, and therefore the City of York Council area. A performance dashboard of six key indicators was used to identify the initial programme of reviews. York was among the first twelve areas to undergo a review in this new methodology.
6. The review took place during the autumn of 2017, and included two onsite periods with focus groups, interviews and visits to services as well as documentary evidence provided by the full range of local partners.

7. The CQC Local System Review concluded with the publication of their report on 22nd December 2017. The full report is available at: <https://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems>
8. CQC continued with the programme of reviews, publishing the national report on the first twenty areas in July 2018. It is available at:
<https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england>
9. In this national report, CQC summarise the ingredients for effective system-working as follows:
 - a common vision and purpose, shared between leaders in a system, to work together to meet the needs of people who use services, their families and carers
 - effective and robust leadership, underpinned by clear governance arrangements and clear accountability for how organisations contribute to the overall performance of the whole system
 - strong relationships, at all levels, characterised by aligned vision and values, open communication, trust and common purpose
 - joint funding and commissioning
 - the right staff with the right skills
 - the right communication and information-sharing channels
 - a learning culture.
10. The thirteen recommendations for York address these aspects of joint working.
11. York Health and Wellbeing Board (HWBB) was required to submit an Action Plan to the Department of Health (now Department of Health and Social Care, DHSC) by 31st January 2018.
12. The Place Based Improvement Partnership was established at the beginning of 2018, to take forward the Action Plan with a view to developing this as a single plan for improvement across the city.

13. Chaired by the Chief Executive of City of York Council, the membership is at the most senior officer level of City of York Council, York CVS, NHS Vale of York CCG, York Teaching Hospital NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Trust, GP Board Representative, NHS England and North Yorkshire Police.
14. The group has identified key work streams which align with the work of the wider Humber, Coast and Vale Sustainability and Transformation Plan. These are:
 - Workforce
 - Digital transformation
 - Estates and capital
15. In September 2018 it was announced that government had commissioned CQC to carry out a Local System Review in three additional areas, and a follow up review to check progress against their action plans in three of the original areas. These were York, Oxfordshire and Stoke-on-Trent. Other areas were expected to undergo a 'desktop' review.
16. The follow up reviews have all taken place. Areas received headline feedback at the end of the 2 day visit. The York progress report was published by CQC on 16th January 2019. It can be found here, by expanding the list under 'our reports of local health and social care systems' and is also attached at **Annex 1**:
<https://www.cqc.org.uk/publications/themes-care/our-reviews-local-health-social-care-systems>
17. The CQC inspection team attended the HWBB Workshop on 25th January to present their report and initiate system wide discussion on our response. As this is a new methodology it is not yet clear whether a new, formal action plan will be required by the Department of Health and Social Care (DHSC) following this.
18. On 1st February it was announced that DHSC has not commissioned CQC to continue the programme of local system reviews. However, this was reversed by an announcement on 13th February that further reviews would be carried out.

Main/Key Issues to be Considered

19. The key messages from CQC were as follows:
 - York has made some progress, but it has been too slow.
 - The Place Based Improvement Partnership has been an important advance, but relationships remain an issue, and not all partners share a view about the primary role of the board.
 - Although partners cited the Health and Wellbeing Strategy as our shared vision, it was not clear that this is well recognised or understood, and people could not translate it directly into action.
 - Some great examples of joined up working at the frontline, such as the One Team, the Integrated Discharge Hub, Live Well York and Social Prescribing, but obstacles to information sharing remain.
 - York has not made significant progress on Joint Commissioning, outside of BCF, and there has been no significant progress on a joint workforce strategy.
 - Performance data shows that people's experience is similar to a year ago, for example on Delayed Transfers of Care. Commissioners are unable to be clear about the impact of action taken.
 - York needs to take a whole system approach to improvement, including full sign up to a clear, shared vision.
 - Partners need to hold each other to account for progress, not wait for external regulators to do so.
 - York needs to continue to align priorities to those of the STP (emerging Integrated Care System) and to develop a stronger voice at a regional level, so the York locality influence is effective.
20. At the workshop, CQC inspectors challenged system leaders in York to work better together on a shared endeavour, to address the barriers to moving at pace, and to ask 'what has changed for older people?'

CQC RECOMMENDATIONS

21. The published report spells out the areas for future focus as follows:

- System leaders should review the York Improvement Plan and assess progress made against the expected impact. Considering this report, system leaders should agree on revised actions, with members of the Place Based Improvement Partnership (PBIP) accountable to the Health and Wellbeing Board for designated actions.
- At our Progress Review we found that progress against the areas for improvement identified at the October/November 2017 LSR was slow. Through the PBIP, system leaders should establish how they can increase the pace of change.
- System leaders should continue to focus on developing relationships and partnership working across the system. For the PBIP to lead partnership working across the system, partners must agree on the collective system vision and strategy and develop a system wide plan that is agreed and signed up to by all system partners. There should be a system approach to new appointments, especially those at a system leader level.
- Directors of Finance across health and care should explore opportunities to work more collaboratively, owning organisational challenges as 'system challenges'. Directors of Finance should also work with commissioning leads to develop plans to facilitate joint commissioning. Commissioners should ensure that a joint commissioning strategy is developed as a matter of priority. Commissioners should also focus efforts on strengthening performance metrics and data collected at a local level to provide a greater understanding the impact of commissioned services and schemes.
- The system should accelerate the development of a system workforce strategy co-produced with independent care providers and VCSE partners.

- The system should continue to work with independent providers and utilise engagement forums to move towards a seven day service model and co-produce a model for trusted assessment.
 - The system should continue to develop and promote the Live Well York website across the system and strengthen information available for people who fund their own care.
22. The HWBB Workshop provided an early opportunity for partners to discuss these findings and to agree the system response.
23. In the first instance, the Assistant Director – Joint Commissioning was asked to co-ordinate the improvement activity. The remainder of this report begins this work.

Review of the 2018 Action Plan

24. The 2018 action plan was updated in preparation for the follow up review in October 2018. It was 'RAG' rated (red, amber, green) as requested by CQC. A further review has been carried out in February 2019, resulting in a version which includes only the residual actions. These are either now completed, ongoing or no longer applicable.

This brief version is attached at **Annex 2**.

25. It is recommended that the relevant, ongoing actions are carried forward into the new plan for 2019.

Revised action plan to be agreed by System Leaders

26. An initial outline of the 2019 action plan is being developed. This draws on the workshop discussion and preliminary consultation with system leaders and stakeholders. It aims to address the key areas for improvement highlighted by the two CQC reviews, and will be included in future updates to HWBB.
27. The governance arrangements and accountability for delivering the 2019 plan represents a key area for HWBB and the Place Based Improvement Partnership.

28. An early action, agreed at the workshop, will be to draw up a Memorandum of Understanding (MOU). This will set out the mutual commitment of partner organisations to joint action plans and shared endeavours, and spell out the responsibilities of the members of the two boards.

Increasing the pace of change

29. The Place Based Improvement Partnership will meet monthly, supported by a number of delivery groups for specific themes or work streams. The priorities of the PBIP are aligned to the STP priorities. A PBIP lead has been nominated for each area, supported by an Executive Director of the council. These are:

Digital	Lisa Winward, Chief Constable, North Yorkshire Police Sharon Houlden, Corporate Director Health, Housing and Adults Services, City of York Council
Estates and Capital	Colin Martin, Chief Executive, Tees, Esk and Wear Valleys Mental Health NHS FT Mary Weastell, Chief Executive City of York Council
Workforce	Mike Proctor, Chief Executive, York Teaching Hospital NHS FT Amanda Hatton, Corporate Director, Children, Education and Communities, City of York Council

30. There will be a review of the working groups which are already delivering activity in these areas, including groups internal to each of the partner organisations. The output of this review will be reported to PBIP. The role of the PBIP is to unblock and enable action where barriers are encountered by the delivery / working groups.
31. The PBIP also performs a vital function identified by CQC in focusing on relationships and partnership working. The 2017 review acknowledged that relationships had been difficult in the past but were improving. The 2018 progress report found progress had been made but tensions remained.
32. The PBIP has committed to engaging in organisational development as a system partnership to support further improvement in relationships, resulting in a 'Team York' identity.

The collective vision with buy in across the system

33. Phil Mettam, Accountable Officer, NHS Vale of York CCG, is leading the work on the single vision and strategy for York, initiated at the HWBB workshop in January 2019.
34. The CQC critique centred on the degree to which the vision of the Joint Health and Wellbeing Strategy was recognised across the system and they found, as a result, there was not system wide buy-in to the vision.
35. CQC did not find the vision, as published, was wrong for York; rather that it was not well known. System leaders agree the vision needs to be articulated more concisely and memorably, building a positive message on the existing vision set out in the Joint Health and Wellbeing Strategy 2017-22. Further work on this will be developed during spring 2019, facilitated by commissioners and co-produced with partners.
36. The HWBB is asked to consider how this work can be taken forward, and engage a wider local audience, for example through our citizen forums and Healthwatch York.

A System Strategy

37. In the light of the CQC reports, partners acknowledge that the JHWB Strategy does not enjoy whole system recognition and as a result, it lacks the buy-in required to achieve meaningful improvements in outcomes for local people.
38. The strategic approach is summarised thus:
 - *Promote independence, choice and control*
 - *Build up community based support*
 - *Support self-care and self-management*
 - *Give early help through targeted and short-term interventions*
 - *Use new technologies*
 - *Reduce the reliance on statutory services*

39. PBIP has made a commitment to strengthen the impact of the high level strategy by developing its key enabling work streams of digital, workforce and estates.
40. That is to say, PBIP will invest energy in answering HOW the strategy will be delivered, as well as WHAT partners will do to improve outcomes.
 - Develop a system wide plan that is agreed and signed up to by all system partners
 - The initial outline of this plan for 2019 will be shared through future updates to HWBB.
 - A system approach to new appointments, especially those at a system leader level
 - This will be addressed as part of the relationship building through PBIP.

Joint Commissioning

41. The Joint Commissioning Strategic Group (JCSG) was established in the autumn of 2018 by the council and CCG to take forward a programme of joint commissioning, beyond existing arrangements for Better Care Fund (BCF). The JCSG comprises the relevant senior officers from both organisations and is jointly chaired by the council Chief Executive and the CCG Accountable Officer.
42. The joint commissioning programme is being developed in response to shared risks and priorities. A working draft of the programme will be shared with the HWBB through future updates.

Workforce Strategy

43. As set out above, Workforce Strategy is one of the three PBIP priority work streams aligned to the STP. It will be led by the Chief Executive of York Teaching Hospital NHS Foundation Trust, supported by the council Corporate Director of Children, Education and Communities.

Seven day service and trusted assessment

44. Progress in implementing the eight changes of the High Impact Change Model (HICM) are reported to NHS England quarterly through BCF monitoring, using a self assessment tool. The Complex Discharge Steering Group leads on this work. Trusted Assessment is the last of the changes to be put in place in York, and is dependent on close partnership working across the statutory and independent sector. The Independent Care Group is contributing to the design of the model in York, which will be co-produced with providers.
45. All areas are required by the BCF national policy framework and planning guidance to have all elements of the HICM established by April 2019. We are working towards achieving this, although this is a challenging timescale.

Live Well York and information for people who fund their own care

46. The development of LiveWellYork is nearing completion, and it will be officially launched during the spring. The site already offers a wealth of health and social care and community information for local people. It will continue to be updated on an ongoing basis. The site generates detailed monitoring information which is showing high numbers of new users each month, and positive feedback for its usability.
47. The Joint Strategic Needs Assessment (JSNA) steering group is in the process of producing a JSNA on the needs of self-funders, which brings together a wide range of information sources to create a richer picture of this group than we have previously enjoyed. This JSNA will help shape how information is provided to support people make good decisions about their care and support needs. In particular, we hope to ensure people who fund their own care do not become dependent on services earlier than other people, but remain as independent and resilient as possible, connected to their communities and benefiting from universal and free services.

Consultation

48. The content of this report is based on a series of partnership discussions, both through the formal governance arrangements, such as PBIP and JCSG, and through the HWBB workshop. BCF

stakeholders have also been included in the preparation of proposals for improvement activities.

Options

49. *n/a.*

Analysis

50. *n/a*

Strategic/Operational Plans

51. This report summarises the York Improvement Plan, developed in response to the Local System Review and the Progress review. It also relates to the BCF Narrative Plan 2017-19, and to the Joint Health and Wellbeing Strategy 2017-22. In addition it supports delivery of the organisational plans of CCG and council, including the Joint Commissioning Strategy.

Risk Management

52. The main areas of risk linked to this report are:

- Failure to make faster progress to improve outcomes will see York continue to perform poorly against important indicators such as delayed transfers of care.
- Failure to articulate the vision more clearly and to embed a sense of shared endeavour will limit York's ability to deliver change for older people who need care and support.
- Failure to carry through a clear and measurable action plan is likely to result in further reviews by CQC.

Recommendations

53. The Health and Wellbeing Board are asked to:

- i. Receive the published report of the CQC progress review of York Local System.

Reason: The Board is accountable for improving the outcomes set out in the report.

- ii. Receive the shortened version of the York Improvement Plan, showing only the remaining actions, as set out in Annex 2.

Reason: in order to formally recognise the progress which has been made and to streamline future work on the plan.

- iii. Consider how the single vision and strategy should be communicated more widely to ensure whole system buy-in.

Reason: to strengthen the approach to improvement.

- iv. Define the roles and responsibilities of HWBB and PBIP for driving the pace of improvement and delivering the action plan.

Reason: to provide clarity and ensure progress is made between quarterly HWBB meetings.

Contact Details

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Corporate Director of Health, Housing
and Adults Services
City of York Council

**Report
Approved**



Date 25.02.2019

Specialist Implications Officer(s)

Wards Affected:

All

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

Annexes

- Annex 1 – CQC progress review of York (published report)
- Annex 2 – updated York Improvement Plan – brief version

Glossary

BCF	Better Care Fund
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CVS	Centre for Voluntary Service
DHSC	Department of Health and Social Care
HICM	High Impact Change Model
HWBB	Health and Wellbeing Board
JCSG	Joint Commissioning Strategic Group
MOU	Memorandum of Understanding
NHS	National Health Service
PBIP	Place Based Improvement Partnership
STP	Sustainability and Transformation Partnership
VCSE	Voluntary, Community and Social Enterprise

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York

Local System Review: Progress Report

Health and Wellbeing Board

Date of Local System Review:
30 October to 3 November 2017

Date of Progress Review:
19 to 20 November 2018

Summary of findings from progress review

What were the key areas for improvement identified in the LSR?

Following the Local system review (LSR) of York in October and November 2017, we revisited the system to look at progress against the submitted improvement plan that was developed in response to our findings.

For ease of reference, the key areas for improvement that we recommended in the LSR in 2017 were:

- Continue to develop strong relationships across the system to address the lack of collaboration and trust between system leaders.
- Develop a wider system vision for the Sustainability and Transformation Partnership (STP) footprint and a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements, to prevent duplication.
- There needs to be a system-wide response to effectively managing the social care market and domiciliary care capacity.
- Introduce an effective system of integrated assessment and reviews of the needs of people using services.
- Prioritise work towards improved performance against the high-impact change model.



- Share learning and experience between staff at the interface of health and social care so there is shared trust and historical cultural barriers are broken down.
- The full implementation of seven-day working should be reviewed across the system to ensure that after receiving care away from home, the people of York are able to return to their usual place of residence at the earliest opportunity.
- Place a greater emphasis on moving towards joint commissioning across the system.
- Complete a review of IT interconnectivity to ensure appropriate data sharing and a more joined up approach across health and social care services.
- Communicate more effectively with people who use services, their families and carers to ensure their voice is heard across the health and social care system.
- Build in clear evaluation of systems to demonstrate the impact on people and the system overall.
- Medicines optimisation should be fully embedded in the system.
- Continuing healthcare arrangements should be more robust and person centred.

System leaders built an improvement plan around these 13 areas for improvement, themed into three projects:

1. **A single plan for City of York**
2. **Enabling integration**
3. **Right care, right place, right time**

We have assessed progress and impact made against the areas of improvement and have grouped into the following themes:

- **Governance & alignment with the STP**
- **Relationships**
- **Joint commissioning**
- **Managing social care capacity**
- **Communicating with people who use services**
- **The high-impact change model and multi-disciplinary working**
- **Medicines management**
- **Continuing healthcare**
- **Digital interoperability**



What progress has been made following the LSR?

- When we carried out our LSR in October/November 2017 we found there to be a history of poor relationships between system leaders, underpinned by a lack of trust – this resulted in a lack of collaboration across the health and care system. During our Progress Review in November 2018, we found that relationships between system leaders had improved but there was still work to do to increase collaboration between system leaders and embed true system working. The Chief Executive Officer of the local authority had taken an active role in developing partnership working with health partners and had improved working relationships with the NHS trust, as well as the CCG. There was a consensus from stakeholders across different organisations and levels that the York system felt more collaborative than it had at the time of the 2017 LSR.
- Alongside improved relationships between system leaders there was also evidence of stronger partnership working at an operational level, aided in part by the system's focus on implementing the high-impact changes for managing transfers of care. The One Team had matured since the 2017 LSR, using the same documentation and establishing a single point of referral which had a positive impact on people's experiences. The Integrated Discharge Team was also working more effectively together to support people to be discharged from hospital. Operational leads reflected that multi-disciplinary working around individual people's needs was more common in York than it had ever been before.
- One of the system's key achievements was the establishment of the Place Based Improvement Partnership (PBIP) which has brought together system leaders from across health and care, as well as the Voluntary, Community and Social Enterprise (VCSE) sector and the Police. Although the Partnership was early in its development, system leaders felt that it had helped to develop relationships and provided a forum for system leaders to engage in strategic negotiations, to challenge each other and overcome barriers to joint working. One system leader described the role of the PBIP as a place to unlock issues that had been preventing the system from working together previously.
- Engagement with independent care providers had improved. Commissioners had introduced forums for providers across health and social care to come together and meet with system. The Independent Care Group for North Yorkshire and York had been given a seat on the Health and Wellbeing Board. This was a significant development in giving providers a stronger voice within the system and signalling strategic intent to engage with providers as system partners.

The system had improved the way that it communicates with the people of York so that it was better able to access the right services and support. At the time of our 2017 LSR, York had a directory of services that was out of date and underused. By the time of the progress



review, the system had launched the Live Well York website (www.livewellyork.co.uk), which is a comprehensive hub of information detailing what services were available locally and continually updated by a network of people working in the system. The system had undertaken considerable engagement with people who use services in the development of the Live Well York website. The system had also engaged with people who use services to increase public awareness of 'home first', a range of initiatives that aims to support people to leave hospital earlier (if they are well enough and the appropriate support and care they need can be carried out at home); and to support people so they don't need to go to hospital. Home first works with people to find the best way to support their healthcare needs and help them to be as independent as possible. The system had gained feedback from people on how best to embed a home first culture with people who use services and staff.

What improvements are still needed to be made?

- While certain relationships across York had improved, we found that there were still relationships that required significant development between some key partners. As was found in the LSR in October/November 2017, the difficult financial position of York's health system remained a significant barrier to partnership working and this was causing tensions between the CCG and York Teaching Hospital NHS Foundation Trust, in particular. The CCG and the trust had developed a long-term plan to address the financial deficit of both organisations collectively as a health system – the local authority was not part of this plan. Finance leads across health and the local authority were not meeting regularly and did not signal intentions to move towards any shared financial agreements outside of the Better Care Fund.
- The establishment of the PBIP demonstrated system partners' commitment to formalising partnership arrangements and improving collaboration, however there was still more work to do to establish the PBIP as the driver for system improvement. At the time of our Progress Review in November 2018 the PBIP was still embryonic, partners had not met many times and not all system leaders were clear on its purpose and priorities – some members were not familiar with the terms of reference for the group. One system leader reflected to us that people in the system had built better relationships but were not necessarily in the right place to hold each other to account. The PBIP has provided the opportunity for this to happen.
- While the PBIP had established workforce as one of its priority workstreams, limited progress had been made since the LSR in October/November 2017 with the system yet to develop a joint workforce strategy.



- At the LSR in October/November 2017 we said that the system should place a greater emphasis on joint commissioning, and by the Progress Review in November 2018 steps had been taken through the creation of the Assistant Director of Joint Commissioning post. However, this had not yet translated into increased joint commissioning activity outside of the Better Care Fund and a joint commissioning strategy was still not in place.
- While independent care providers now had opportunities for discussion with the system, some providers told us that they did not yet feel they were being engaged with as system partners, where they could work together to develop solutions to system problems, such as workforce and the home care market.
- While the system had established strategic provider forums, providers were not clear on the system's strategic approach to managing the social care market in the future, especially the home care market which was still experiencing significant challenge.
- The system had begun to establish some of the high-impact changes for managing transfers of care however there was still work to do to fully embed them into practice. The system still had some way to go to implement seven-day services across the system and needed to build on the developing relationships with independent care providers to co-produce a trusted assessor model.
- No significant progress had been made in digital interoperability since the LSR in October/November 2017. System leaders acknowledged that challenges of organisations working on different systems had not been resolved.
- While progress was being made in some areas the pace of this progress was too slow. There had been changes to leadership within several key posts in the system however this was not unusual in York and the system needed to find a way to make progress despite changes in leadership.

Background to the review

Introduction and context

Between August 2017 and July 2018 CQC undertook a programme of 20 reviews of local health and social care systems at the request of the Secretaries of State of Health and Social Care and for Housing, Communities and Local Government. These reviews looked at how people move between health and social care services, including delayed transfers of care, with a focus on people aged 65 and over. The reports from these reviews and the end-of-programme report, [Beyond barriers](#), can be found on our [website](#).

CQC was asked by the Secretaries of State to revisit a small number of the areas that received a LSR to understand what progress had been made. This report presents the findings from our Progress Review in York.

Findings from the original LSR

When we undertook the LSR in York in October/November 2017 we identified the following areas for improvement:

- Continue to develop strong relationships across the system to address the lack of collaboration and trust between system leaders.
- Develop a wider system vision for the STP footprint and a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements, to prevent duplication.
- There needs to be a system-wide response to effectively managing the social care market and domiciliary care capacity.
- Introduce an effective system of integrated assessment and reviews of the needs of people using services.
- Prioritise work towards improved performance against the high-impact change model.
- Share learning and experience between staff at the interface of health and social care so there is shared trust and historical cultural barriers are broken down.



- The full implementation of seven-day working should be reviewed across the system to ensure the people of York are able to return to their usual place of residence at the earliest opportunity.
- Place a greater emphasis on moving towards joint commissioning across the system.
- Complete a review of IT interconnectivity to ensure appropriate data sharing and a more joined up approach across health and social care services.
- Communicate more effectively with people who use services, their families and carers to ensure their voice is heard across the health and social care system.
- Build in clear evaluation of systems to demonstrate the impact on people and the system overall.
- Medicines optimisation should be fully embedded in the system.
- Continuing healthcare arrangements should be more robust and person centred.

How we carried out the Progress Review

Our review team was led by:

- Ann Ford, LSR Programme Delivery Lead, CQC
- Rich Brady, Lead Reviewer, CQC

The review team included: one other Reviewer, an Integrated Care Manager, a Director of Finance, two Analysts and a National Clinical Advisor. We were supported by two Specialist Advisors with backgrounds in local government and health leadership.

The Progress Review considered progress against the improvement plan that was developed following the original LSR in October/November 2017.

We looked at:

- Performance across key indicators
- Performance against the system improvement plan
- Stakeholder reflections on progress

We highlight areas where the system is performing well, and areas where there is scope for further improvement.



Prior to visiting the system, we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local system provide an update on the progress made against the improvement plan and feedback on this progress through a System Overview Information Request (SOIR). We consulted with national partners involved in supporting the system following the initial review and with organisations that represent people who use services, their families and carers.

- The people we spoke with included:
- System leaders from the City of York Council (the local authority), the Vale of York Clinical Commissioning Group (the CCG), York Teaching Hospital NHS Foundation Trust (the trust), Tees, Esk & Wear Valleys Mental Health Foundation Trust (the mental health trust) and elected members.
- People who work in the system across community and hospital teams.
- Local Healthwatch and York Centre for Voluntary Services (CVS).
- Independent providers of adult social care.

Detailed findings

System progress against key indicators

When we carried out our LSR of York in October/November 2017 we produced a local data profile containing analysis of a range of information from national data collections as well as CQC's own data. A refreshed local data profile was produced in September 2018.

For the purpose of this progress review we also analysed York's performance over time for six indicators:

- A&E attendance (65+)
- Emergency admissions (65+)
- Emergency admissions from care homes (65+)
- Hospital length of stay (65+)
- Delayed transfers of care (DToC) (18+)
- Emergency hospital readmissions (65+)

We looked at how York's performance against the England average had changed since the original data profile was produced, and at how performance had changed against their own history. Except for DToC, the data goes up to March 2018. DToC data goes up to July 2018.

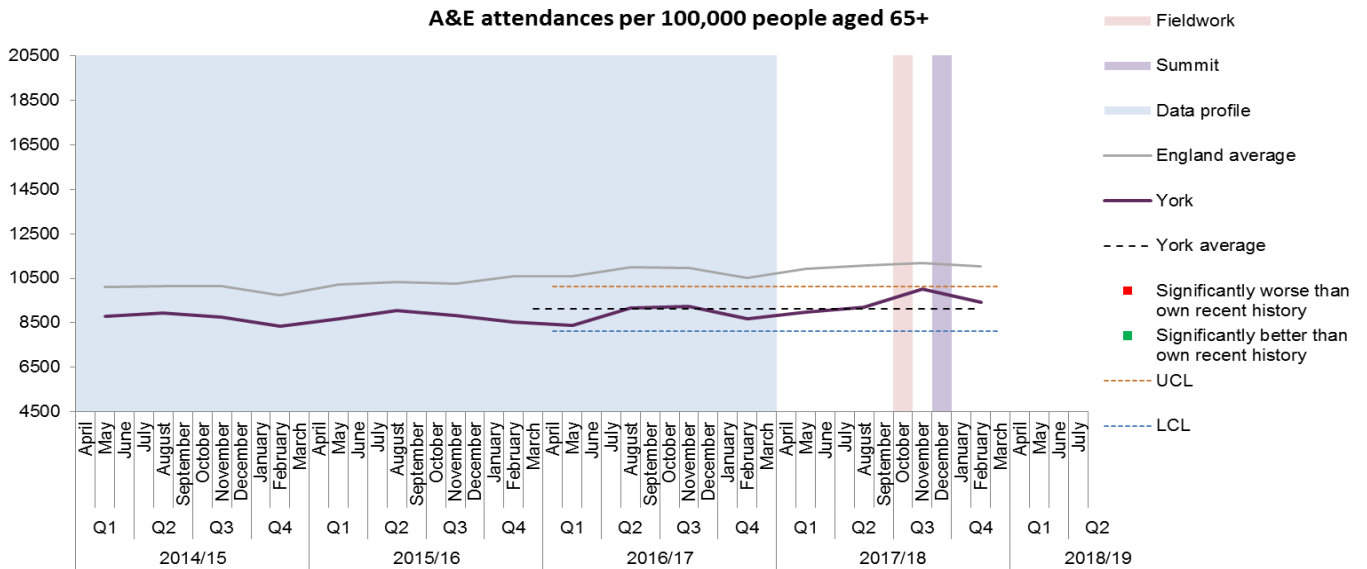
The graphs below show the data for the six indicators. Overall our analysis shows that since we produced the original data profile York's A&E attendances for older people have remained lower than the England average, but rates of emergency admissions have remained higher.

Performance had deteriorated for admissions from care homes, and was now worse than the England average. York maintained a better-than-average performance for length-of-stay. Its performance for delayed transfers of care deteriorated and, more recently improved but was still above the England average.



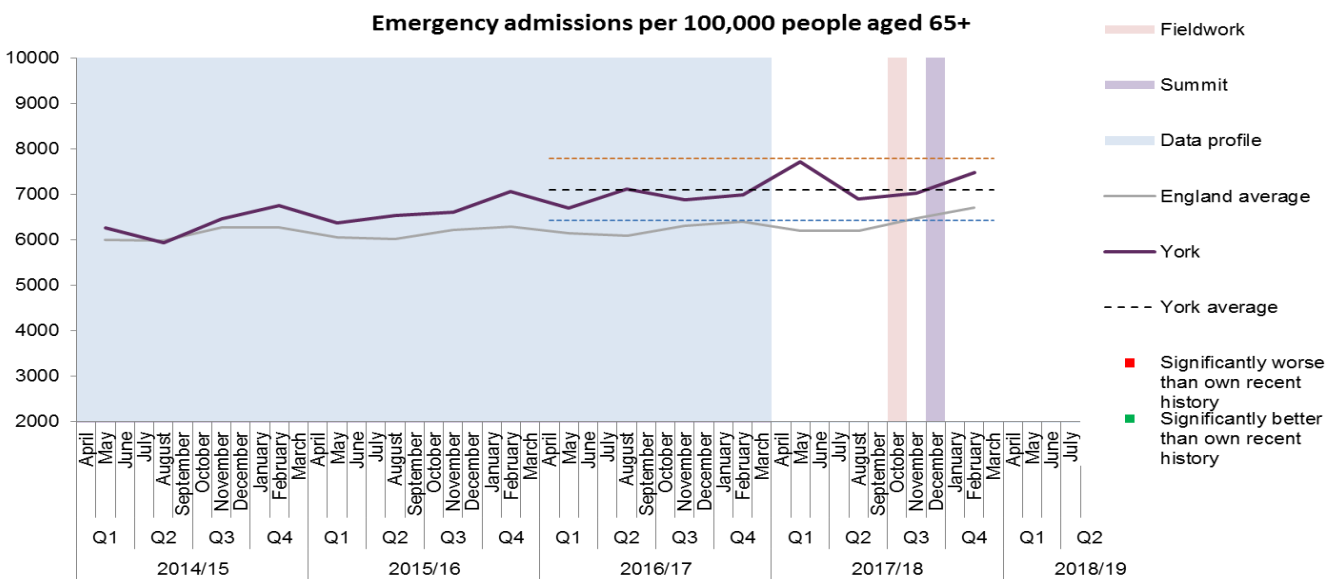
Since we produced the original data profile, York’s rate of A&E attendance (65+) had remained lower than the England average. The rate had increased overall, but had not changed significantly against the system’s average.

Figure 1: A&E attendances (65+)



Since we produced the original data profile York’s rate of emergency admissions (65+) had continued to be higher than the England average. Performance had fluctuated, but not significantly against the system’s average.

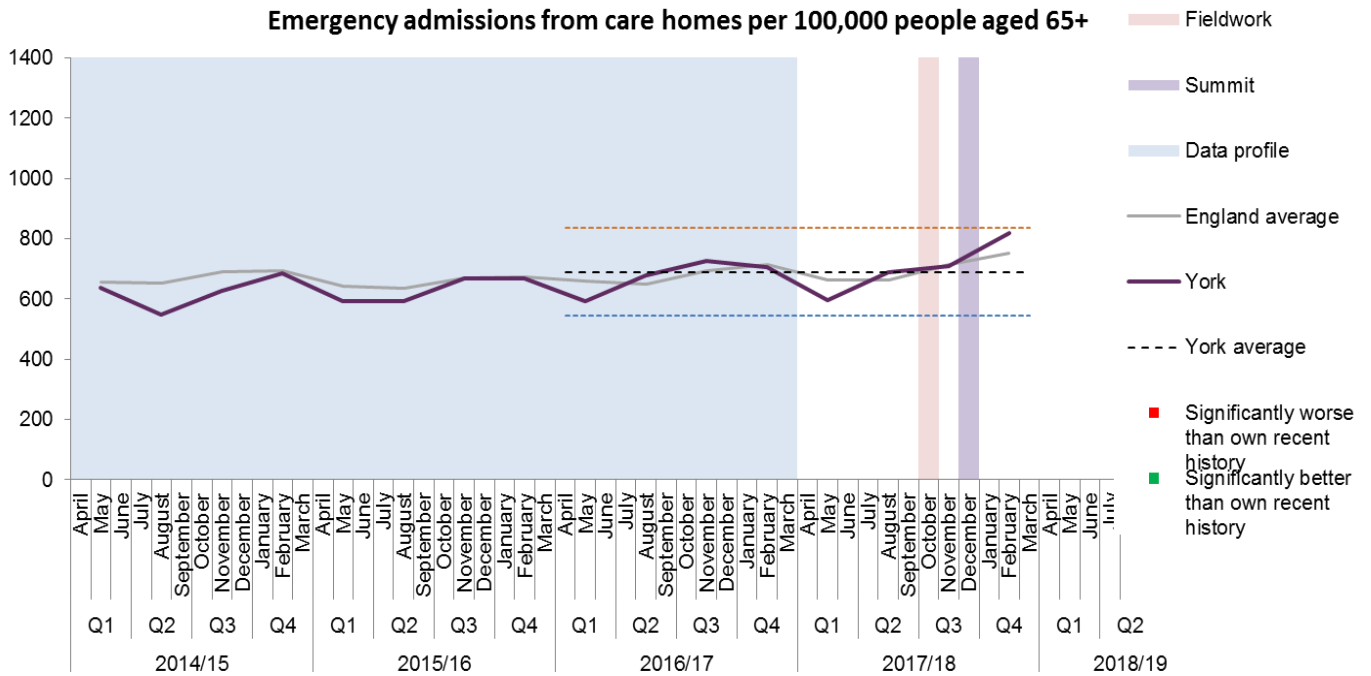
Figure 2: Emergency admissions (65+)





York's rate of emergency admissions for people living in a care home (65+) had increased since the original data profile. The rate is now higher than the England average.

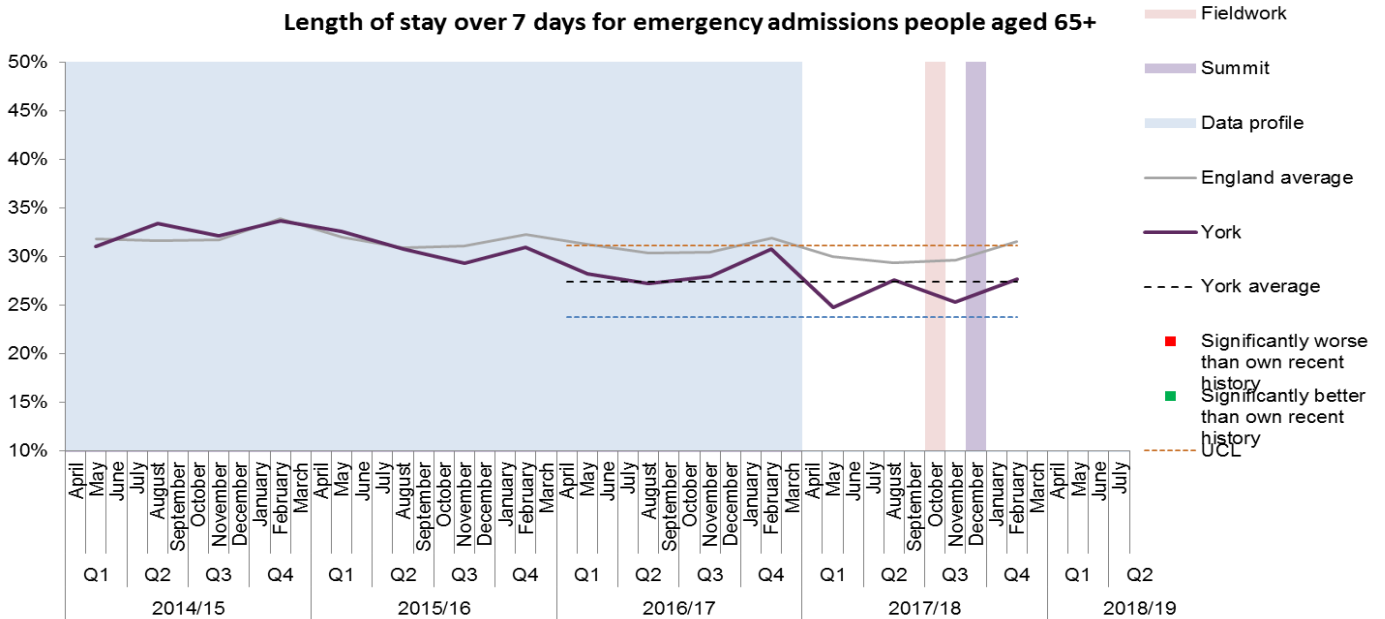
Figure 3: Emergency admissions from care homes (65+)



York's percentage of emergency admissions (65+) lasting longer than seven days had continued to remain lower than the England average. It increased slightly overall during 2017/18 from 25% to 28%.

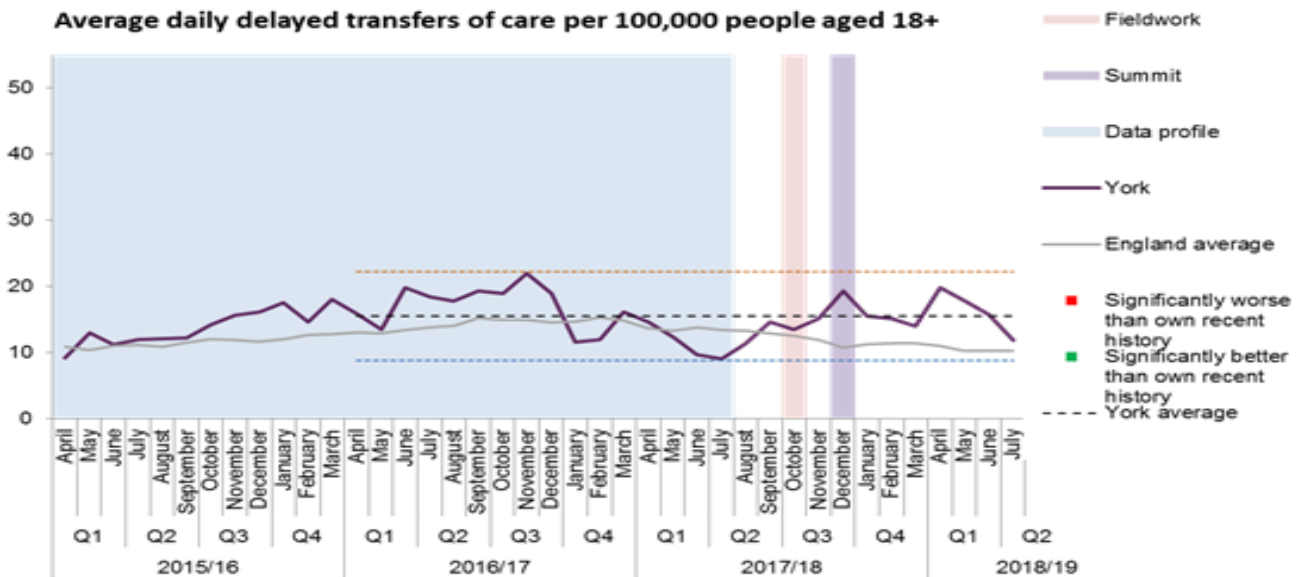


Figure 4: Length of stay (65+)



York’s rate of delayed transfers of care (18+) increased since we produce the original data profile. Performance peaked at 20 days (April 18) and was significantly higher than the England average. However, recent performance had since improved and is now closer to the England (10.3) average.

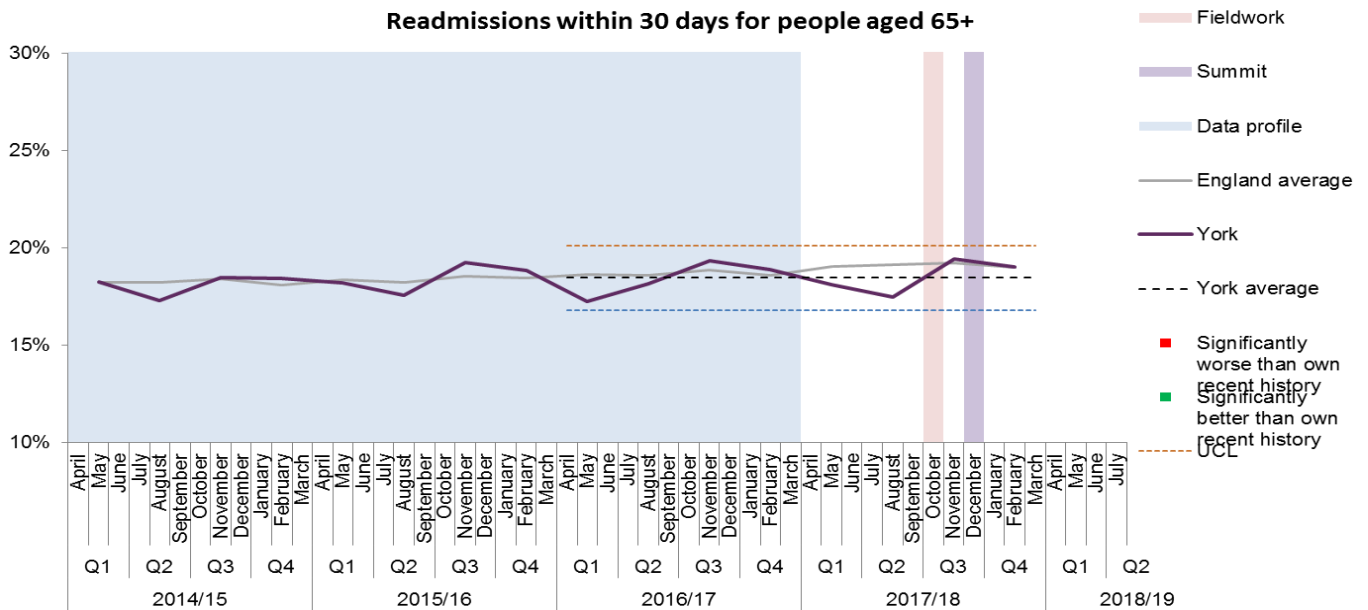
Figure 5: Delayed transfers of care (18+)



The percentage of York’s emergency hospital readmissions (65+) within 30 days of discharge increased marginally during 2017/18 from 18% to 19% and now reflects the England average.



Figure 6: Readmissions within 30 days (65+)



System progress against the improvement plan

What improvements have been made since the LSR?

Governance & alignment to STP

- Although there were still significant challenges that the system faced, since our LSR in October/November 2017 the system had made some progress. One of York's key achievements had been the establishment of the PBIP, chaired by the Chief Executive Officer of the local authority. The partnership was established in April 2018 with membership of Chief Executives / Chief Officers of the local authority, the CCG, the NHS trust, the NHS mental health trust and the York Centre for Voluntary Services (CVS). The partnership also had GP, North Yorkshire Police and NHS England representation. The PBIP was the system's strategic partnership response to system issues with a focus on promoting prevention and population health for York. The PBIP led delivery of the York Improvement Plan and would oversee workstreams for Digital, Workforce and Capital & Estates. At the time of our review the PBIP had agreed to establish programme support to manage and co-ordinate the delivery of these workstreams.



- The PBIP was established as the key framework for progressing system working. It had responsibilities for overseeing the development of integration between health and social care in York and ensuring the strategic alignment of the wider health and care system (the STP) with the Health and Wellbeing Strategy priorities and objectives. Although the partnership was early in its development, system leaders felt that it had helped to develop relationships and provided a forum for system leaders to engage in strategic negotiations, to challenge each other and overcome barriers to joint working. One system leader described the role of the PBIP as a place to unlock issues that had been preventing the system from working together previously.
- Our LSR in October/November 2017 identified that work was required for York to establish closer links with and alignment to the Humber, Coast and Vale Sustainability and Transformation Partnership (STP). At the Progress Review we were told that the links to the STP had been strengthened through improved engagement between the CCG and STP and through the representation of the York system on STP workstreams. The STP lead confirmed that York's attendance at meetings had improved in the last year and that the STP was engaged in supporting health and social care partners in York to work better together. Pharmacy leads told us that they have improved links with the STP and were now part of an STP wide medicines optimisation group where they were able to engage with leads from the other CCGs in the STP footprint.

Relationships

- When we carried out the LSR in October/November 2017 we identified that York had a long history of difficulties in partnership working which was underpinned by a lack of trust, however during our Progress Review we found that relationships were improving. Around the time of and since the original review we found there had been significant changes in leadership across the system. These include the Chief Executive Officer of the trust and the Corporate Director of Health, Housing and Adults Services in the local authority, both posts were being covered by interim appointments at the time of our Progress Review. A newly appointed Executive Director of Primary Care and Population Health had been appointed in the CCG as well as a newly appointed Chief Finance Officer. The Chief Executive Officer of York CVS had also been recently appointed prior to our Progress Review. Despite changes in leadership, relationships and partnership working had improved to some extent by the Progress Review, system leaders told us that new appointments had contributed to this. There was a consensus from stakeholders across different organisations and levels that the York system felt more collaborative than it had at the time of the 2017 LSR.
- At the leadership level, it was clear that relationships had strengthened between some partners, and the formal establishment of the PBIP would provide the forum for this to continue. The Chief Executive Officer of the local authority had taken an active role in developing partnership working with health partners and had improved working relationships



with the trust, as well as the CCG, jointly attending a 12-week leadership course with the CCG Accountable Officer earlier in 2018. Taking on the role of Chair of the PBIP also signalled a commitment to closer working relationships with system partners.

- At an operational level, we saw good relationships and collaborative working across multi-disciplinary teams of professionals. For example, in the Integrated Discharge Team there was a greater understanding of roles and responsibilities, with even the finer details of the different language used across organisations understood. In the One Team, parts of the team had become collocated and shared documentation which improved communication and reduced duplication. Operational leads reflected that multi-disciplinary working around individual people's needs is more common in York than it had ever been before.

Joint commissioning

- Our LSR in October/November 2017 found that limited joint commissioning was taking place in York. At that time a Head of Joint Commissioning had been appointed and a joint commissioning strategy approved which was expected to pave the way for more aligned commissioning functions and pooling of budgets. At the Progress Review in November 2018 the most significant development towards joint commissioning was creating the post of Assistant Director of Joint Commissioning across the local authority and the CCG. This demonstrated a joint commitment from the local authority and the CCG to invest in greater leadership over joint commissioning, and the role was regarded across the system as being important for maintaining dialogue and aligning thinking across the two commissioning bodies. Colocation of commissioners was also helping to build relationships. Although steps had been taken, a joint commissioning strategy had yet to be established.
- Since the LSR in 2017, Vale of York CCG has participated in the Commissioning Capability and Capacity Programme as part of a national initiative by NHS England. The CCG used this as an opportunity to bring together health and local authority senior leaders to focus on commissioning. We were told that the Programme had engaged senior leaders and had contributed to improved relationships across the local authority and the CCG. In addition, we saw an increased engagement with the York CVS as a system partner.

Managing social care capacity

- At the LSR in October/November 2017 we identified that York needed to develop a system wide response to managing the social care market to ensure there was capacity in the system to meet demand. At the Progress Review in November 2018 system leaders told us that they had invested in their engagement with social care providers. They had established a Partners in Care provider forum and had used funding from the Better Care Fund to invest in the Independent Care Group for North Yorkshire and York, the representative body for independent providers.



- The Independent Care Group for North Yorkshire and York had been given a seat on the Health and Wellbeing Board. This was a significant development in giving providers a stronger voice within the system and signalled strategic intent to engage with providers as system partners.
- There were forums for providers to come together and meet with the system. Providers found the Partners in Care forum useful, as this was CCG led and it helped to establish links between independent social care providers and health commissioners. In addition to the Providers in Care forum, the local authority had refreshed the Home Care Provider Forum which has met for the first time in its new format in March 2018, and had focused on issues including recruitment, workforce and service development. Providers told us that they had found the engagement around workforce particularly helpful.

Communicating with people who use services

- We found that since our LSR in October/November 2017 the system had improved the way that it communicates with the people of York so that they are better able to access the right services and support. At the time of our 2017 LSR, York had a directory of services that was out of date and underused. By the time of the Progress Review in November 2018 the system had launched the Live Well York website, a comprehensive hub of information detailing what services were available locally – this was continually updated by a network of people working in the system. Its development had benefitted from a collaborative approach between the local authority, the CCG, York CVS, Healthwatch, and Age UK.
- The system had undertaken a considerable amount of engagement with people as part of the development of Live Well York and had placed emphasis on making the website accessible, providing audio and language translation functions. Healthwatch York reviewed the website content to ensure that it was understandable to different groups. For older people who do not access information online, the website includes a function to create personalised booklets of the information they need, and the option to print them as hard copies. The group overseeing the development of Live Well York had also linked into the libraries so that computer classes taught there would use the website as part of the class. Project leads felt they had the support from across the system for it to succeed, people were talking about it and engaging with the product.
- To provide people with the opportunity to have face-to-face conversations about services in the community the local authority had also introduced three 'Talking Points' located in different parts of the city where people could book an appointment to speak with adult social care staff, making it quicker and easier to get advice, and to start outcomes based support planning. A fourth Talking Point opened after our review, with more planned in 2019.
- The system had taken part in an engagement exercise with other organisations in the North Yorkshire and York area to increase public awareness of 'home first' and to gain feedback



from people who use services on how best to embed a home first culture with people and staff. Over 400 people took part in discussions about home first and the findings were used to revise the system's Joint Transfer of Care Protocol.

The High-impact Change Model and multi-disciplinary working

- At our LSR in October/November 2017 we recommended that the system should prioritise work towards improving performance against the high-impact change model for managing transfers of care, with an emphasis on implementing seven-day working across the system. During our Progress Review in November 2018 we saw evidence of early progress of some of the high-impact changes that were making a difference. At the end of Q2, 2017-18 the system reported in their Better Care Fund return that none of the high-impact changes had been fully established. At the end of Q2, 2018-19 the system reported in their Better Care Fund return that four of eight high-impact changes had been 'established' with plans in place to establish a further three by March 2019. While these had been established, the implementation was in early stages and it was expected that once embedded they would have a greater impact. The high-impact changes established were:
 1. **Early discharge planning:** A revised approach to SAFER* (best practice in patient flow) had been introduced at the trust with a focus on early discharge planning. The trust had also introduced a pilot of an Occupational Therapist supporting pre-operative assessment of vascular patients to enable pre-admission discharge planning to start.
 2. **Multi-disciplinary/multi-agency discharge teams:** The system had introduced an Integrated Discharge Hub with a multi-agency, integrated discharge team, bringing together hospital social work teams from the local authority (alongside two neighbouring local authorities) with a discharge liaison nurse. This had improved communication between staff and reduced duplication of assessments.
 3. **Home First/discharge to assess:** The system had reviewed discharge to assess pathways with the One Team supporting the ongoing development of a supported discharge approach at home.
 4. **Enhanced health in care homes:** The system had introduced a Care Home Virtual Team which provided a wraparound service, bringing together primary care staff with support from a consultant geriatrician and community mental health teams to support care home residents. A Care Home and Dementia Team was also providing a seven-day service to support people being discharged from hospital as well as providing training to care home staff.

* **SAFER: S - Senior Review.** All patients will have a senior review before midday by a clinician able to make management and discharge decisions; **A – All patients** will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting; **F - Flow** of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am; **E – Early discharge.** 33% of patients will be discharged from base inpatient wards before midday; **R – Review.** A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mindset.



- Operational staff we spoke with told us that the implementation of the high-impact changes had a positive impact on people's experiences of transfers of care, including assessments, and were also facilitating better multi-disciplinary working. A 'home first' or 'why not home, why not today?' culture was beginning to embed within the hospital. We were told that this, along with the revised approach to SAFER, had a positive impact on people moving through the hospital quickly and the integrated discharge team were better able to support people with a more timely and collaborative approach to discharge planning. The implementation of seven-day working for social workers and discharge liaison nurses, while not increasing the overall discharge at weekend rate was showing improvements in progressing plans at weekends. The Complex Discharge Steering Group had also developed a performance framework based on collectively agreed improvement targets to measure impact of initiatives.
- The One Team, which brought together health intermediate care (community response team and primary care short term care service) with local authority reablement services and voluntary sector wellbeing support, had developed its approach to integrated care and reablement. The team had developed universal documentation and a single point of referral which meant that people did not have to wait to be seen by as many professionals and reduced duplication in assessments. Parts of the team had become co-located since the 2017 LSR. The system had intentions to move towards commissioning the One Team as a single service to remove the barriers and inefficiencies created by operating from different organisations, however this was still in early development.
- The Local Area Coordinator service in York had expanded since the 2017 LSR from covering three to now seven of the 21 electoral wards. Each coordinator covered areas of 9,000 to 12,000 people and had undertaken work to embed a strengths-based approach and further developed links between support services that were able to support people in their usual place of residence.

Medicines management

- At our LSR in October/November 2017 we said that medicine optimisation was not fully embedded in the system and that progress was needed in this area. At our Progress Review in November 2018 the system told us that funding secured through NHS England had helped to increase the level of pharmacy support in the system. By the time of our Progress Review the system had recruited six practice pharmacist posts with the funding secured from NHS England who would work to support people living in care homes.

Continuing healthcare

- At our LSR in October/November 2017 we identified that there was a lack of awareness of continuing healthcare (CHC) funding arrangements amongst frontline staff and that the



system should work to ensure arrangements were more robust and person-centred. By the time of our Progress Review in November 2018, significant work had been undertaken within the CCG and the Complex Discharge Steering Group to improve processes for completing CHC assessments. Improvements had been made to pathways, joint training was being provided to staff involved in CHC assessments and information packs for staff and people who use services had been produced. At the time of our Progress Review in November 2018 the CCG was now meeting key national performance targets for the location and timeliness of assessments.

- The CCG had placed significant emphasis on ensuring they had an acute understanding of the challenges with CHC, and had undertaken a 'deep dive' audit relating to the whole system fast track pathway. The Trust had undertaken a deep dive audit relating to delays in patient flow. These audit reports identified that the fast track tool was not always being used in line with the national framework and that the right documentation was not always being used to make decisions. These audits have led to a refresh of fast track application templates, the development of a fast track referral policy, and improved care plans for patients who are at the end of life.

Digital interoperability

- At our LSR in October/November 2017 we said that a review of IT interconnectivity should be completed to ensure appropriate data sharing and a more joined up approach across health and social care. Staff told us that progress had been slow in this area however a multi-agency Digital Integration Group had been established to begin to explore opportunities. The group met monthly and was overseen by the Chief Constable of the North Yorkshire Police, demonstrating a commitment to developing digital solutions for health and social care as well as in wider public services. To progress digital interconnectivity operational staff felt that there was a need for more senior sponsorship from across the system as it was difficult to see how progress was to be made in this area.

What improvements are still needed to be made?

Governance & alignment to STP

- The establishment of the PBIP demonstrated system partners' commitment to formalising partnership arrangements and improving collaboration. However, there was still more work to do to establish the PBIP as the driver for system improvement. At the time of our Progress Review in November 2018 the PBIP was still embryonic in its development, partners had not met many times and not all system leaders were clear on its purpose and priorities – some members were not familiar with the terms of reference for the group. While some system leaders felt that the PBIP was the place to deliver the vision of the Health and Wellbeing



Strategy, others were not familiar with the Health and Wellbeing Strategy and felt that the Partnership would be better utilised as a place to monitor performance and hold system partners to account.

- We heard that further work was planned to further establish the PBIP and its purpose, both amongst system leaders and with staff working within partner organisations. Three workstreams had been established through the PBIP and while partners had agreed to establish programme support to manage and co-ordinate the work, there was not a plan for how these would be delivered at the time of our Progress Review in November 2018. For the PBIP to lead partnership working across the system, partners must agree on the collective system vision and strategy and develop a system wide plan that is agreed and signed up to by all system partners.

Relationships

- While certain relationships across York had improved, we found that there were still relationships that required significant development between some key partners. As was found in the LSR in October/November 2017, the difficult financial position of York's health system remained a significant barrier to partnership working and this was causing tensions between the CCG and the trust. This was exemplified by the approach to planning for winter 2018/19. At the time of our Progress Review there was not a shared understanding of the total financial resource available in the system for winter and strong differences in opinions on how money should be allocated was not helping to build trust between partners.
- Both the CCG and the trust said that they were experiencing 'significant financial challenge', while the local authority was projected to achieve financial balance for the upcoming financial year. At our LSR in October/November 2017 the difference in financial position was a barrier to joint working, this was still impacting on relationships at the time of the Progress Review in November 2018. The CCG and the trust had developed a long-term plan to address the financial deficit of both organisations collectively as a health system – the local authority was not part of this plan. Finance leads across health and the local authority were not meeting regularly and did not signal intentions to move towards any shared financial agreements outside of the Better Care Fund.
- Below the system leader level there was an increase in multi-disciplinary working and improved relationships at an operational level however some partners felt that there was still an opportunity to better involve GPs in multi-disciplinary working arrangements.
- At the time of our Progress Review in November 2018, the trust was in the process of recruitment for a new Chief Executive Officer. System partners highlighted the importance of this appointment in the interest of system working, and were offering to be involved in the recruitment of this post, if possible.



Joint commissioning

- At the LSR in October/November 2017 we said that the system should place a greater emphasis on joint commissioning, and by the Progress Review in November 2018 steps had been taken through the creation of the Assistant Director of Joint Commissioning post. However, this had not yet translated into increased joint commissioning activity outside of the Better Care Fund and a joint commissioning strategy was still not in place.
- At the time of the 2017 LSR a joint commissioning strategy had been approved by the Health and Wellbeing Board, however by the time of the Progress Review in November 2018 this had not been delivered. We were told that there had been strategies in the past that were not delivered, so the system had recently established a joint commissioning steering group to oversee the development of the strategy. Despite this, it was unclear what the timescales were for the development of a joint commissioning strategy and how this would be developed.
- While there had been a reduction in the proportion of emergency admissions (65+) lasting longer than seven days (length of stay) commissioners were unable to isolate specifically the initiatives which had contributed toward this. System leaders told us that they did not have access to sufficient data to effectively evaluate the impact of all services and schemes and that the Better Care Fund Performance and Delivery Group was exploring how they could improve access to greater levels of intelligence and data.

Managing social care capacity

- At our LSR in October/November 2017 independent providers told us they were not engaged in the system's strategic planning. At our Progress Review in November 2018 we found that independent providers now had greater opportunities for discussion with the system, however they told us that they did not yet feel they were fully engaged with as system partners, where they could work with commissioners to develop solutions to system problems, such as workforce and the home care market.
- Providers were not clear on the system's strategic approach to managing the social care market in the future, especially the home care market which was still experiencing significant challenge. While the local authority's market position statement (October 2017) identified the need to focus on preventative care, maintaining independence and promoting resilience, it did not set the system's commissioning intentions for home care, an important partner in helping the system realise these ambitions.
- Sixty-five per-cent of people who access social care in York fund their own care. The high proportion of people who fund their own care was impacting on the way the market functions, with people better able to exercise choice over what care they receive and care providers able to charge high fees that the local authority cannot sustain. These challenges aside,



progress had not been made to work with the sector to create capacity and enable commissioning of care in a sustainable way.

- At our Progress Review in November 2018 we found that establishing a sustainable workforce across health and social care continued to be a challenge for the system. The trust was continuing to use high numbers of agency staff, and in adult social care, estimated turnover rates had increased from 31.0% in 2016/17 to 36.3% in 2017/18. As part of the system's improvement plan they set out to develop a refreshed workforce strategy, however this had not materialised by the time of the Progress Review. Discussion about how the system should address workforce issues were still taking place at the time of our Progress Review and the VCSE sector had not been part of these discussions. While the system had established a workforce workstream that would report into the PBIP, work was not due to begin until programme management support had been established. The system should accelerate the development of a workforce strategy co-produced with partners.

Communicating with people who use services

- The system had come a long way in improving the way in which it communicates with people who use services, exemplified by the development of Live Well York, which was providing more accurate information and advice to people who use services, their families and carers. However, further work was needed to better engage health partners such as the trust and the mental health trust in its ongoing development. We found there was also an opportunity, through the website, to improve the offer to people who fund their own care or people who receive direct payments.

The High Impact Change Model and multi-disciplinary working

- At our LSR in October/November 2017 we found that the system had not made enough progress in establishing the high-impact changes for managing transfers of care. At our Progress Review in November 2018 we found that while progress had been made to establish four of the high-impact changes (with plans to further establish three more in 2019) there was still work to do to ensure that these were fully embedded into practice. For example, while the system had begun to establish the 'home first' culture in the hospital, operational staff felt that progress was needed to ensure this was embed into practice. It is important that the system continues to monitor and evaluate the impact of initiatives to support the implementation of the high-impact changes so that they become embedded into practice.
- The system had set ambitions to establish seven-day working across the system by Q4 2018/19, however at the time of our Progress Review in November 2018 there was still significant work to do to achieve this aim. In the system's Better Care Fund return they acknowledged that care homes and domiciliary care homes can be unwilling to accept new referrals at the weekend which is a barrier to providing seven-day services. Through the



development of strategic provider forums there is an opportunity to work more closely with providers to establish a model for system-wide seven-day working.

- Limited progress had been made to implement the trusted assessor model and this was acknowledged by system leaders. There was evidence of trusted assessments taking place within the One Team however progress had not been made to develop a trusted assessor model across health and social care. In the system's Better Care Fund return, system leaders felt that there was a low appetite from providers to develop a trusted assessor model. Again, through the development of strategic provider forums there is opportunity to work with care homes and home care providers to build better relationships and co-produce a trusted assessor model.
- Good progress had been made in the development of the One team, however the team is still operating as three different organisations, and this created practical barriers and inefficiencies in collaborative working.

Continuing Healthcare

- Despite improvements to pathways and processes and the system now meeting key performance targets, there had been an increase in the proportion of people who were dying in hospital. An internal audit of Fast Track CHC requests showed that during a four-month period, 173 Fast Track requests were made, and 33% (57) of these people died in hospital. Staff told us that the limited home care provision had been having an impact on the ability to deliver CHC Fast Track in York and that in some cases, home care visits were being overprescribed to people, which was placing pressure on the already limited capacity. Staff told us that work had led to some reduction in the size of care packages being prescribed for Fast Track recipients which was helping with capacity. The system reported to us that changes made to the discharge to assess pathway to enable more assessments to be undertaken outside of hospital have resulted in more DTOC being attributed to CHC, while packages of care and placements are sought. There was clear commitment from CHC leads to improve CHC processes and improve people's experiences, especially people making Fast Track applications.

Digital interoperability

- No significant progress had been made in digital interoperability since our LSR in October/November 2017. System leaders acknowledged that challenges of organisations working on different systems had not been resolved. The One Team still found information sharing a barrier, for example we were told that they did not have a single point for referrals and had to develop 'work arounds' to these challenges. A project to support the One Team with dedicated management resource was being scoped at the time of the Progress Review in November 2018.



What are the reflections of system leaders in York?

- Following the LSR in October/November 2017 the system developed a 'York Improvement Plan' using the areas for improvement identified in the LSR report. Using the York Improvement Plan system leaders established actions and sub-actions against each area for improvement. At the time of the Progress Review in November 2018 many of these actions had been completed, however system leaders reflected to us that they did not feel the completed actions fully reflected the wider system impact against the areas for improvement and that further progress was needed. System leaders told us that the improvement plan no longer provided the framework that would set out what they needed to achieve over the next year to deliver on the priorities set out in the 2017 LSR report and they would need to continue to build on the progress they had made.
- System leaders told us that while they had made improvements in some areas, there were issues identified in our LSR in October/November 2017 that were still prevalent when we returned for the Progress Review in November 2018. Relationships had improved but there was still work to do to establish a culture of system working across health and social care. System leaders acknowledged the importance of the appointment of the Chief Executive Officer of the trust in building this culture.
- System leaders recognised that the pace of change in York was slow and that while many of the actions in the York Improvement plan had been completed this did not reflect the impact that system leaders wanted to have achieved.
- System leaders told us that considering the changes in leadership in some of the partner organisations, relationships and partnership working had improved. System leaders told us that the PBIP had been established as the place for senior leaders to come together and drive system working but acknowledged that this would take time to embed.

Direction of travel

Areas for future focus

- System leaders should review the York Improvement Plan and assess progress made against the expected impact. Considering this report, system leaders should agree on revised actions, with members of the PBIP accountable to the Health and Wellbeing Board for designated actions.



- At our Progress Review we found that progress against the areas for improvement identified at the October/November 2017 LSR was slow. Through the PBIP, system leaders should establish how they can increase the pace of change.
- System leaders should continue to focus on developing relationships and partnership working across the system. For the PBIP to lead partnership working across the system, partners must agree on the collective system vision and strategy and develop a system wide plan that is agreed and signed up to by all system partners. There should be a system approach to new appointments, especially those at a system leader level.
- Directors of Finance across health and care should explore opportunities to work more collaboratively, owning organisational challenges as 'system challenges'. Directors of Finance should also work with commissioning leads to develop plans to facilitate joint commissioning. Commissioners should ensure that a joint commissioning strategy is developed as a matter of priority. Commissioners should also focus efforts on strengthening performance metrics and data collected at a local level to provide a greater understanding the impact of commissioned services and schemes.
- The system should accelerate the development of a system workforce strategy co-produced with independent care providers and VCSE partners.
- The system should continue to work with independent providers and utilise engagement forums to move towards a seven-day service model and co-produce a model for trusted assessment.
- The system should continue to develop and promote the Live Well York website across the system and strengthen information available for people who fund their own care.

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York Health and Wellbeing Board**CQC Local System Review****October – December 2017****Place Based Improvement Plan – January 2019**

This version of the plan includes only the residual actions as at October 2018

Introduction

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

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

Current Position

CQC conducted a progress review on the action plan in November 2018. The report was published in January 2019. It is available here: <https://www.cqc.org.uk/local-systems-review#reports>

This document summarises the residual actions from the autumn update.

Next Steps

Following the publication of the progress review a new whole system plan is being developed. The first step advised by CQC was to fully review the remaining actions from the initial plan. These are captured in the following pages.

Recommendation 1:					Lead Officer:
Work is required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements, to prevent duplication.					Mary Weastell and Phil Mettam
Date Plan Approved: 31-1-18			Review Date: January 2019		
Ref.	Actions	Lead	Date for Completion	status	Evidence / Additional Information
1.3	Map the current governance arrangements across the STP / A&E Delivery Board footprints such as the range of sub groups which meet for specific responsibilities, or task and finish activities.	Pippa Corner	February 2018	ongoing	Basic mapping has been carried out. However, arrangements continue to evolve. Delivery Boards and sub groups for each area of work are established. (STP, HWBB, PBIP, A&E DBd, DTB etc) New map required as part of 2019 plan
Recommendation 2:					Lead Officer:
Work should continue at pace to develop strong relationships across the system to address the lack of collaboration and trust between system leaders.					Mary Weastell and Phill Mettam
Date Plan Approved:		31-1-18	Review Date:		January 2019
Ref.	Actions	Lead	Date for Completion	status	Evidence / additional information
2.5	Align CQC action plan with other integration and improvement opportunities	Pippa Corner	June 2018	ongoing	propose this plan is subsumed in a new plan for 2019. this would close this action
2.6	Adopt the CQC Relational Audit Questionnaire to assess progress (annual)	Clr Runciman (HWBB chair)	June 2018		this does not appear to be available. propose this action is subsumed in the OD work described in 2.8 and continues in plan for 2019. this would close this action

2.8	<p>Develop organisational development programme to focus on working relationships between system leaders and partner organisations.</p> <p>Revisit the Systems Leadership Training which was delivered across the partnerships in 2016. Build on this for whole system organisational development.</p> <p>Consider external facilitation for YIB development.</p>	PBIP	March 2018	ongoing	<p>There is agreement in principle to invest in further OD programme once all senior leadership roles have been appointed.</p> <p>carry forward in 2019 plan</p>
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<p>Recommendation 3:</p> <p>The system should build in clear evaluation of systems to demonstrate the impact on people and the system overall.</p>	<p>Lead Officer:</p> <p>Simon Bell, Michael Melvin (DASS)</p>
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Date Plan Approved: 31-1-18	Review Date: January 2019
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Ref.	Actions	Lead	Date for Completion	status	Evidence / additional information
3.1	Strengthen the existing HWBB performance framework, learning from good practice elsewhere.	Terry Rudden	April 2018	ongoing	this should be carried forward in 2019 plan
3.2	Establish a whole system network of performance / data specialists to add value to existing work and minimise duplication	Terry Rudden	February 2018	ongoing	this should be carried forward in 2019 plan
3.3	Map our shared metrics and the existing data collection, how it is used and where reported. Include options for agreeing system wide deep dives.	Terry Rudden	April 2018	work in progress	this should be linked to Joint Commissioning and Digital interoperability in 2019 plan

3.4	Develop a YIB Dashboard to monitor the effectiveness of this action plan in achieving measurable improvement in performance outcomes plus an action log.	Terry Rudden	June 2018	work in progress	this should be carried forward in 2019 plan
Recommendation 4: There needs to be a greater emphasis on moving towards joint commissioning across the system.					Lead Officer: Michael Melvin (DASS) Phil Mettam
Date Plan Approved: 31-1-18			Review Date: January 2019		
Ref.	Actions	Lead	Date for Completion	status	Evidence / additional information
4.1	Update and continue implementation of HWBB Joint Commissioning Plan 2017-18, including the establishment of joint posts, currently under discussion (CYC / CCG).	Pippa Corner	March 2018	ongoing	propose this action is revised as new programme is being developed, which should form part of 2019 plan. this would close this action
4.2	Ensure the training and learning needs of commissioning teams are addressed, and joint training is put in place for commissioning competencies and skills.	Sandra Garbutt	September 2018	N/A	nominations have been made for the 2019 programme. Opportunity shared with CCG. close this action
Recommendation 5 : There needs to be a system-wide response to effectively managing the social care market and domiciliary care capacity.					Lead Officer: Michael Melvin (DASS)
Date Plan Approved:		31-1-18	Review Date		January 2019
Ref	Actions	Lead	Date for Completion	status	Evidence / additional information
5.1	Build on the existing approach to the Market Position Statement with partners.	Gary Brittain	July 2018	work in progress	this work is being initiated as part of Joint commissioning programme and should form part of 2019 plan

5.5	Establish joint health and social care apprenticeships to build capacity	Julia Massey (Learning City Partnership, CYC)	May 2018		- no capacity to progress at the present time defer this action pending appointment of Julia's successor
5.7	Undertake a capacity and demand exercise to understand the market requirements of the system, modelling the impact of the agreed change programme	PBIP	September 2018	work in progress	this work has commenced and will report in April / May via BCF. close this action
Recommendation 6: A review of IT interconnectivity should be completed to ensure appropriate data sharing and a more joined up approach across health and social care services.					Lead Officer: Lisa Winward (Chief Constable, NYC)
Date Plan Approved:		31-10-18		Review Date:	January 2019
Ref	Actions	Lead	Date for Completion	status	Evidence / additional information
6.3	Use of NHS Number on all care records to be standardised.	Roy Grant / Mike Richardson	July 2018	work in progress	The work required is currently being impact assessed before referral to CYC Change Board. update required
6.5	Develop a protocol relating to moving data and viewing it as a short term solution, prior to achieving commonality of platform. (eg to support out of hours GPs to view full care records of others' patients).	Shaun Macey Kevin Smith	September 2018	ongoing	digital interoperability will form part of the 2019 plan.
6.6	Work on the business process and information sharing requirements for discharge plans and weekend discharges.	Glynn Shaw	June 2018	work in progress	Technical Project Managers have been identified to deliver the work this will form part of the 2019 plan

Recommendation 7 :					Lead Officer:	
Work should be undertaken to share learning and experience between staff at the interface so there is shared trust and so understanding and historical cultural barriers are broken down.					Michael Melvin (DASS) Michelle Carrington Wendy Scott	
Date Plan Approved:		31-1-18		Review Date:		January 2019
Ref	Actions	Lead	Date for Completion	Status	Evidence / additional information	
7.2	Map which frontline teams are 'at the interface'. Identify key teams (eg One Team) to commence joint organisational development activity and create time for teams to build relationships and discuss shared purpose.	Mike Richardson	April 2018	Ongoing	Capacity and Demand exercise will cover this and report via BCF. close this action	
7.6	Build in routine process for responding to Healthwatch York reports – via Improvement Board	Pippa Corner Catherine Scott	June 2018	ongoing	AD Joint Commissioning leading this for system. close this action	
Recommendation 8 - COMPLETE						
Recommendation 9 : An effective system of integrated assessment and reviews of the needs of people using services should be introduced.					Lead Officer: Wendy Scott, Denise Nightingale Michael Melvin (DASS)	
Date Plan Approved: 31-1-18			Review Date: January 2019			
Ref	Actions	Lead	Date for Completion	Status	Evidence / additional information	
9.1	Link R9 to R10. Identify a named lead individual and supporting group to be responsible for this area.	Wendy Scott / Denise Nightingale / (DASS)	January 2018		HICM will form part of 2019 plan close this action	
9.3	Develop and implement shared referral and assessment documentation across areas of service.	Glynn Shaw/ Vicky Mulvana- Tuohy	September 2018	ongoing	HICM will form part of 2019 plan close this action	

9.4	Identify other teams to utilise shared referral and assessment documentation as it is developed.	Pippa Corner Steve Reed	June 2018		HICM will form part of 2019 plan close this action
9.9	Devise and promote a communications and engagement development plan relating to general discharge planning.	Steve Reed	June 2018	work in progress	HICM will form part of 2019 plan close this action
Recommendation 10: The system should prioritise work towards improved performance against the high impact change model.					Lead Officer: Wendy Scott
Date Plan Approved: 31-1-18			Review Date: January 2019		
Ref	Actions	Lead	Date for Completion	Status	Evidence / additional information
10.5	Raise awareness of the High Impact Changes among staff, services and stakeholders.	Sandra Garbutt	June 2018	ongoing	HICM will form part of 2019 plan close this action
10.8	Identify priority areas to accelerate HIC delivery to be 'established' through YIB	Steve Reed Pippa Corner	February 2018	work in progress	HICM will form part of 2019 plan close this action
Recommendation 11 : The full implementation of seven day working should be reviewed across the system to ensure the people of York are able to return to their usual place of residence at the earliest opportunity.					Lead Officer: Wendy Scott (Michael Melvin (DASS))
Date Plan Approved: 31-1-18			Review Date: January 2019		
Ref	Actions	Lead	Date for Completion	Status	Evidence / additional information
11.1	Identify lead individual and supporting groups for HIC, including mapping existing work.	Wendy Scott	January 2018		HICM will form part of 2019 plan close this action
11.4	YIB to agree level of expectation on 7 day working for the whole system – for example how this affects Acute Trusts, Primary Care, Social Care, VCS and independent sector.	Wendy Scott Michael Melvin (DASS)	June 2018	ongoing	HICM will form part of 2019 plan close this action
Recommendation 12 – COMPLETE					

Recommendation 13: Continuing healthcare arrangements should be more robust and person centred.					Lead Officer: Denise Nightingale Michael Melvin (DASS)
Date Plan Approved: 31-1-18			Review Date: January 2019		
Ref	Actions	Lead	Date for Completion	Status	Evidence / additional information
13.7	Develop new work force arrangements.	Denise Nightingale Kyra Ayre	June 2018	work in progress	Trusted assessor piloted with 1 care home who had discharge to assess beds update required
13.8	Explore opportunities for joint social care and NHS roles in terms of reviewing current customers (including assessment of needs against the packages of care)	Denise Nightingale Kyra Ayre	December 2018	work in progress	Pilot role being undertaken between MH OHP occupational therapist and S117 team update required
13.9	Explore joint commissioning Including development of PHB's, brokerage, and the development of specialist provision (market shaping)	Denise Nightingale Gary Brittain	December 2018	work in progress	this will form part of the joint commissioning programme in the 2019 plan close this action



Health and Wellbeing Board

13 March 2019

Report of the Assistant Director - Joint Commissioning, (BCF Lead)
NHS Vale of York Clinical Commissioning Group and City of York
Council.

Better Care Fund Update

Summary

1. This report is for information. It sets out the following:
 - Progress against national targets that the Better Care Fund (BCF) is designed to positively influence.
 - An update on national reporting to NHS England on use of the BCF
 - Update on NHS England planning and guidance
 - Information on a recent co-production event to promote closer integration and achieve better outcomes for patients
 - Progress with the Whole System Demand and Capacity Model

Background

2. The Health and Wellbeing Board has received regular reports from the Better Care Fund Performance and Delivery Group. These reports have previously informed the board of planning requirements and assurance processes for the 2017-19 period.

Main/Key Issues to be considered

Better Care Fund Quarterly Returns – governance and assurance

3. The quarterly returns for the BCF were submitted in line with requirements covering Q3 of the 2017-19 Plan on the 25th of

January. Reporting on the Improved Better Care Fund (iBCF) was not required this quarter. National guidance for the Better Care Fund 19/20 has not yet been published (at the time of writing).

4. The quarterly performance return requires a self-assessment of the area's progress on the High Impact Change Model. The latest self-assessment is included as **Annex 1**. The model itself was shared with the HWBB in July 2018.
5. The Q4 return is due for submission on the 18th of April, 2019. As a result of this timing, the quarterly return will rely on forecasts and provisional data for performance targets.
6. The outturn position on the BCF Dashboard for Q3 is attached at **Annex 2**.
7. At the time of reporting to NHSE, we were not on track to meet our targets for NEA, Residential Admissions or DTOC for Q3. We will not be able to measure Reablement (proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services) until Q3 and Q4, so it will not be possible to report 2018-19 results until 2019-20 Q1 at the earliest.

NEA - Reduction in non-elective admissions

8. Up To Month 8, NEAs were 6% above plan (967 admissions). This is only slightly above the 5.7% over plan in Q2. This position is primarily the result of an increase in Zero Length of Stay admissions and 1-3 day Length of Stay admissions which are a feature of our local model. Ambulatory care and acute medical assessment wards are in place to ensure patients are assessed, treated and discharged within 24 hours in order to minimise the number of patients requiring admission to other acute hospital wards and to reduce waiting times and pressures in A&E.
9. The CCG and the main acute provider are now 9 months into the Aligned Incentives contract and are having collaborative discussions around improving emergency pathways for patients as well as ensuring that patients are receiving quality care at the right place at the right time.

Residential Admissions - Rate of permanent admissions to residential care per 100,000 population (65+)

10. There were 209 admissions during the first three quarters of 2018-19, a rate of 557 per 100,000 population aged 65+.
11. This is slightly higher than the number of admissions in the corresponding period during 2017-18 (205). The rate of admissions has slowed during the third quarter of 2018-19. CYC's Adult Social Care transformation programme has been implemented to reduce the need for people to enter residential and nursing care.

DTOC – Delayed Transfers of Care

12. There was an increase in the level of DToC in Q3 (31 beds/day) compared with Q2 (28 beds/day) in the York system.
13. To continue to improve our performance against this target we are utilising Step Up / Step Down beds, improving the discharge pathway (implementing the High Impact Change Model and SAFER in hospital), and investing in new approaches, such as live-in care to support discharge. While York is currently meeting the trajectory of the DTOC Target, we recognise this is extremely challenging for the system, and may not be sustainable throughout the remainder of the winter.
14. A case study describing the outcomes from Step Up / Step Down beds is attached at **Annex 3**.

NHS England Planning and Guidance

NHS Operational Planning and Contracting Guidance 2019-20

15. The NHS has published final 2019-20 Operational Planning and Contracting Guidance for NHS organisations. This full Planning Guidance provides guidance following the publication of the NHS long term plan. The reference to DToCs in the guidance has been updated.
16. The Government's Better Care Fund Policy Framework and the detailed Planning Requirements will set out Delayed Transfers of Care (DToC) expectations for 2019-20. In order to support planning in advance of these publications, CCGs and Health and Well Being Boards (HWBs) should, as a minimum, plan to continue to deliver

the current reductions in the DToC rate or to maintain their performance if these targets have been achieved already.

The NHS Long Term Plan

17. NHS England has recently launched its Long Term Plan. The plan set out the roll out of Integrated Care Systems everywhere by April 2021 with local authorities to be represented on partnership boards in every area. The NHS has also committed to continue to support local approaches to pool health and social care budgets.
18. The Long Term Plan recognised that the Better Care Fund (BCF) has provided an opportunity for councils and the NHS to work together. The BCF is regarded as a success in many areas, with local authorities and CCGs contributing more than their minimum required investment to support integration.
19. However the National Audit Office has reported that the funding mechanism is overly complex, and there is a lack of clarity on the return from investment. The funding has also sometimes been used to replace core council funding rather than add to investment at the interface between health and care services.
20. The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government with NHS England are therefore reviewing the BCF to ensure it meets its goals. The review will conclude in early 2019, and 2019/20 will continue to include clear requirements to continue to reduce DTOCs and improve the availability of care packages for patients ready to leave hospital.

Integration – local perspective

21. Building on the initial planning event held in November 2018, we have further developed our commissioning commitments for 2019-20 through a co-production workshop in February 2019. This session included members of the BCF Performance and Delivery Group, scheme representatives and partners, including NHSE Better Care Manager. The purpose was to shape our more detailed plans for the use of the increased iBCF in the coming year, which offers an opportunity for one-off schemes to test new approaches, enhancements to existing schemes and bridging funds for schemes which will be funded from other sources in subsequent years.

22. The planning process is continuing under the governance of the BCF Performance and Delivery Group, and will be formalized in March 2019, assuming national guidance has been published.
23. A new proposal which emerged from the event and gathered wide support was an aim to establish an intermediate, short term facility where people could make longer term decisions about their care, away from the acute hospital setting. Other proposals were also supported in principle, but dependent on the learning from the Capacity and Demand Exercise, which will inform our commissioning ahead of next winter.

Whole System Demand and Capacity Model

24. Venn Consultancy has been engaged by the Council and CCG to undertake a whole system demand and capacity modelling exercise.
25. This project, and the associated system modelling work, will support partners in York to determine how best to meet the increasing demands faced by the health and care system.
26. There are a number of elements to this work:
 - A baseline of population 'needs' (for urgent and unplanned care services), based on actual demand for services
 - An understanding of what capacity does and doesn't exist to meet the needs of the population
 - The identification of the key 'levers' within the system that influence how much capacity is required, including; flows of people, delays and pathways
 - Initial identification of unit cost information to understand the cost of care, care pathways and the cost to the system of supporting people in the wrong service
27. The output of the work will be a system modelling tool that will provide a significant degree of insight and whole-system understanding to support planning and delivery of health and care services in a sustainable way in the future.

The work is endorsed by NHS England and has been undertaken in a number of other regions.

28. Venn are likely to start work on site in York during the week commencing Monday the 4th of March and the work is likely to be completed by mid-June 2019.

Consultation

29. The BCF Performance and Delivery Group is a multi-agency partnership, working in a co-production model to develop plans and proposals. The group reaches out to providers of schemes when considering plans, and requires schemes to provide evidence of service user experience as part of their routine and annual evaluation.

Options

30. Not applicable.

Analysis

31. Not applicable.

Strategic/Operational Plans

32. As above:
- Integration and Better Care Fund Plan

Implications

33. There are no new implications as a result of this report. A verbal update on the planning guidance for 2019/20 will be provided at the H&WBB if it has been published at that time.

Risk Management

34. Risks which have been previously reported to the board in relation to BCF remain relevant. York system is currently projecting a non-compliant position on the HICM by April 2019 in that it will not have fully established a Trusted Assessor system. Further discussions are taking place with the aim of bringing this forward.

Recommendations

35. The Health and Wellbeing Board is asked to note this report.

Reason: To keep the HWBB up to date in relation to the Better Care Fund.

Contact Details

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Phil Mettam
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NHS Vale of York Clinical
Commissioning Group

Report Approved **Date** 26.02.2019

Specialist Implications Officer(s) None

Wards Affected:

All

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

Annexes

Annex 1 – High Impact Change Model (HICM) self-assessment as at Q3 2018/19

Annex 2 – BCF National Metrics – outturn 2017-18

Annex 3 – Case Study

Glossary

BCF	Better Care Fund
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CVS	Centre for Voluntary Service
DHSC	Department of Health and Social Care
HICM	High Impact Change Model

HWBB	Health and Wellbeing Board
JCSG	Joint Commissioning Strategic Group
MOU	Memorandum of Understanding
NEA	Non Elective Admissions
NHS	National Health Service
PBIP	Place Based Improvement Partnership
RATS	Rapid Assessment and Treatment Service
STP	Sustainability and Transformation Partnership
VCSE	Voluntary, Community and Social Enterprise

ANNEX 1

						Narrative			
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Established	Established	Established		Significant cultural change needed across a range of disciplines to pull discharge planning earlier in patient journey, this is incorporated as part of overall SAFER implementation rather than addressing piecemeal. Limited work to date from commissioners for pre-operative discharge planning in primary care - this has been highlighted as an issue through local 'Home First' engagement exercises.	SAFER refresh at York FT includes focus on earlier discharge planning, local delivery plans in place for each clinical area with ongoing review process with senior leadership team. Intensive roll out for targeted taken place, this is developing criteria led discharge approach in a number of wards. Integrated discharge hub have developed electronic internal referral and initial fact finding process to support earlier intervention in complex discharge planning - initial pilot developed with Elderly wards and rolled out across all wards through July 2018. Additional funding for weekend discharge liaison and weekend social work is allowing earlier input for patients identified at weekend and earlier access to families. Pilot of discharge planning with OT in vascular pre-op assessment commenced in Q3.	Evaluation from elsewhere to support commissioning of pre-operative discharge planning in primary care
Chg 2	Systems to monitor patient flow	Plans in place	Plans in place	Plans in place	Established		Availability of analytical capacity across the system to undertake detailed capacity and demand required.	Weekly multi-agency discharge events set up through winter months with additional daily system escalation as required. Winter plan successfully deployed additional capacity through intermediate care based on OPEL level and activity surges. Winter plan included increase in domiciliary and step down bed capacity to proactively address expected increase in demand over winter period. Better Care Fund has agreed to prioritise capacity and demand exercise for system (most recent plan is that this will be for the CYC footprint to allow the work to progress).	Already flagged as an area of required support, BCF Manager continues to work with local system to take forward.
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Established	Established	Established		Capacity of discharge hub to attend all daily ward based MDTs (Board Rounds). Capacity of CHC teams to continue to support Integrated Hub - ability of CHC to provide D2A service	Integrated Discharge Hub bringing together discharge liaison and hospital social work teams commenced in December 2017. Hub leading multi-agency redesign of complex discharge pathway and working through ward based discharge liaison officers to strengthen links between hub and ward based teams. Hub are testing ward based social workers for high referring areas and exploring opportunities for social workers to join weekly MDTs. Discharge to assess beds commissioned on pilot basis for CHC patients from December 2017 and new pathways developed to be introduced from January 2018. Following review of pilot, CCG have confirmed ongoing funding for 1 discharge to assess CHC bed and exploring options to utilise community beds to extend this further. End of life specialist nurse and social worker to work alongside discharge hub for 12 months to improve fast track referral process.	N/A
Chg 4	Home first/discharge to assess	Established	Established	Established	Established		Capacity within system to implement transformational change in so many areas simultaneously. Constraints on short term discharge support due to lack of capacity in long term domiciliary care.	Ongoing development of the 'One Team' to improve access to short term intermediate care and reablement to support discharge to assess approach. One Team are piloting a discharge to assess model that prevents the need for social care assessment in hospital for people who require reablement. Vision for service being refreshed through new commissioning intentions to be agreed in Q4. Additional funding secured by CYC to increase capacity in reablement again in 2018-19 and increase home care capacity. Capacity and demand exercise recommended by BCF group to enable accurate capacity planning to deliver a D2A approach.	Evaluation from elsewhere on long term savings associated with increased short term capacity to deliver discharge to assess model

Chg 5	Seven-day service	Plans in place	Plans in place	Plans in place	Established		Care homes and domiciliary care agencies remain unwilling to accept new referrals at the weekend. Need for HR process to change terms and conditions of social care staff to move to seven day working	Trial of 7 day social work presence in hospital commenced in December 2017, funding received to commence 7 day discharge liaison nurse presence in hospital and weekend reablement co-ordinator from March 2018. BCF funding secured to maintain 7 day social work and discharge liaison presence - currently being delivered through staff goodwill so not meeting required for T&C change but recruitment underway to permanent posts in discharge liaison and CYC plan to address through future focus programme over next six months.	N/A
Chg 6	Trusted assessors	Plans in place	Plans in place	Plans in place	Plans in place		Independent care group have tested enthusiasm amongst care home managers for trusted assessment model with mixed response - workshop session to be held in January 2019 to better understand the discharge processes, identify areas where system changes can be made [from the point a care home is contacted] to reduce delays and improve the patient experience and to discuss trusted assessor as one potential option for improvement. Aiming to identify willing care providers to scope / test out any recommended options.	Some areas of good practice (trusted assessment well established for intermediate care and being trialled for reablement service) and discussions on single assessment process and documentation started through Integrated Discharge Hub and One Team projects. Trusted assessment for patients moving to discharge to assess CHC beds agreed and piloted in Q4 - ended in March 18 following conclusion of winter pilot but ongoing conversations regarding trusted assessment work with care home involved. The Independent Care Group is supporting the wider system in considering a trusted assessment approach.	Financial support to bring forward a dedicated role to pilot trusted assessment with care homes and / or home care.
Chg 7	Focus on choice	Plans in place	Plans in place	Plans in place	Established		Choice remains a significant factor in DTOC performance. Voluntary sector not currently involved in discussions about self-funders. Cultural challenge to embed choice protocol at ward level	Transfer of Care Protocol includes Choice. Pathway Development Manager and Hospital social work team addressing consistent practice at referral stage. Multi-agency workshop to review and re-write Transfer of Care Protocol took place in July 2018 and agreed 'Why not home?, Why not today?' project will lead re-writing of protocol with a planned implementation date of April 2019 to allow time for engagement, communication and training of staff - counting and coding workshop scheduled for October 2018. Public health undertaking topic specific needs analysis for self-funders to inform work required - discussed by multi-agency steering group in December 2018 and presentation from 'Care Home Selection' independent provider that can support patients and their families in choosing a home scheduled for 1 February. Discharge hub are taking a case management approach with self-funders to improve the co-ordination and consistency of support to this patient group.	N/A
Chg 8	Enhancing health in care homes	Established	Established	Established	Established		Capacity in the system and workforce in independent sector. Engagement of CCG care home project leads into wider work on supporting discharge - discussions ongoing to address and make links more evident	Care homes pilot to reduce admissions to hospital from care homes (through Priory Medical Group), Quality initiatives established in CCG, Quality Manager appointed and in post.	N/A

Annex 2 - BCF National Metrics - Quarterly Performance to end of Q3 2018/19

Indicator	Description	Previous Years outturn			2017/18						2018/19						Polarity	
		2014/15	2015/16	2016/17	Actuals				Total Plan	Outturn	Total plan	Actuals				Q3 YTD Actual		Q3 YTD plan
					Quarter 1	Quarter 2	Quarter 3	Quarter 4				Quarter 1	Quarter 2	Quarter 3	Quarter 4			
CCG_NEL	Reduction in non-elective admissions (General & Acute)	19,662	20,819	22,639	5,676	5,520	5,984	5,955	22,850	23,135	22,977	6,020	5,910	6,370		18,300	17,160	Missing Target
<p>Performance Summary NEA activity is 1140 admissions (6.6%) above plan at the end of Q3. There have been increases in NEA for General surgery, General Medicine and Geriatric Medicine. Growth in admissions in these specialities is consistent with the introduction of the 'Acute Medical Model' at the main provider, which aims to reduce waiting times in A&E and the ability to diagnose, treat and discharge patients back to their usual place of residence within 24 hours, reducing the need for admission onto general and acute wards within the hospital.</p>																		
BCF1	Delayed Transfers of Care: Raw number of bed days	8,130	8,463	10535 (115/152)	1,895	1,840	2,445	2,314	5,913	8494 (108/152)	7,347	3,006	2,560	2,807		8,373	5,510	Missing Target
<p>Performance Summary Performance has deteriorated from 2017-18 during the first half of the year partly because of increases in the numbers of older people being admitted to hospital, and continuing pressures on ensuring that those discharged are placed in appropriate settings. Adult social care continues to have difficulty in finalising suitable home care packages, and the NHS struggles with appropriate residential and nursing care placements. Seven day working and the One Team have been initiated to ensure that these will improve in the coming months.</p>																		
ASCOF2B(1)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	0.815	0.7571	0.793 (111/152)	No Data	No Data	No Data	0.925	0.83	0.925 (15/152)	0.93	No Data	No Data	No Data		N/A	N/A	Unkown
<p>Performance Summary Recently published data shows that 93% of those who were offered a reablement service in 2017-18 Q3 were still at home during Q4. This is a substantial increase from the level reported in 2016-17 (80%), achieved through better identification of a pathway for clients where reablement is the most suitable option. The development of the "One Team" working (between hospital and social care) should improve discharge pathway working.</p>																		
ASCOF2A(2) & BCF2	Long-term support needs met by admission to residential and nursing care homes, per 100,000 population (older people) (YTD Cumulative) (New definition for 2015/16)	683	683	648 (87/152)	163	187	197	109	589	656 (100/152)	592	240	155	163		557	444	Missing Target
BCF2	Number of permanent admissions to residential & nursing care homes for older people (65+)	241	260	248 (87/152)	61	70	74	41	221	246 (100/152)	222	90	58	61		209	167	Missing Target
<p>Performance Summary The number of admissions, at 557 per 100,000 population in the first three quarters of 2018-19, is above the target rate, but the number of admissions in Q2 and Q3 (see BCF2 below) is almost two thirds the rate that it was in Q1. There were 61 admissions during 2018-19 Q3, a rate of 163 per 100,000 population aged 65+. This is a reduction of 32% compared with Q1 and a reduction of around one fifth compared with the same period a year earlier. It shows that the Transformation Programme that CYC has embarked on to ensure that older people do not enter homes is having a substantial impact.</p>																		

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Case Study for Health and Wellbeing Board

Provided by Fulford Nursing Home – describing the outcomes from the Step Up / Step Down beds commissioned through BCF.

Review submitted on 13 December 2018 from a **Website Submission** by **Jane B** (Daughter of Resident). on Thursday 13 December 2018 . Relates to December 2018.

*Mum used the rehab care at Fulford Nursing Home for a couple of weeks. **She was a little apprehensive about doing this at first, but have got to say she settled in quickly and all the staff were fab with her. The Oc health team visited every day and got her back on her feet again.** The food was also very good she said. Homemade cakes and scones, a choice at every meal. It all really helped to get her back on her feet again. It also gave us peace of mind that someone was there for her 24/7. Thank you so much for all you did for our mum, she'll be back for visits and a natter.*

How likely would you be to recommend Fulford Nursing Home? **Extremely Likely**

Review submitted on 8 August 2018 from a **Postal Card** by **Jean S** (Resident). on Wednesday 8 August 2018 . Relates to July 2018.

***Was nice to be home** but your care was excellent and I couldn't have wished for better. Thank you.*

How likely would you be to recommend Fulford Nursing Home? **Extremely Likely**

Review submitted on 8 August 2018 from a **Postal Card** by **N S** (Respite Resident). on Wednesday 8 August 2018 . Relates to July 2018.

Very helpful and aided my recovery.

How likely would you be to recommend Fulford Nursing Home? **Extremely Likely**

Background Note

In the last 12 months 86 admissions to hospital have been prevented by ensuring an assessment has taken place at Rapid Assessment and Treatment Service (RATS) in the Accident emergency department at York Hospital. This early identification of the need for support and rehabilitation has ensured York residents do not spend an unnecessary period of time in hospital.

As the Occupational therapy team and Physiotherapy team can attend to these residents in a timely manner and work closely with the nurse team at Fulford the outcomes for these residents are positive with 86% of residents returning home.

4% of residents were assessed during their rehab as needing some long term care, 6% returned to hospital and 3% sadly died during their stay.

The residents on arrival at A and E do not expect to then be directed to a nursing home and can sometimes be reluctant to take up the offer however our feedback and survey results indicate that although they do wish to return home their stay and experience of receiving care and support is positive.

This, I believe, is because we are achieving the outcome the residents and families want which is to return home but also giving the reassurance that in the event of care needs changing in the future there are a variety of care options in York that are available and provide excellent care.

This is achieved by the strength and depth of the working relationships created between the Hospital, RATS, Community Response Team and Fulford Nursing Home and the trust that has built over the 4 years of this scheme that started as a pilot through the Better Care Fund.

It is very easy to get lost amongst outcomes, pathways and process but at the heart of this scheme are people. These events in people's lives affect not only the person and their confidence but the whole family network and the very fact that these ladies and gentleman have returned to their homes and been able to remain there is a positive for all and should be celebrated. I have had the great privilege of meeting these 86 people and their families, every one unique and with a great life story and to be able to support them to continue their story how they want to live it is just wonderful.

Elizabeth Hancock,

Fulford Nursing Home.

February 2019.



Health and Wellbeing Board

13 March 2019

Report of the Director of Public Health

Living & Working Well Performance Report**Summary**

1. The attached performance summary (Annex A) outlines the current position against a set of indicators in respect of the living and working 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 living and working 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.
4. It also included some information about NHS Health Checks.

Main/Key Issues to be Considered

5. The key updates are included within the Annex.

Consultation

6. Consultation has not been undertaken on this paper.

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.

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 living and working well element of the joint health and wellbeing strategy 2017-2022.

Contact Details

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Chief Officer Responsible for the report:

Sharon Stoltz
Director of Public Health
City of York

**Report
Approved**



Date 04.03.2019

Wards Affected:

All

For further information please contact the author of the report

Annex

Annex A – Living & Working Well Performance Report

Glossary for the report and annex

AAA – Abdominal Aortic Aneurysm

CVD – Cardiovascular Disease

CYC – City of York Council

IBA – Identification and Brief Advice

NHS – National Health Service

ONS – Office of National Statistics

Q – Quarter

TEWV – Tees, Esk and Wear Valleys NHS Foundation Trust

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ANNEX A

Business Intelligence Hub

2017-2022 Joint Health and Wellbeing Strategy

Living and Working Well Indicators

February 2019

Author: Mike Wimmer

Date: 27.2.2019

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ANNEX A

Summary of Key Points

Uptake of Screening Programmes

- York has higher screening uptake rates for Abdominal Aortic Aneurysm (AAA) and for breast, bowel, and cervical cancer. Trends in the uptake of cervical and breast screening are falling in York in line with national trends.

Workplace Wellbeing

- 29 employers engaged with the pilot workplace Yorwellbeing service and 1,183 employees received a mini health check. A workplace wellbeing strategy is currently being developed.

Excess Weight

- 60.4% of York adults are estimated to have excess weight. Local health check data shows that more men (69.7%) have excess weight than women (55.7%). A Healthy Weight Strategy for York is currently being developed.

Admissions to hospital for alcohol related conditions

- Rates of alcohol related admissions in York are above national and regional averages and rates are increasing for both genders.
- In 2018, 497 people received treatment in York for alcohol dependence.
- Alcohol IBA (Identification and Brief Advice) training is being delivered to primary care services, 3rd sector organisations and relevant CYC teams.

Inequality in Life Expectancy

- The inequality in life expectancy between more deprived and less deprived areas of York is lower than national averages but the gap for males is increasing over time.
- Circulatory conditions and Cancer account for 60% of the gap for males.

NHS Health Checks

- NHS Health Checks provide screening for Cardiovascular disease (CVD) risk factors and offer appropriate advice re: healthier lifestyle choices. An increasing number are being carried out each month.

Employment for people with learning disabilities / mental health.

- There is an improving trend in the % of people in York with a learning disability or mental health problem who are in paid employment.

Self Reported Wellbeing

- York has a higher % of people who report high levels of anxiety.

ANNEX A

Introduction

In the Living and Working Well Section of the Health and Wellbeing Strategy we agreed to monitor our progress on the following areas:

- improving uptake of all screening programmes;
- the number of major employers signed up to the Workplace Wellbeing Charter;
- reducing the number of adults classed as overweight or obese;
- sustaining a reduction in the rate of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause;
- York being nationally recognised as a more equal city, with a measurable reduction in the gap in outcomes between different wards;
- increasing the number of people with a learning disability or mental health condition in employment;
- more people, particularly from vulnerable groups, telling us they are happy with their health and wellbeing.





Uptake of Screening Programmes

York has higher uptake rates for Abdominal Aortic Aneurysm screening and for breast, bowel, and cervical cancer screening.

Compared with benchmark: ● Better ● Similar ● Worse ○ Not compared

* a note is attached to the value, hover over to see more details

Export table as image

Indicator	Period	York		Region England		England		
		Count	Value	Value	Value	Worst	Range	Best
2.20i - Cancer screening coverage - breast cancer (Female, 53-70 yrs)	2018	16,894	78.9%	75.0%*	74.9%*	56.3%		81.5%
2.20iii - Cancer screening coverage - bowel cancer (Persons, 60-74 yrs)	2018	17,721	61.7%	60.3%*	59.0%*	41.0%		68.4%
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage (Male, 65)	2017/18	834	85.3%	83.3%*	80.8%*	35.8%		100%
2.20ii - Cancer screening coverage - cervical cancer (Female, 25-64 yrs)	2018	37,640	71.7%	74.2%*	71.4%*	51.6%		79.2%

Trends in the uptake of cervical and breast screening are falling in York in line with national trends.

Further information will be provided in the Annual Health Protection Report which will be presented to the Board at a subsequent meeting.

ANNEX A

Workplace Wellbeing

- It was originally intended that we would monitor the number of major employers signed up to the Workplace Wellbeing Charter however this was amended to monitoring the number of employers in York who have engaged with the pilot workplace health element of the Yorwellbeing service.
- 29 employers participated and 1,183 employees in these organisations received a mini health check and a number went on to do online and face to face NHS health checks.
- Anonymous and aggregated feedback on the results of the mini health checks was provided to the employers so they could better understand the health profile of their workforce.
- A workplace wellbeing strategy is currently being developed.

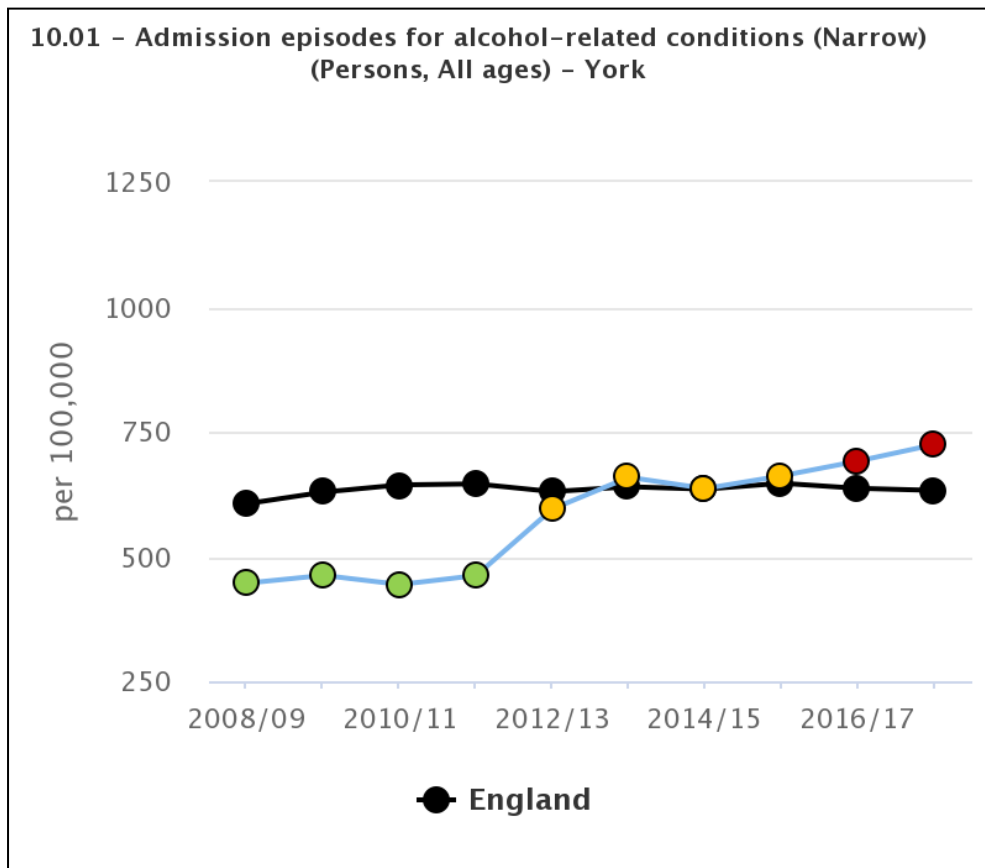
Excess Weight in Adults

- 60.4% of the adult population in York were estimated to be overweight or obese based on a 2016/17 survey of 423 residents.
- This represents a slight increase from 59.4% in 2015/16
- The England average is 61.3% and the Regional average is 65.3%.
- Another source of data on excess weight in adults is the NHS Health Check Programme, delivered by the YorWellbeing Team. A total of 1,156 adults aged 40-74 have had their BMI measured as part of a health check in York.
- 61.7% were overweight or obese (69.7% of males and 55.7% of females).
- A Healthy Weight Strategy for York is currently being developed.

ANNEX A

Alcohol Related Admissions

- In 2017/18 there were 1,422 admissions to hospital for alcohol related conditions a rate of 724 per 100,000 of population, higher than national (632) and regional (697) averages.
- Rates are higher for males (928) than for females (545).
- Rates have been rising in York for both genders for the last few years.



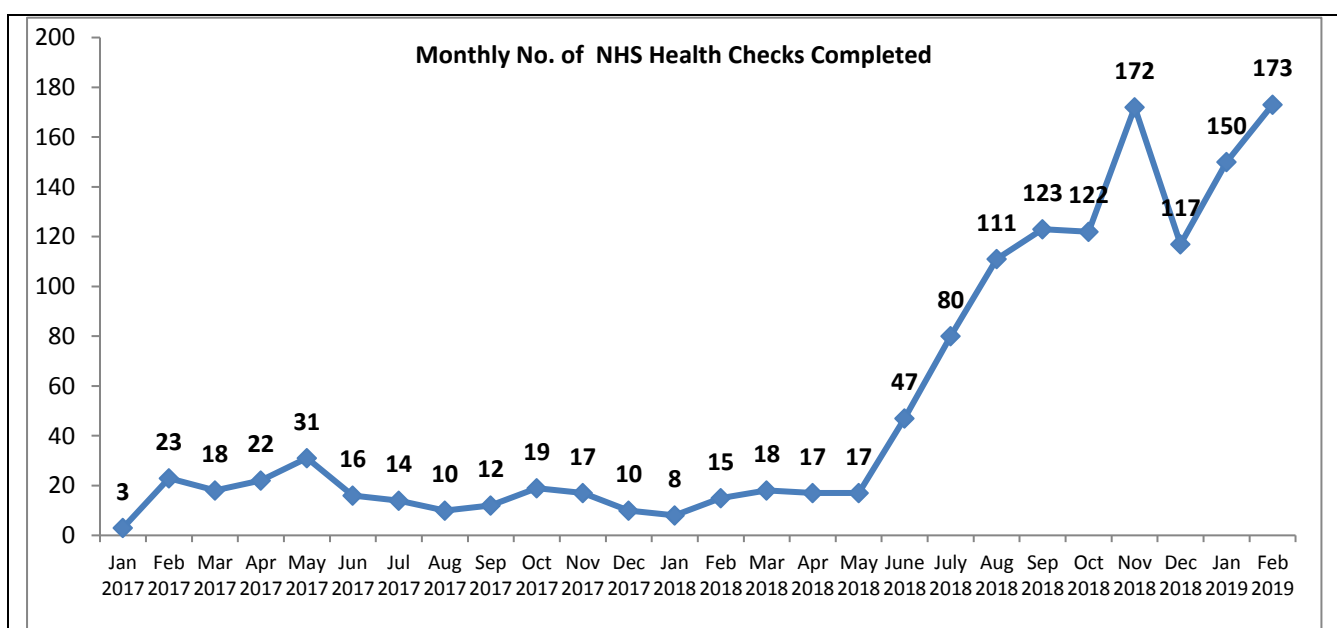
- Support and Treatment for those dependent on alcohol in York is provided by Changing Lives. A total of 497 people received treatment in York in 2018 for alcohol dependence (380 for alcohol use only and 117 for alcohol and non-opiate use). 155 of these people completed treatment successfully in 2018.
- We are continuing to offer Alcohol IBA (Identification and Brief Advice) training to primary care services, third sector organisations and relevant CYC teams. The aim of the training is to give staff the confidence to discuss a patient/customer's alcohol consumption, by identifying their current alcohol use, offering advice on the effects of alcohol and how to drink less, and to make a referral (if required) to community alcohol services. IBA training sessions are continuing to be offered across the city through 2019/20.

ANNEX A Inequality in Life Expectancy

- Inequality in life expectancy across the city is measured by the ‘slope index’. A higher figure means a greater disparity in life expectancy between more deprived and less deprived areas of the city.
- The index in York is 5.2 years for women and 8.9 years for men. The figures in York are lower (better) than the national averages (7.4 years and 9.4 years respectively).
- The inequality in life expectancy for males is increasing (worsening). In 2012-14 the value was 5.6 years, in 2015-17 it was 8.9 years
- Circulatory conditions (e.g. Coronary Heart Disease and Stroke) and Cancer account for around 60% of the difference in male life expectancy between the most and least deprived quintiles in York. For Women, respiratory conditions are the largest single factor (24.6%).
- The Yorwellbeing health check programme has a key role to play in tackling the key causes of the inequalities in life expectancy. The checks provide screening for cardiovascular risk factors (e.g. blood pressure, cholesterol, obesity) and appropriate advice is offered regarding healthier lifestyle choices. Smoking cessation support is also provided.

NHS Health Check Programme

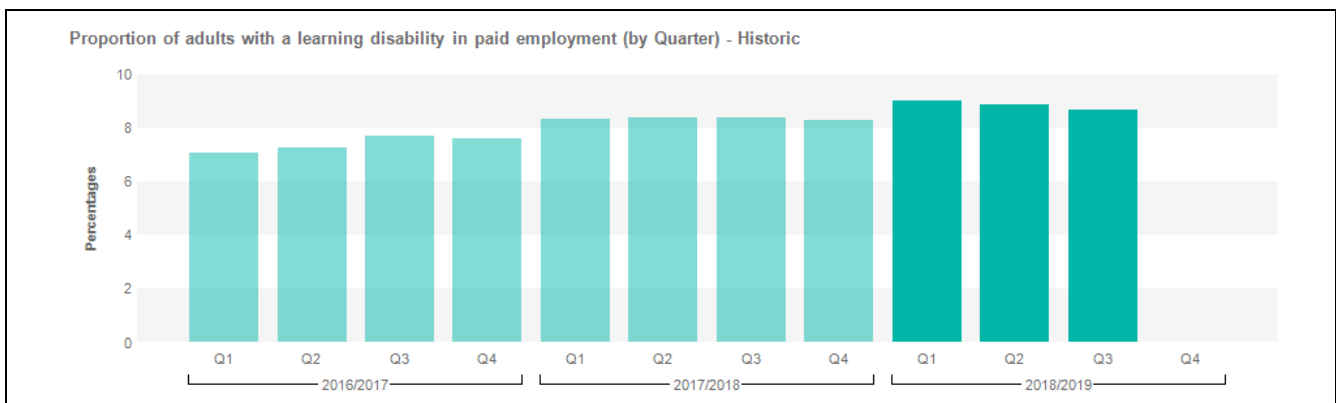
- The number of NHS health checks carried out each month is increasing. 1,129 checks have been delivered so far in 2018/19 with a further 100 already scheduled for March.



ANNEX A

Employment for people with learning disabilities / mental health.

- There is a strong link between employment and enhanced quality of life. Having a job reduces the risk of being lonely and isolated and has real benefits for a person's health and wellbeing.
- In 2018-19 Q3 8.7% of adults with a learning disability were in paid employment compared with 8.4% in 2017-18 Q3.



- In 2018/19 Q2, 21% of adults in contact with secondary mental health services were in paid employment, compared with 10% in 2017/18 Q2.



- These figures are now taken from NHS Digital as they include people not known to CYC's main provider of mental health services, TEWV.

ANNEX A Self Reported Wellbeing

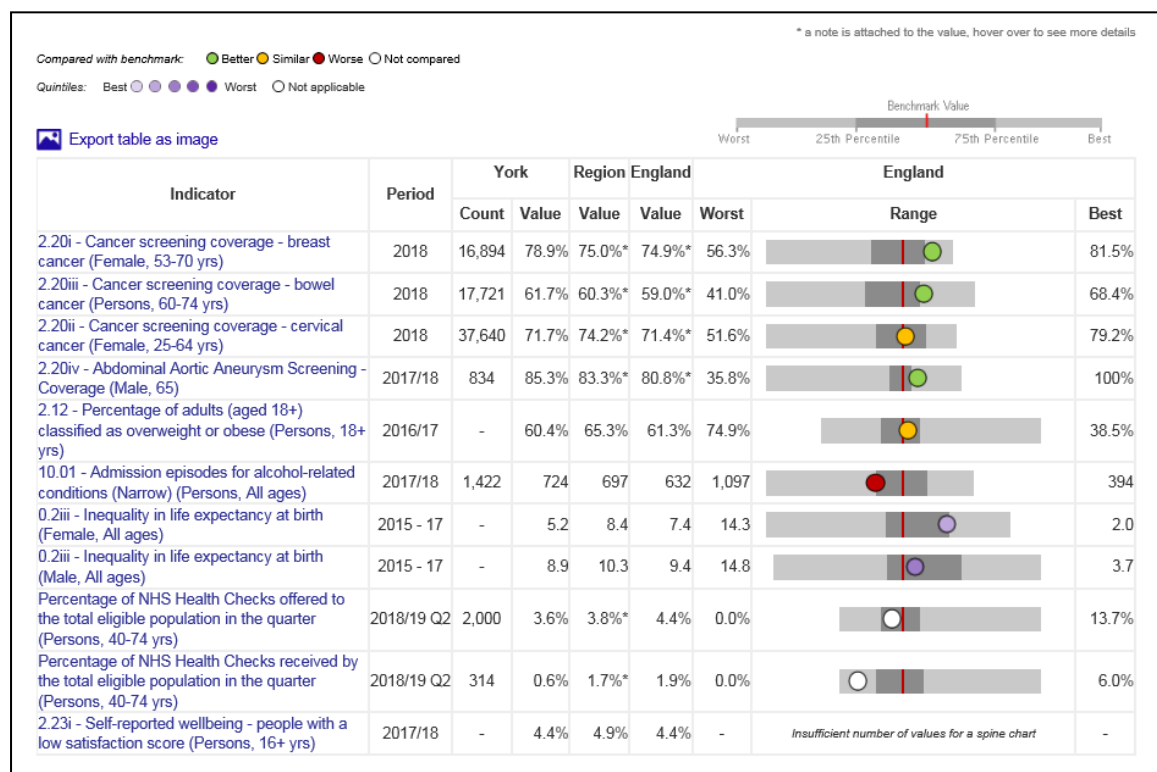
- People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. ONS are currently measuring individual/subjective well-being based on questions included on the Integrated Household Survey for people aged 16 and over
 1. Overall, how satisfied are you with your life nowadays?
 2. Overall, how happy did you feel yesterday?
 3. Overall, how anxious did you feel yesterday?

Compared with the national average York has:

- the same % of people who report low levels of satisfaction with their life (4.4%)
- a similar % of people who report low levels of happiness (9.5% v 8.2% in England)
- a higher % of people who report high levels of anxiety (24.2% v 20% in England)

Summary Scorecard

- A Public Health England scorecard showing some of the key indicators relating to Living and Working Well is shown below. The red vertical line indicates the England average and a value to the right of this line is desirable across all the indicators.
- The scorecard shows ‘at a glance’ that alcohol related admissions are high and the % of health checks received are low compared with the national average. Health check performance should improve when the recent increase in checks is reported.





Health and Wellbeing Board

13 March 2019

Report of the Director of Public Health**Update on development of a Healthy Weight Strategy in the City of York****Summary**

1. This report updates the Health and Wellbeing Board (HWBB) with progress on the development of a Healthy Weight Strategy for adults and children in the City of York, and invites any comments from the board about the strategy.
2. The report seeks approval to undertake public consultation on the draft strategy.

Background

3. The Healthy Weight Steering Group (HWSG) was established in April 2018 to co-ordinate the implementation of the Healthy Weight strategy for children and adults, involving key stakeholders specifically:
 - a) To prevent and reduce the numbers of adults and children that are obese in the city of York.
 - b) To oversee the implementation and ensure delivery of the Healthy Weight strategy.
 - c) To oversee the partnerships and manage the inter-relationships between task and finish groups.
4. One of the first aims of the group was to establish the extent of obesity of adults and children in York and any gaps in weight management services. The group has met six times since April 2018 to explore these issues.

5. To achieve the aims and objectives of the group, membership constitutes representatives from a wide range of organisations with a particular interest and focus on healthy weight in the City of York. These include members from the organisations and teams listed below but membership is increasing:
 - NHS:
 - Clinicians
 - Managers
 - NHS Vale of York Clinical Commissioning Group (CCG)
 - City of York Council (CYC) teams:
 - Public Health
 - Healthy Child Service
 - Commissioning and Contracts
 - Local Area
 - Strategic Business Intelligence
 - Travel Planning
 - Communications, Communities and Equalities
 - Voluntary Organisations:
 - Good Food York
 - York Older People's Assembly
 - Food Poverty Alliance
 - Public Health England (PHE)
 - University of York
 - North Yorkshire Sport
6. A draft Healthy Weight strategy has been developed utilising local evidence on obesity rates and input from the expertise of the steering group. The strategy has a life course approach to enable individuals of any age to achieve and maintain a healthy weight.

Main/Key Issues to be Considered

7. The Living and Working Well Theme of the Joint Health and Wellbeing Strategy states that we will support people to achieve and maintain a healthy weight, including promoting the benefits of walking and eating healthily.
8. The board agreed that they would scrutinise and challenge the development and delivery of local health and care services to ensure a focus on physical activity and healthy weight is embedded in the management of long term conditions. The board agreed to monitor progress on reducing the number of adults classed as overweight or obese.

9. The National Child Measurement Programme (NCMP) measures both the height and weight of children at school in reception year (aged 4 and 5 years of age) and Year 6 (aged 10 and 11 years of age). The obesity rate amongst reception children in York (8.5%) is not significantly different to the England average of 9.6% and the rate amongst year 6 children is 16.1% which is significantly lower than the England average of 20%.
10. However, the obesity rate approximately doubles from reception to year 6 for children in York and a number of inequalities exist. There is considerable variation by ward, where obesity rates are 2.5 times higher in the most deprived wards compared with the least deprived. Obesity rates are also significantly higher for boys in year 6 compared with girls and significantly higher for reception aged children from ethnic minorities.
11. 59.4% of adults in York are estimated to be overweight or obese (BMI>25) which is not significantly different to the England average of 61.3% and York has the lowest rates in the Yorkshire and Humber region. When compared with similar local authority neighbours York ranks seventh lowest for excess weight and/or obesity (out of 16).
12. Recent data reveals that overall physical activity levels in the City of York are good for both children and adults.
13. Recent data from a Sport England Active Lives survey of children and young people (aged 5-16 years of age) in 2017/18 revealed that compared with England and similar local authority neighbours, children in York engage in high levels (60 minutes or more) physical activity every day. This is mostly attributable to physical activity performed outside of school. Compared with regional and similar local authority neighbours children attending schools in York have slightly higher levels of physical activity.
14. Whilst the levels of physical activity performed indoors is lower for children residing in York in comparison with regional rates and comparatively similar local authorities in England, this may be because of high levels of activity outdoors.
15. With regards to physical activity the percentage of adults in York that are physically active has increased over recent years up to 72% in 2016/17. York also had a higher percentage of adults that

do any walking once per week (85.5% in 2016/17) and cycle at least 3 times per week (14.8% in 2016/17) when compared with England and local authorities that are similar to York. Individuals living in deprived areas may experience difficulties accessing services that provide sporting and leisure facilities.

Consultation

16. The Healthy Weight Strategy is being progressed through the Healthy Weight Steering Group, membership of which has been outlined in paragraph five above.

Options

17. The board is asked to consider approving the draft Healthy Weight Strategy and ensure that they are satisfied that it aligns with The Living and Working Well Theme of the Joint Health and Wellbeing Strategy.
18. The Board is asked to approve a wider public consultation on the draft Strategy.

Analysis

19. Local data reveals that whilst obesity levels for adults and children are in the main similar to rates for England, inequalities in relation to obesity rates in adults and children are related with differences in socio-economic factors, ethnicity and gender. It should also be noted that achievement of similar rates to England is undesirable and nationally there is ambition to reduce the rates of obesity.
20. Physical activity levels of children and adults in York are good but could be improved. There is a need to target those not engaged in any physical activity.
21. The draft Healthy Weight Strategy outlines how we will support individuals in York to achieve and maintain a healthy weight taking a life course approach by modifying the obesogenic environment to reduce inequalities.

Strategic/Operational Plans

22. The work of the Healthy Weight Steering Group relates to the Council Plan priority to focus on frontline services for residents, and the Joint Health and Wellbeing Strategy.

Implications

23. **Financial** - There are no financial implications to this report. The HWSG is undertaken within the budget of Public Health.
24. **Human Resources (HR)** - There are no HR implications.
25. **Equalities** - The aim of the HWSG is to enable all residents of the City of York to achieve and maintain a healthy weight.
26. **Legal** - There are no legal implications.
27. **Crime and Disorder** - There are no relevant implications.
28. **Information Technology (IT)** - There are no IT issues relating to this report.
29. **Property** - There are no property issues relating to this report.

Risk Management

30. The recommendations within this report do not present any risks which need to be monitored.

Recommendations

31. The Health and Wellbeing Board are asked to:
 - a. Receive the update on the work being carried out to understand the obesity levels of adults and children in York.
 - b. Approve the draft Healthy Weight Strategy for consultation
 - c. Agree to receive the final version of the Healthy Weight Strategy when it is finalised.

Reason: To keep the HWBB informed of issues relating to obesity in York and provide assurance that action is being taken to address any areas where concerns are raised.

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**Chief Officer Responsible for the
report:**

Sharon Stoltz
Director of Public Health

**Report
Approved**



25/02/19

Annexes

Annex 1 - Draft Healthy Weight Strategy

Healthy Weight, Healthy Lives Strategy

Foreword



Introduction

The City of York Council Healthy Weight Strategy aims to support individuals in York lose excess weight and maintain a healthy weight. Achieving a healthy weight increases life expectancy and also has financial benefits by utilising limited resources effectively.

The causes of obesity are complex and maintaining a healthy weight is affected by a range of factors including physical, environmental, social and emotional. This strategy has been developed using locally available evidence of the extent of obesity in York, national guidance and input from a City of York Council Healthy Weight Steering Group (HWSG). The HWSG comprises of individuals from a wide range of organisations with the expertise and knowledge to support individuals of all ages to live healthy lives and achieve and maintain a healthy weight. The strategy also considers the needs and views of the residents of York to ensure that recommendations and support services are appropriate.

As obesity can affect individuals of any age this strategy has focussed on how individuals can be supported in achieving and maintaining a healthy weight throughout the life course. It is important to recognise that individuals of differing age groups will require different kinds of support to help them achieve a healthy weight and the strategy therefore focuses on three key life stages:

- Pre-conception to early adulthood (0-18 years of age) – Starting Well and Growing Well
- Adults (18 – 65 years of age) – Living and Working Well
- Older adults (65 years and older) – Aging Well



What is a healthy weight?

A healthy weight for an individual is one which is appropriate for their height, and provides health benefits. Where this value is above the healthy weight range an individual is at increasing risk of a wide range of adverse health effects and wellbeing, including type 2 diabetes, high blood pressure and poor mental health. Food and drink are converted by the body into energy. Gradually over time if the intake of both is greater than the amount of energy being consumed through physical activity and the capability of the body to break down food through metabolism then an individual will store this excess energy as fat reserves and become overweight. Where excess body fat has significantly accumulated an individual will become obese.

Measuring healthy weight, overweight and obesity

Methods used to assess whether an individual is a healthy weight vary and depend upon the age of the individual but other factors such as ethnicity are also important and will be discussed in greater detail.

For adults the recommended measure is the body mass index (BMI) which is calculated by dividing body weight (kilograms) by height (meters) squared. A healthy weight is defined as a BMI between 18.5-24.9 kg/m²(NICE 2014) For Asian adults however, the BMI at which health risks would be of concern are lower, and for older people up to 65 years of age they are higher (NICE 2014). Whilst the BMI measure is a practical estimate of adiposity (fat levels) in adults, it is not a direct measure (NICE 2014).

Measurement of an adult's waist circumference is a direct measure of abdominal fat and this measure is useful where an individual has a BMI of 35kg/m² or less. Males with a waist measurement of 37 inches and females with a waist measurement of 31.5 inches are at increased risk of health risks. Individuals with a BMI of 35kg/m² or more are at risk regardless of waist circumference.



BMI classification for adults (NICE 2014)

Classification	BMI
Underweight	<18.5
Healthy weight	18.5 – 24.9
Overweight	25 – 29.9
Obese	30 – 39.9
Morbidly obese	>40

When assessing whether a child is of a healthy weight the BMI is adjusted for a child's age and gender against reference charts to give a BMI percentile (or centile) (NICE 2014). This compares the child's BMI to children of the same age and gender. For example if a child is 5 years old and his BMI falls at the 70th percentile, this means that 30% of 5 year old boys have a higher BMI and 70% have a lower BMI than that child. Those children that have a BMI centile in the overweight and obese range are more likely to become overweight or obese adults. In a clinical setting a child with a BMI greater than or equal to the 91st but below the 98th centile would be classed as overweight and greater than or equal to the 98th centile as obese.

Causes of overweight and obesity

The causes of obesity are complex and a range of factors which impact our lives can influence and increase the likelihood of becoming overweight or obese. These factors can include:

- Biology and Genetic influences
- Food production
- Food consumption
- Societal influences
- Psychological influences



- Individual activity
- Environment
- Socio-economic factors

Environmental factors are particularly important in influencing whether an individual will gain weight. The term obesogenic environment has been used to describe one in which it is more likely that an individual will gain weight and in which it is more difficult to lose weight. This would be an environment in which it is more challenging for a person to have access to healthy foods or opportunities to engage in physical activities which would aid weight loss and help maintain a healthy weight. Obesogenic environments include those where there are limited public services to enable people to access:

- 1) Shops that sell affordable, healthy foods. Individuals that have limited opportunities to travel and are surrounded by a density of shops that predominantly sell cheap convenience foods are at increased risk of gaining weight. There is also an increased density of fast food outlets (202 in York and above the national average) (PHE 2016).
- 2) Affordable sports and leisure facilities and green spaces. Safe environments which encourage people to walk or cycle to school or work and housing developments that have been designed to encourage children to play outside help to decrease the chances of weight gain and help maintain a healthy weight. Children that live near green spaces are less likely to experience an increase in BMI over time (Bell 2008).

Socio-economic factors can be particularly important in the opportunities available to individuals. Individuals living in more deprived communities are less likely to have the resources from which to access healthy foods and opportunities to access physical activities.

Prevalence of obesity and those that are overweight in York

The Healthy Weight Strategy has been informed by the latest evidence of the prevalence of the numbers of individuals that are overweight and obese in York and has been compared with national and regional rates. In addition although local authorities differ in many respects, (for example geographically and socio-economically), robust statistical methods have been developed by Public Health England to enable meaningful comparisons with data relating to the residents of the City of York and other similar local authorities in England.



Childhood Obesity

The National Child Measurement Programme (NCMP) measures both the height and weight of children at school in reception year (aged 4 and 5 years of age) and Year 6 (aged 10 and 11 years of age). The obesity rate amongst reception children in York (8.5%) is not significantly different to the England average of 9.6% and the rate amongst year 6 children is 16.1% which is significantly lower than the England average of 20% (PHE 2018 NCMP Local Authority profile)

Infographic showing obesity rates amongst reception children in York (8.5%)



Infographic showing obesity rates amongst year 6 children in York (16.1%)



However, the obesity rate approximately doubles from reception to year 6 for children in York and a number of inequalities exist. There is considerable variation by ward, where obesity rates are 2.5 times higher in the most deprived wards compared with the least deprived, please see table 1 and ward map below (CYC Business Intelligence Hub 2018). Obesity rates are also significantly higher for boys in year 6 compared with girls, and significantly higher for reception aged children from ethnic minorities (CYC Business Intelligence Hub 2018).



Table 1: Childhood Obesity Rates and Deprivation in York by Ward 2013/14 to 2015/16

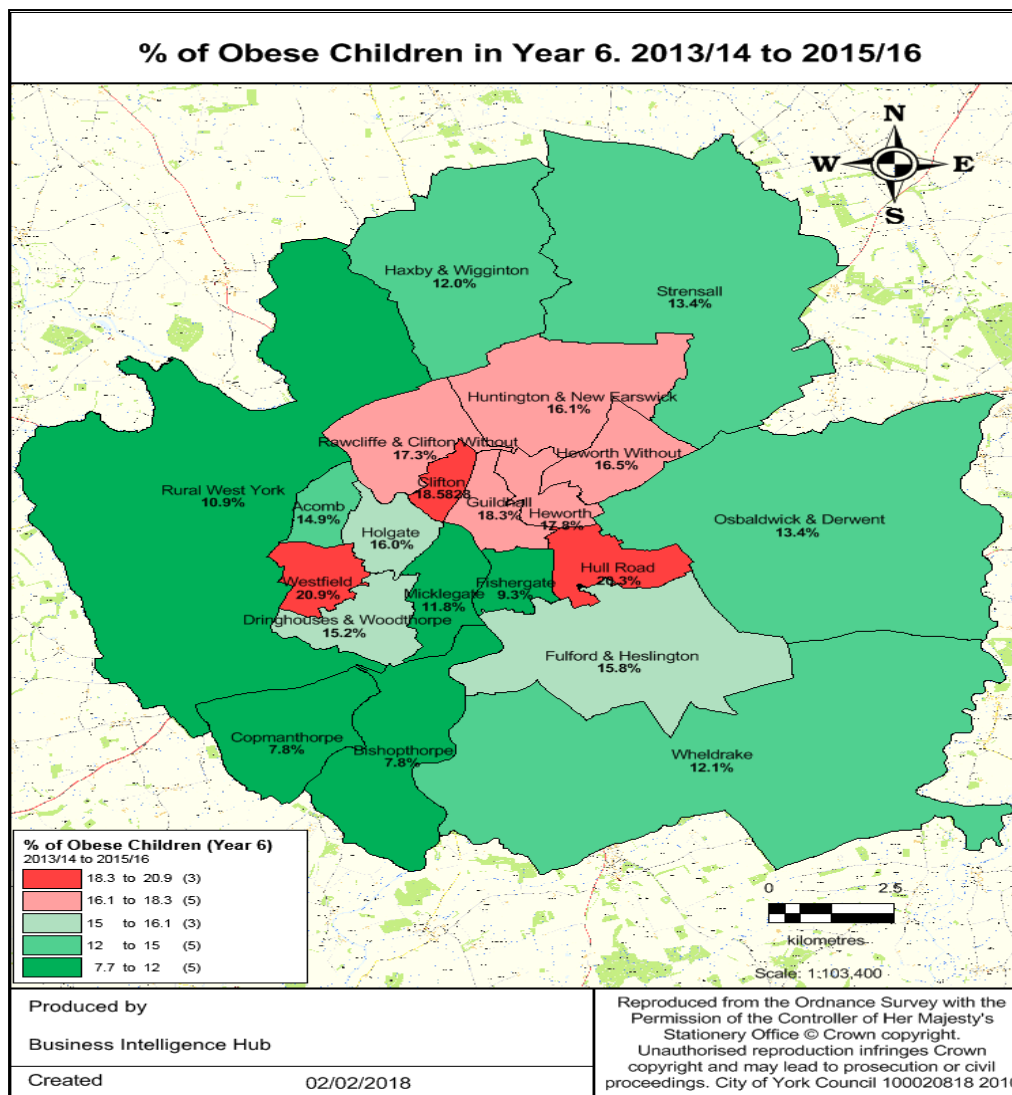
Ward	% of reception year children recorded as being obese	% of Year 6 children recorded as being obese	IMD Deprivation Score: (higher numbers indicate greater deprivation)
Westfield	8.7%	20.9%	25.6
Clifton	8.1%	18.6%	24.3
Guildhall	9.9%	18.3%	16.7
Heworth	7.8%	17.8%	16.7
Micklegate	8.7%	11.8%	14.9
Hull Road	11.3%	20.3%	14.6
Holgate	8.9%	16.0%	13.7
Acomb	11.6%	15.0%	12.6
Huntington and New Earswick	7.7%	16.1%	12.3
Dringhouses and Woodthorpe	7.6%	15.2%	9.5
Fishergate	9.1%	9.3%	9.3
Strensall	4.2%	13.4%	7.1
Rawcliffe and Clifton Without	6.4%	17.3%	7
Osbaldwick and Derwent	8.1%	13.4%	6.6
Rural West York	6.6%	11.0%	6.5
Fulford and Heslington	7.8%	15.8%	5.9
Bishopthorpe	4.4%	7.8%	5.5
Heworth Without	6.7%	16.5%	5.2
Haxby and Wigginton	5.3%	12.0%	4.8
Wheldrake	6.4%	12.1%	4.3
Copmanthorpe	4.4%	7.8%	2.5



York Average	7.8%	15.2%	12.2
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Variations in obesity rates in Year 6 children in York by ward





Adult Obesity

59.4% of adults in York are estimated to be overweight or obese (BMI>25) which is not significantly different to the England average of 61.3% and York has the lowest rates in the Yorkshire and Humber region (PHE 2015/16). When compared with similar local authority neighbours York ranks seventh lowest for excess weight and/or obesity (out of 16) (PHE 2015/16).

Infographic showing obesity rates amongst adults in York (59.4%)



Physical activity

Recent data reveals that overall physical activity levels in the City of York are good for both children and adults. The strategy will therefore focus upon improving opportunities for individuals, (for example those living in deprived areas that may experience difficulties accessing services that provide sporting and leisure facilities) and encouraging and supporting those that engage in very minimal levels of physical activity to be more active for example through improved signposting of existing and newly developing services.

Recent data from a Sport England Active Lives survey of children and young people (aged 5-16 years of age) in 2017/18 revealed that compared with England and similar local authority neighbours, children in York engage in high levels (60 minutes or more) physical activity every day (CYC Business Intelligence Hub analysis Sport England Active Lives Survey: Children and Young People 2017/18). This is mostly attributable to physical activity performed outside of school. Compared with regional and similar local authority neighbours children attending schools in York have slightly higher levels of physical activity (CYC Business Intelligence Hub analysis Sport England Active Lives Survey: Children and Young People 2017/18). Whilst the levels of physical activity performed indoors is lower for children residing in York in comparison with regional rates and comparatively similar local



authorities in England, this may be because of high levels of activity outdoors (CYC Business Intelligence Hub analysis Sport England Active Lives Survey: Children and Young People 2017/18).

With regards to physical activity the percentage of adults in York that are physically active has increased over recent years up to 72% in 2016/17 (PHE Physical Activity profile 2018). York also had a higher percentage of adults that do any walking once per week (85.5% in 2016/17) and cycle at least 3 times per week (14.8% in 2016/17) when compared with England and local authorities that are similar to York (PHE Physical Activity profile 2018).

Inequalities in Obesity

Deprived communities are more likely to have higher rates of obesity and there is evidence of this in York. Socio-economic factors can act as a barrier to individuals in deprived communities from accessing healthy affordable food and opportunities to engage in physical activity. Both of which are important in aiding weight loss and allowing individuals to maintain a healthy weight. Patients in the most deprived areas can often live in 'food deserts' where accessibility to affordable healthy foods is limited. Individuals living in these communities may have limited access to private and/or public transport services or opportunities to access areas where healthy affordable food is available. This results in them accessing local stores selling cheaper, less healthy, convenience foods such as ready meals.

In York when the prevalence of obesity for children in school reception year is combined for the years 2012/13 till 2016/17 there is a greater rate of obesity as deprivation increases with the exception of the very most deprived children (those classified in the 20% most deprived). The same trend can also be observed for those children in year 6 (CYC Business Services Authority York Obesity Information 2018).

Obesity rates for children in year 6 overall are good in York, however, there is considerable variation by ward where 7.8% of children in Copmanthorpe are overweight compared with 20.9% in Westfield (2.5 times higher in the most deprived ward compared with the least deprived ward) Business Intelligence Hub analysis – Obesity and Excess Weight in York – Year 6 obesity - % of obese children in Year 6 2013/14 to 2016/16 – variation by ward (2018).



It is not just socio-economic factors where inequalities exist. Obesity rates for boys in year 6 are significantly higher than for girls in year 6 and obesity rates are also significantly higher for reception children that are from black or asian ethnic minorities (CYC Business Intelligence Hub – Childhood obesity levels inequalities York 2012/13 – 2016/17 (2018)).

In summary whilst obesity can affect any member of the population there are groups of individuals that are at a greater risk of becoming overweight and developing obesity. These groups include:

- Children
- Those from Black and Ethnic Minorities
- People living in more deprived communities
- Older people
- People with poor mental health
- People with a disability (HSE 2013)

Impacts of obesity

Individuals that are obese are at risk of a number of medical conditions including Type 2 diabetes, cardiovascular disease, hypertension, liver kidney disease and lower quality of life and decreased mortality. Children that are overweight or obese are more likely to become obese in adulthood. Impacts for children will also be more immediate though such as emotional and behavioural problems, low self-esteem, bullying and increased school absences as well as bone and joint problems and difficulties breathing (National statistics 2015).

During maternity women that are overweight during pregnancy are at risk of developing gestational diabetes mellitus, and increased risks of pre-eclampsia and complications during caesarean delivery. Mothers that maintain excess weight post partum are more likely to become obese later in life as well as the immediate impacts upon foetal development and the health of the child.



Economic costs

Public Health England estimate that the NHS spent £6.1 billion on overweight and obesity related health in 2014/15 and the overall cost to the wider society of obesity was estimated at £27 billion.

The UK wide costs to the NHS attributable to overweight and obesity are projected to reach £9.7 billion by 2050 with wider costs to society estimated to reach £49.9 billion per year (Health Matters: Obesity and the food environment 2017).

Healthy Weight Strategy

Who has developed the strategy?

Through the direction of the Health and Wellbeing Board it was decided to form a Healthy Weight Steering Group which met for the first time in April 2018 and was established to co-ordinate the development and implementation of a Healthy Weight Strategy for children and adults in York. Members of the group represent a wide range of organisations which include the NHS, City of York Council and the voluntary sector. Members bring to the group knowledge and expertise and are involved either with the commissioning or delivery of services and support that help residents of the City of York lose excess weight and live healthy lives.

Members of the Healthy Weight Steering Group comprise of frontline health professionals (for example Consultants, GPs, nurses and midwives) and the commissioners of NHS services (for example the CCG) that support individuals in losing excess weight and maintaining a healthy weight. Their insights have informed the development of the strategy through discussions in the gaps in existing weight management services, the challenges faced by frontline clinicians, and the development of appropriate cost effective measures. The group also includes individuals from organisations representing the Healthy Child Service, older people and those involved in encouraging and providing physical activities for the residents of York. This allows for collaboration between those providing the commissioning and delivery of clinical services and the wider community including schools and workplace environments to maximise opportunities for individuals to undertake physical activity and eat healthy foods, through appropriate advice and services that support behaviour change.



What is the vision?

The vision of the Healthy Weight Strategy is to inform, enable, motivate and empower individuals, families and communities to achieve and maintain a healthy weight. As public expenditure is limited it is important that the strategy has clearly defined measurable targets. The Healthy Weight Steering Group (HWSG) provides a forum from which to ensure delivery of the strategy and monitor its success. If necessary the strategy could be modified by the Healthy Weight Steering Group using local data and results from monitoring so that limited resources are targeted where there is demonstrable benefit.

A whole systems approach will be used and there is no single solution. We will work with other partners to deliver the strategy. There will be a range of interventions, prevention based (at population level), community based through to specialist weight management services across the workforce and community.

Evidence base for the strategy comes from key documents and most up to date NICE guidance

Healthy Weight Strategy

- 1) **Modify the obesogenic environment making it more favourable for individuals to achieve and maintain a healthy weight** by:
 - a) Developing and signing up to the Healthy Weight Declaration.
 - b) Working together with those involved with city planning.
 - c) Incorporating social value into procurement processes to benefit the healthy weight agenda.

- 2) **Support individuals in achieving and maintaining a healthy weight throughout the Life Course:**
 - a) **Starting and Growing Well** - In maternal and early years settings we will do this by:
 - Providing consistent messages and support for women by training front line health workers:



- Pre-conception to those thinking about becoming parents.
- Post-partum to mothers 6-8 weeks after delivery.

By supporting individuals:

- In schools by supporting opportunities for children to engage in physical activity. Every school and child signs up to the Daily Mile.

b) Living and working well

By promoting consistent messages to adults and support individuals to engage with weight management recommendations and services. Provide brief intervention training for GPs and other front line health workers. Developing interventions for people who are above a healthy weight targeted at those most in need

c) Ageing Well

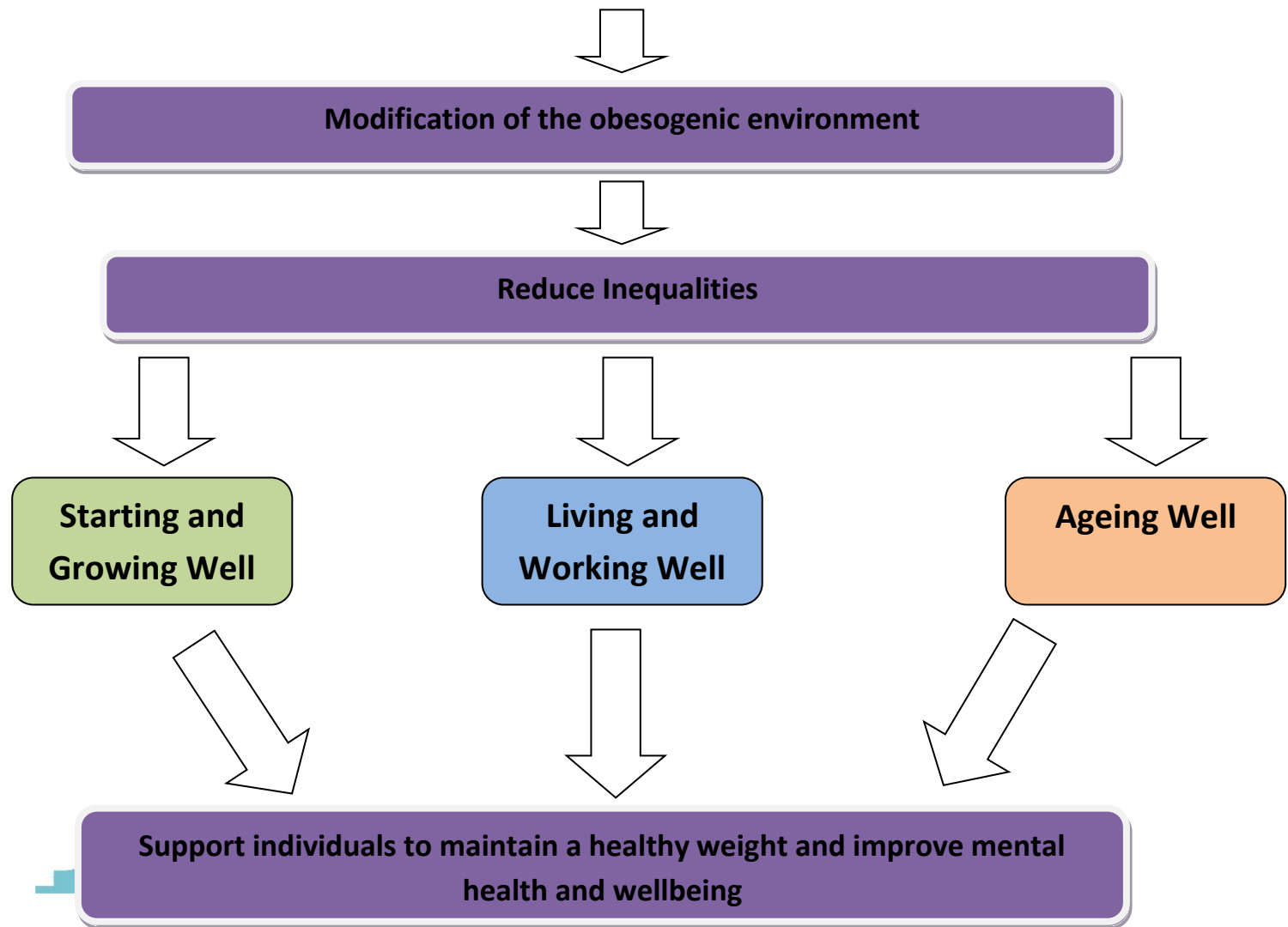
By providing consistent messages to older adults and supporting them to engaging in appropriate physical activity and a healthy diet.

- 3) Provide targeted weight management interventions for individuals with the aim of reducing inequalities that exist within York.
- 4) Through public engagement explore and develop an understanding of the wants and needs of the residents of York with regards to weight management interventions.



Summary of strategy

Vision: The vision of the Healthy Weight Strategy is to inform, enable, motivate and empower individuals, families and communities to achieve and maintain a healthy weight.



Strategic Priorities

1) **Modifying the Obesogenic environment**

There is a need for a holistic and multi-faceted approach to the commissioning and provision of services across multiple organisations to address the causes of obesity and support individuals lose weight and maintain a healthy weight. We will take action to help the population of York make better choices for themselves and their families and ensure healthy food and activity choices are the easy and preferred choice. We will maximise opportunities for participation in healthy behaviours in our local communities, particularly for those most at risk.

What we will do:

- There will be collaborative working with those involved in city planning to improve access to all residents in the city to areas where healthy affordable food is available to support a healthy lifestyle and achieve a healthy weight. Good access to green spaces will help to create environments that support physical activity.
- Incorporate social value into procurement processes to benefit the healthy weight agenda and support individuals in achieving and maintaining a healthy weight.
- Sign up to the Healthy Weight Declaration

2) **Giving every child the best start in life**

There are a number of key points within the life course in which targeted interventions can prevent weight related health inequalities and obesity and these include those considering starting a family, during pregnancy, infancy and early childhood up to age 5 (Marmot 2010 and WHO 2014). We acknowledge that family can mean different things to different people, and it is important that all families are supported appropriately to enable their children to have access to healthy food and opportunities for physical activity.



What we will do:

- Ensure that health professional working with pregnant women and pre-school aged children are able to support those they work with to achieve and maintain a healthy weight
- Encourage every school to undertake the Daily Mile. Working with North Yorkshire sport to explore how this could be achieved pragmatically.
- Encourage bikability training for children and promoting urban cycling skills to parents including improving accessibility to equipment to enable safe cycling.
- Provide messages with the Sports Directory sent to schools emphasising the usefulness of the document to schools and parents

3) Ensure that adults are equipped with knowledge to achieve and maintain a healthy weight and have access to services to address excess weight issues:

The strategy focuses upon preventing individuals becoming overweight and obese but there is a need to ensure that those that have excess weight are referred appropriately to weight management services.

What we will do:

- Ensure that messages about losing excess weight are consistently clear and concise by providing brief intervention training for GPs and other frontline healthcare workers involved in weight management interventions.
- Establish tier 2 and tier 3 weight management services with a referral pathway that is clear for practitioners. Signposting to such services will be made clear so that potential users are aware of weight management services that are available
- Work with practices across tier 2 and tier 3 services to support them and ensure that services are appropriate through monitoring and guidance from the Healthy Weight Steering Group.



4) **Support older people to stay active and maintain independence:**

It is important that older people are appropriately supported in achieving and maintaining a healthy weight.

What we will do:

- Encourage the use of physical activity interventions which are appropriate for the individual.
- Support organisations that provide opportunities for older people to engage in social activities that reduce social isolation, increase physical activity and maintain independence.

5) **To reduce the inequalities associated with gaining excess weight across the city**

Some communities are disproportionately affected by excess weight. In York there is considerable variation by ward where obesity rates in the most deprived wards are 2.5 times greater than the least deprived for year 6 children. The strategy aims to reduce inequalities in excess weight across the city.

What we will do:

- Engage with deprived communities and explore what support individuals require to assist them in losing excess weight and maintaining a healthy weight. This will aid the targeting of limited resources and interventions to reduce identified inequalities with obesity.
- Identify community champions that can deliver guidance to individuals in deprived communities that require support in losing excess weight.
- Explore how voluntary organisations that provide services associated with food (for example food banks) and physical activity can be supported in helping to reduce inequalities in access to healthy food and physical activities



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Appendix

HWSG involvement in the development of the strategy

A service mapping exercise was undertaken by the HWSG utilising vignettes to enable group discussions to ascertain the pathway individuals of various ages would follow from identification of being overweight, through to the services that are currently available to support them lose excess weight. This provided an opportunity to identify where there are currently gaps in services for individuals across the life course for residents of York, and explore pragmatic cost effective methods which would help to identify individuals that are overweight and to support them



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Health and Wellbeing Board

13 March 2019

Report of the Corporate Director of Health, Housing and Adult Social Care and the Corporate Director of Children's Services, Education and Communities

All Age Learning Disabilities Strategy

Summary

1. The All Age Learning Disabilities Strategy has been written through a consultative process. Views have been sought as to what is important for people with learning disabilities, and their carers, to ensure we are addressing their priorities.
2. The Learning Disabilities Needs Assessment and updated statistics forms the evidence base for the Strategy.
3. This report asks the Health and Wellbeing Board to formally ratify the Strategy.
4. Additionally, the All Age Learning Disabilities Strategy is being brought to the attention of the Health and Wellbeing Board for consideration in terms of governance structures. Responsibility for operational delivery of the actions plans will be held with the All Age Learning Disabilities Partnership.

Background

5. The Health and Wellbeing Board (HWBB) agreed to commission an All Age Learning Disabilities Strategy in 2017, following the successful launch of the All Age Autism Strategy and Mental Health Strategy. A separate Carers' Strategy is nearing completion following a period of extensive consultation.
6. This is the first All Age Learning Disabilities Strategy (attached as **Annex A and Annex B**). Through this Strategy we can work towards making York a better, more inclusive, City for all its residents.

7. The Health and Wellbeing Board's Strategy for 2017-22 identified four principal themes to be addressed. Learning Disabilities cuts across all these themes with the HWBB stating:
 - i. Mental Health and Wellbeing - improve the services we offer to those with learning disabilities, and progress will be monitored on regular sharing of information between GPs and CYC about people with learning disabilities.
 - ii. Starting and Growing Well - improve services for vulnerable mothers, including very young mothers, single parents, parents with learning disabilities, or those whose children have learning disabilities
 - iii. Living and Working Well says the Board will lead by example in the employment of people with learning disabilities, and other vulnerable groups
 - iv. Aging Well – whilst the Board does not specifically mention learning disabilities all the areas highlighted apply equally to learning disabilities.
8. The HWBB Strategy also highlights some of the groups where there is evidence of poorer outcomes and people with learning disabilities are highlighted in this.
9. An independent researcher and writer was employed by the City of York Council in Autumn 2017. He undertook a literature review, reviewed existing data, attended events, and met with local groups and individuals in order to set the scene for the All Age Learning Disabilities Strategy. From this process it was agreed that the strategy would be short with other documents key forming the evidence base.
10. During this process the Learning Disabilities Partnership formed and met for the first time in June 2018. The Learning Disabilities Partnership is a group of partners including people with learning disabilities, their families/carers, the voluntary sector, education, health and social care. The main focus of the initial meeting was establishing the Partnership and reviewing an early draft of the Strategy.
11. A working group was established to take forward the work of the independent researcher and develop and shape the Strategy further.

12. The four key priorities areas highlighted within the Strategy are:
 - i. Education, life-long learning and employment
 - ii. Being as healthy as possible
 - iii. Independent living
 - iv. Participating in society
13. Behind the Strategy will sit comprehensive action plans for each priority area of work which will be owned by sub-groups for each priority area. These action plans will set out how we will work together to achieve the desired outcomes within these areas. They will include how we will measure impact and the difference to people's lives.
14. The strategy is not focused on specialist service delivery, or only on those people who are in touch with services. Its main focus is on how we can ensure all people with learning disabilities are included in our communities in York.
15. This strategy does not duplicate or supersede existing programmes of work and statutory responsibilities of the partner organisations, such as the Transforming Care Programme. The Learning Disability Partnership will not commit the resources of partner members; the governance for decision making is unchanged by the establishment of the partnership.

Main/Key Issues to be Considered

16. The new All Age Learning Disabilities Strategy will run for 5 years from 2019 - 2024. It is a high level strategy and will be underpinned by comprehensive action plans.
17. The action plans will be owned by the All Age Learning Disabilities Partnership. The Health and Wellbeing Board are asked to consider whether they wish to receive annual progress updates from the Partnership.

Consultation

18. The All Age Learning Disabilities has been developed by using a co-production approach with an independent researcher employed by City of York Council for a year to gather views through attending and engaging with groups, reviewing data and pertinent documents

and writing an initial draft of the Strategy. This has subsequently been progressed through a process of engagement sessions and through the setting up of the Partnership Board and Learning Disabilities Working Group. Stakeholders such as the council Health, Housing and Adults Services Directorate Management Team and the CCG Executive Team have also been consulted.

19. Stakeholder engagement and consultation has led the development of the Strategy and is described in the table below.

Timeline for the development of the All Age Learning Disabilities Strategy	
Sept 2017 to June 2018	Ed Washer consults and writes the first draft of the All Age Learning Disabilities Strategy
26 June 2018	First Meeting of the All Age Learning Disabilities Partnership – focus on formation of Partnership and the Strategy
25 th Sept 2018	All Age Learning Disabilities Partnership (LDP) Meeting – focus on the Strategy
13 th Nov 2018	LDP working group for the draft strategy meeting
21 st Nov 2018	The Strategy is taken to the VCS Forum for Learning Difficulties to discuss / comment
11 th Dec 2018	All Age Learning Disabilities Partnership (LDP) Meeting – focus on the Strategy
18 th Dec 2018	LDP working group for the draft strategy meeting
22 nd Jan 2019	LDP working group for the draft strategy meeting
6 th Feb 2019	The Strategy is taken to the CCG Executive Meeting for discussion / comment
28 th Feb 2019	The Strategy will be taken again to the VCS Forum for Learning Difficulties to discuss / comment
13 th March 2019	Final Draft to the HWBB

Options

20. There are no specific options for the Board.
21. The Health and Wellbeing Board are asked to ratify the All Age Learning Disabilities Strategy and indicate whether they wish to receive annual progress updates.

Strategic/Operational Plans

22. The aspirations, vision and priorities of both National legislation and local strategic plans, including the Joint *Health and Wellbeing Strategy*, need to be embedded and owned locally to meet the needs of the whole community including people with learning disabilities. Achieving better outcomes for everyone with learning disabilities and their families / carers requires joint working by local partners and the Health and Wellbeing Board is well placed to lead this approach.

Implications

23. There are no known implications in relation to the following in terms of dealing with the specific matters before Health and Wellbeing Board Members; Financial, Human Resources (HR), Equalities, Legal, Crime and Disorder, Information Technology (IT) and Property.

Risk Management

24. The Health and Wellbeing Board has a crucial role to play in overseeing the implementation of the All Age Learning Disabilities Strategy. Achieving better outcomes for everyone with a learning disability requires local partners to work together and the Health and Wellbeing Board will give the support, guidance and leadership needed to ensure that the aspirations within the All Age Learning Disabilities Strategy are achieved.

Recommendations

25. The Health and Wellbeing Board are asked to:
- i. Ratify the All Age Learning Disabilities Strategy
 - ii. Receive annual updates from the All Age Disabilities Strategy Group.

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

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**Report
Approved**

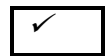


Date 01.03.2019

Specialist Implications Officer(s)

Wards Affected:

All



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

Annexes

**Annex A – All Age Learning Disabilities Strategy for York, 2019-2024
Annex B - All Age Learning Disabilities Strategy Summary**

Final Draft

All Age Learning Disabilities Strategy

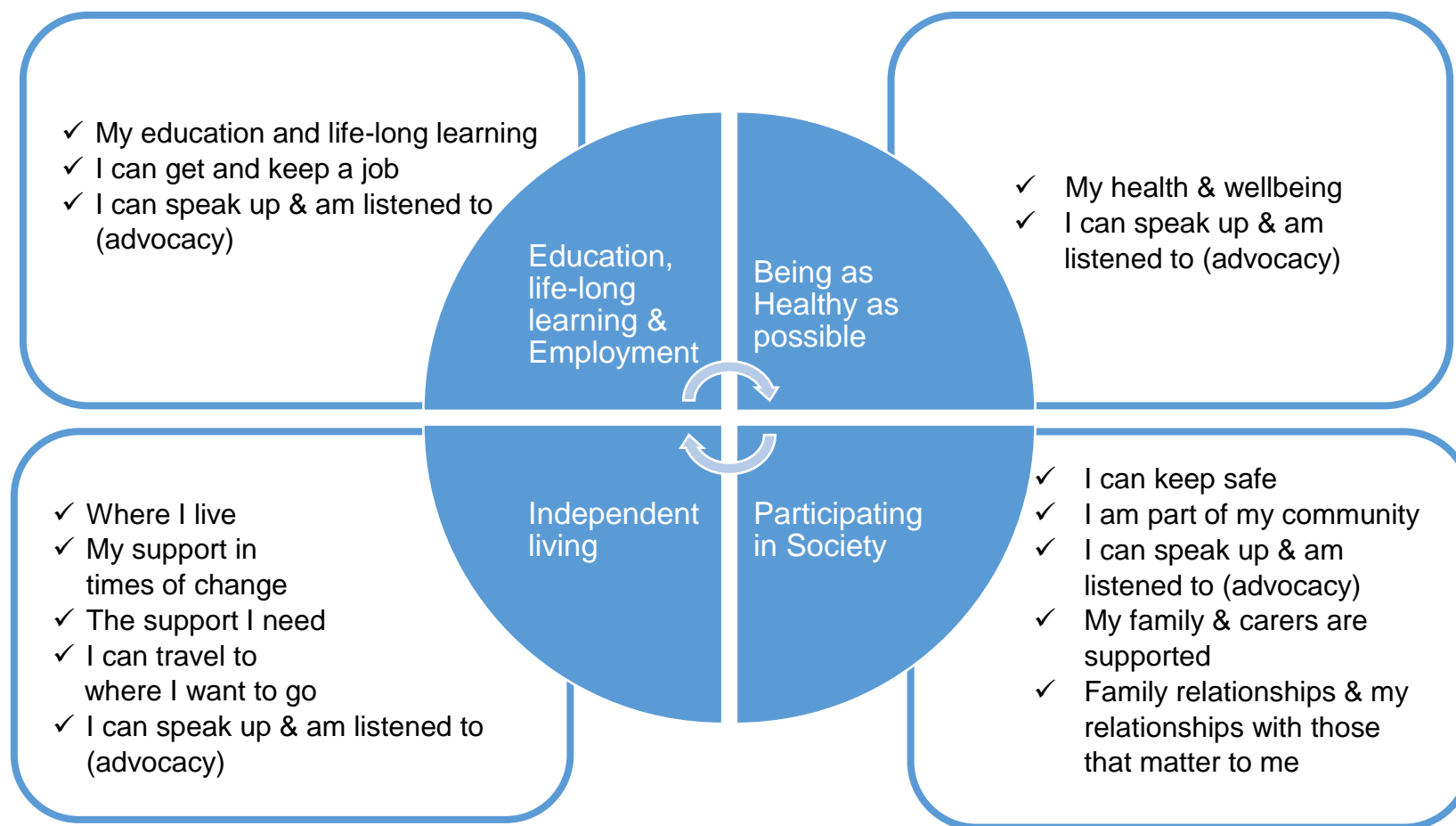
2019-2024

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Strategy on a page

This Strategy is the first All Age Learning Disabilities Strategy for York and was coproduced by the new Learning Disabilities Partnership. It does not try to describe everything we know about learning disabilities in York or cover every issue. It aims to set out the Partnership’s four priority areas shown in the diagram below and described in more detail in the Strategy. The Partnership will lead and co-ordinate the delivery of the Strategy.



Vision

For every resident of York to enjoy the best possible emotional and mental health and wellbeing throughout the course of their life.

Mission Statement

To make sure people with learning disabilities (and their children and families/carers) are valued through full inclusion in education, citizenship, meaningful employment, advocacy, and have the opportunity to live as independent a life as possible and to enjoy a full range of relationships.

Foreword

This Strategy is our opportunity to help make York a fully inclusive City for people with learning disabilities and their families/carers. This Strategy is important; it has been coproduced by people with learning disabilities and their families/carers, together with the voluntary sector, education, health and social care.

Based on the lived experience of those with learning disabilities and their families/carers, the four main priority areas, and the focus areas within them, have been agreed by the Learning Disability Partnership.

Through this Strategy we can work towards making York a better, more inclusive, City for all its residents.

Introduction

This Strategy was written by the Learning Disabilities Partnership. It sets out the main areas of focus to help to make York a more inclusive city for people with learning disabilities and their families/carers.

This Strategy is focussed on inclusion and improving health and wellbeing of those with learning disabilities in York. It is part of wider programmes of work which will feed into the outcomes and aspirations of this Strategy.

The Learning Disabilities Partnership is a group of partners including people with learning disabilities, their families/carers, the voluntary sector, education, health and social care. It will oversee the implementation of the Strategy through giving direction and feedback to working groups which will report to the Learning Disabilities Partnership.

The Learning Disabilities Partnership wishes to highlight the input and contribution of people who have learning disabilities and have direct lived experience into the writing of this Strategy.

This is the first All Age Strategy and is for every resident of York with a learning disability, as well as those who support them.

The Learning Disabilities Partnership knows that everyone needs to be involved to make this Strategy work. We need to make sure that everyone is included and everyone's voice is heard, so that the Strategy can make a difference.

This Strategy **does not** cover big programmes of work already being undertaken by Health or by the City of York Council, for example, the Transforming Care Programme.

What is a learning disability?

A learning disability affects the way individuals learn new things, the way they understand information and how they communicate. Some people with a learning disability can talk easily and look after themselves but may need a bit longer than usual to learn new skills. Other people may not be able to communicate verbally but use other communication methods such as Makaton, gestures and vocalisation and need the support of other people to get their thoughts or feelings understood.

A person with a learning disability can also have physical disabilities including sensory impairments and mobility difficulties. Some adults with a learning disability are able to live independently, while others need help with everyday tasks, such as washing and dressing. This depends on the person's abilities and the level of care and support they receive.

Children and young people with a learning disability may also have special educational needs (SEN).

York supports the social model as a way of understanding disability. The model says that disability is not caused by an individual's health

condition or impairment but by the way society treats people and creates barriers for them.

The barriers tend to fall into three categories:

- the environment – including inaccessible buildings and services
- people's attitudes – stereotyping, discrimination and prejudice
- organisations – inflexible policies, practices and procedures

The social model encourages society to become more inclusive.

Facts on a page for learning disabilities – national



2 people in every 100 have a learning disability

3x



The annual cost of bringing up a child with learning disabilities is **three times higher** than bringing up a non disabled child.



20x

People with learning disabilities are **20 times more likely** to have epilepsy than the general population.



2x

Children with special educational needs (SEN) are **twice as likely** as other children to be bullied regularly.



16.8%

of people with a learning disability play sport at least once a week, compared with **39.9%** of the general population.



1 in 13...

disabled children receives regular support service of some kind from the local authority.

Facts on a page for learning disabilities – York



In York, **12.9%** of children with learning disabilities are in primary mainstream schools, **22.8%** are in secondary mainstream schools and **44%** are educated in special school.



Age 50+

39 in every **100** adults with a learning disability who are known to Adult Social Care are **aged over 50**.



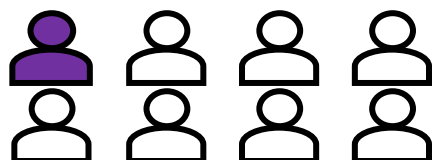
533

adults with a learning disability are known to Adult Social Care.



8.3%

of adults known to Adult Social Care in York, are in **employment** (March 2018)



1 in 8

adults who has a learning disability living in York is known to Adult Social Care.

For more detailed information please refer to the **Joint Strategic Needs Assessment for Adults with Learning Disabilities (March 2016)**

Context

In York, we want to support everyone to be as independent and as healthy as possible and to be included in their communities. As children grow into adults we aim to promote independence and teach skills that enable individuals to live a fulfilling and independent life.

As medical advances continue we know that children with more complex disabilities are living much longer into adult life. We also know that adults are living longer but there is still a big gap in life expectancy; information from a range of sources consistently shows that people with learning disabilities die much younger than the general population.

The general population in York is approximately 208,000, with 22,610 of that population aged between 5 and 18 years old.

Table 1 below shows that 516 (2.3% of the school age population) have a primary need of a moderate learning difficulty and above.

Primary Need as at January 2017 School Census (table 1)

Includes January 2018 data for York

Table 1				
Setting	Category	York (%) 2017	York (%) 2018	National 2017 (%)
Primary mainstream	Moderate	12.50	12.60	20.70
	Severe	0.20	0.20	0.60
	PMLD*	0.10	0.10	0.30
Secondary mainstream	Moderate	22.00	22.00	22.20
	Severe	0.80	0.80	0.50
	PMLD*	0.00	0.00	0.10
Special school	Moderate	16.20	12.50	13.20
	Severe	15.50	8.50	23.30
	PMLD*	12.30	6.70	8.10

* Profound and Multiple Learning Disabilities

In York there is estimated to be a continued rise in adults with a learning disability. This growth can be seen in Table 2¹ below. The percentage increase is the same as the population growth for all of York.

Predicted to have a learning disability	2017	2020	2025	2030	2035
18-24	822	802	797	876	877
25-34	749	772	777	740	762
35-44	605	618	672	709	709
45-54	636	613	571	578	625
55-64	518	555	593	571	528
Total (18-64)	3,331	3,360	3,411	3,474	3,501

Like the general population, the average age of death for people with learning disabilities is also increasing. General population data for York² indicates that there is predicted to be a rise of 27% in the number of those with a learning disability over the age of 65, as shown in table 3.

Age of People predicted to have a learning disability	2017	2020	2025	2030	2035
65-74	440	449	440	493	532
75-84	251	270	327	347	352
85	103	110	130	157	207
Total (65 and over)	794	829	897	997	1,091

As the life expectancy of adults with learning disabilities increases there is also a significant increase in the likelihood that there may be an increase in certain conditions and diseases. (People with learning disabilities are 20 times more likely to have epilepsy, eight times more likely to have severe mental illness and five times more likely to have dementia. They are also three times more likely to suffer with

¹ POPPI data, April 2018

<http://www.poppi.org.uk/index.php?pageNo=374&PHPSESSID=akhp6muj58i2ojelln1cung6&sc=1&loc=8301&np=1>

² POPPI data, April 2018

<http://www.poppi.org.uk/index.php?pageNo=374&PHPSESSID=akhp6muj58i2ojelln1cung6&sc=1&loc=8301&np=1>

hypothyroidism and almost twice as likely to suffer diabetes, heart failure, chronic kidney disease or stroke³.)

Our Strategy

The Learning Disability Partnership was launched in June 2018. The group has taken on the oversight for the All Age Learning Disability Strategy.

Lots of different people and groups were asked about what things are important to them. A full summary of this work is available.

You told us – key messages

- The voice of those with learning disabilities needs to be heard, listened to and acted on when decisions are being made about services and facilities.
- There needs to be more help to navigate health services.
- There is still a lot of work to be done to reduce health inequalities.
- Children and young people are not always supported to contribute fully to their planning.
- Parents and unpaid carers need more practical support.
- There needs to be increased training to support education staff to fully differentiate the curriculum for children and young people with learning disabilities.
- The Partnership should explore opportunities for integrated working.
- More attention needed for all transitions, times of change.
- Plan for people who need different accommodation.
- Support people to employ Personal Assistants.
- Some people need help to make and maintain relationships.
- Support for parents with a learning disability is not always easily available.
- Partnership should influence the development of a work strategy to improve work opportunities.
- Using public transport can be a problem.
- Feeling able to contribute to society and being welcome to do so.
- Consistent approach across all education settings.
- Need to make sure all voices are heard.

³ Learning Disability Today, website, December 2016, <https://www.learningdisabilitytoday.co.uk/people-with-learning-disabilities-have-significantly-lower-life-expectancy-than-the-general-population>

- Person with learning disabilities becoming carers themselves for older parents.

What makes a good life

The Partnership decided that there are 12 focus areas that would help to improve the lives of people with learning disabilities living in York. These 12 areas are included within our **four** priority headings:

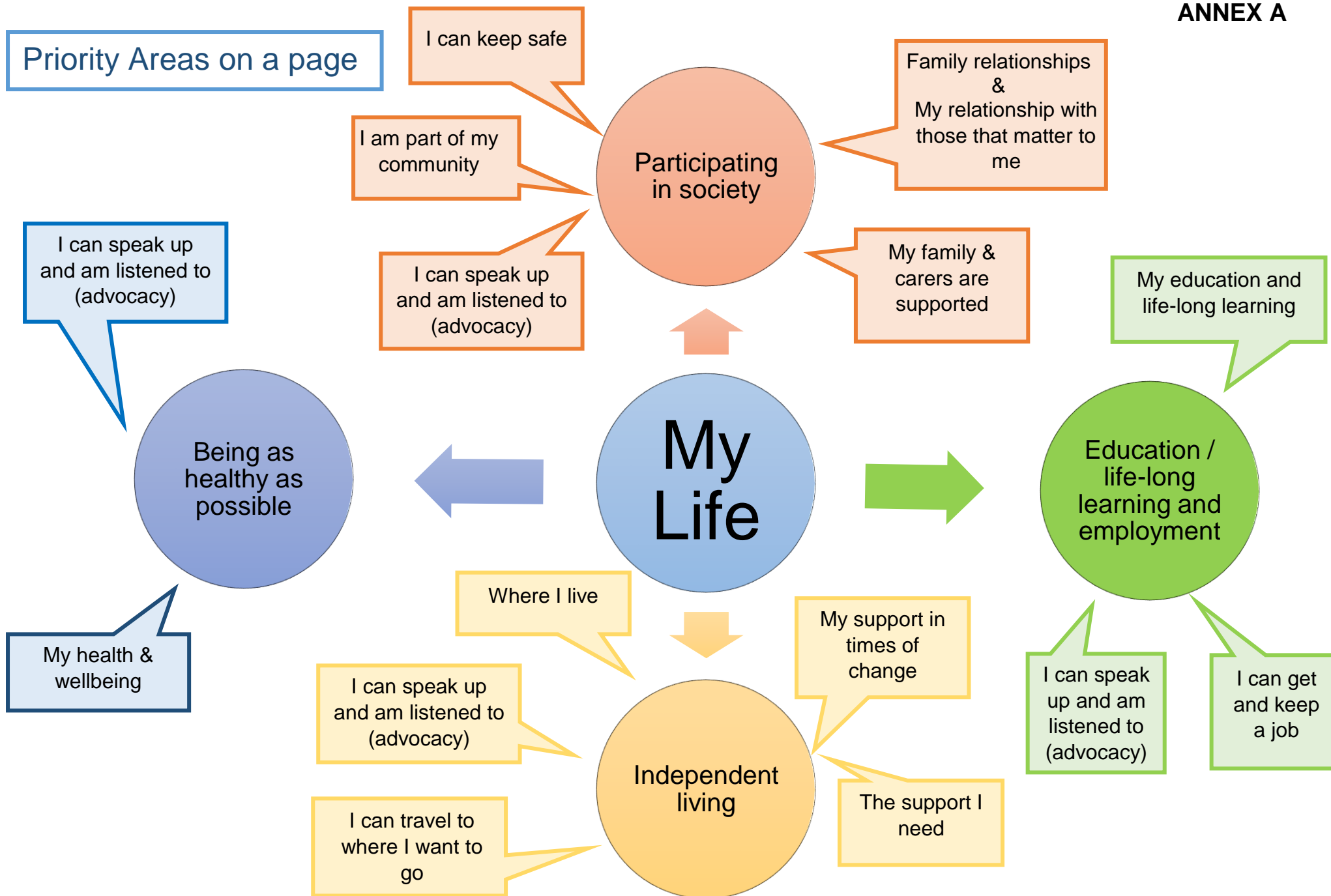
1. Education / life-long learning and employment
2. Independent living – helping people with a learning disability to have choice and control over their lives and the support they receive.
3. Participating in society –having friends and supportive relationships, and participating in, and contributing to, the local community.
4. Being as healthy as possible

Advocacy (I can speak up and am listened to) is a key priority which cuts across all four priority headings.

	Focus Areas	Focus Area definition	Priority Area
1	My education and life-long learning	I have a good, consistent education whilst at school. My learning doesn't stop at the end of school; like everyone else, I need to continue to learn for employment, leisure and for overall quality of life.	Education / life-long learning and employment
2	I can get and keep a job	Work is important not just for the money I earn, but also for the confidence and self worth I get from having a job.	Education / life-long learning and employment
3	Where I live	People need a place to live and I may need support, whether I am living on my own or with parents, my partner or spouse, or with my friends.	Independent living
4	My support in	Important changes happen at	Independent

	Focus Areas	Focus Area definition	Priority Area
	times of change	different stages of my life: information about these changes and the help that is available to help me through these changes is important.	living
5	The support I need	I might sometimes need support, either long term or short term, to help me live well.	Independent living
6	I can travel to where I want to go	Transport is a vital service for people to be able to access health services, learning opportunities, employment, leisure and to make and maintain relationships.	Independent living and Participating in Society
7	I can keep safe	I might need help to keep safe, for example from people trying to take my money, to abuse me physically or sexually, or to steal my identity.	Participating in society
8	I am part of my community	Being part of the community I live in is important so I can make and keep a natural support network.	Participating in society
9	I can speak up and am listened to (advocacy)	My voice and opinions are important and valued. Through speaking up I can gain control over my life, make my own choices and can be as independent as possible. I may need support to get my views and wishes heard through advocates, and people who support me, as well as the wider community.	Participating in society
10	My family and carers are supported	The right information and support is given to me and my family.	Participating in society
11	Family relationships & my relationships	Relationships are important to everyone, whether they are with parents, school friends,	Participating in society

	Focus Areas	Focus Area definition	Priority Area
	with those that matter to me	sexual partners, spouses and children, work colleagues or adult friends. I might need support to make and maintain relationships.	
12	My health & wellbeing	Good health and wellbeing brings many benefits for people with learning disabilities. Healthier people tend to be happier and play a more active role in society, in their local communities, and in their relationships with friends and family. Poor health and wellbeing can affect our everyday quality of life. It is important that there is accessible information about health issues for example: diabetes, men's health, women's health, maternity care, hospital passports, weight issues etc.	Being as healthy as possible



Priority Area One - Education / life-long learning and employment

Our main Priorities:

- ! There are more opportunities for people with profound and multiple learning disabilities to access life-long learning and training.
- ! All Education and Health Care Plans include preparing for adulthood outcome for all children (All plans are already supposed to include it from age 14), with the ambition to extend this to all children.
- ! Support people from college into employment.
- ! Better preparation support to become work ready.

The Learning Disability Partnership will monitor progress on:

- ✓ Map opportunities for people with PMLD in life-long learning and training and monitor increase.
- ✓ Numbers of EHC Plans with preparing for adulthood outcomes
- ✓ Number of supported internships.
- ✓ There will be a clear pathway to employment.

Priority Area Two – Independent living

Helping people with a learning disability to have choice and control over their lives and the support they receive.

Our main Priorities:

- ! Make sure, where possible, that there is enough time for change to happen.
- ! Plans made to support all transitions look at a person's whole life – for example, taking into account education, training, employment, having a family, health and care aspects when planning.
- ! There are plans to address the accommodation needs for people with learning disabilities in the City, making sure there is choice so young people can stay local.
- ! There is accessible information about Direct Payments (DPs) and Personal Assistants (PAs) and ongoing support for the person with a learning disability in their role as employer.

The Learning Disability Partnership will monitor progress on:

- ✓ Plans will demonstrate whole life planning.
- ✓ Plans to address the accommodation needs for people with learning disabilities, including the option of shared home ownership.
- ✓ There is accessible information and advice about employing PAs along with Direct Payments and Personal Budgets.

Priority Area Three – Participating in society

Having friends and supportive relationships, and participating in, and contributing to, the local community

Our main Priorities:

- ! All voices are heard, including; children, young people, adults and older adults, and these views are acted on.
- ! To engage with families with regard to their experiences, through a variety of forums.
- ! People with learning disabilities who are parents, receive good information and support.
- ! Promote safe places scheme, We Care (police) and the reporting of hate crime.

The Learning Disability Partnership will monitor progress on:

- ✓ Work is being undertaken to engage with all groups and findings are being fed back and responded to.
- ✓ Families with their lived experiences are sought and positive use of these findings is demonstrated.
- ✓ Information and support that is available is easily accessible.
- ✓ There are more safe places in the City.

Priority Area Four – Being as healthy as possible

Our main Priorities:

- ! Promote Annual Health Checks and Health Screenings such as cervical and breast cancer screening, information on contraception, having babies etc.
- ! To make sure all of health, including GPs and medical practices, have better training about how to communicate well with people with learning disabilities.
- ! Early and appropriate support is given to parents/carers with a learning disability.
- ! To make sure the mental health and wellbeing of people with learning disabilities is recognised as separate to their learning disability.

The Learning Disability Partnership will monitor progress on:

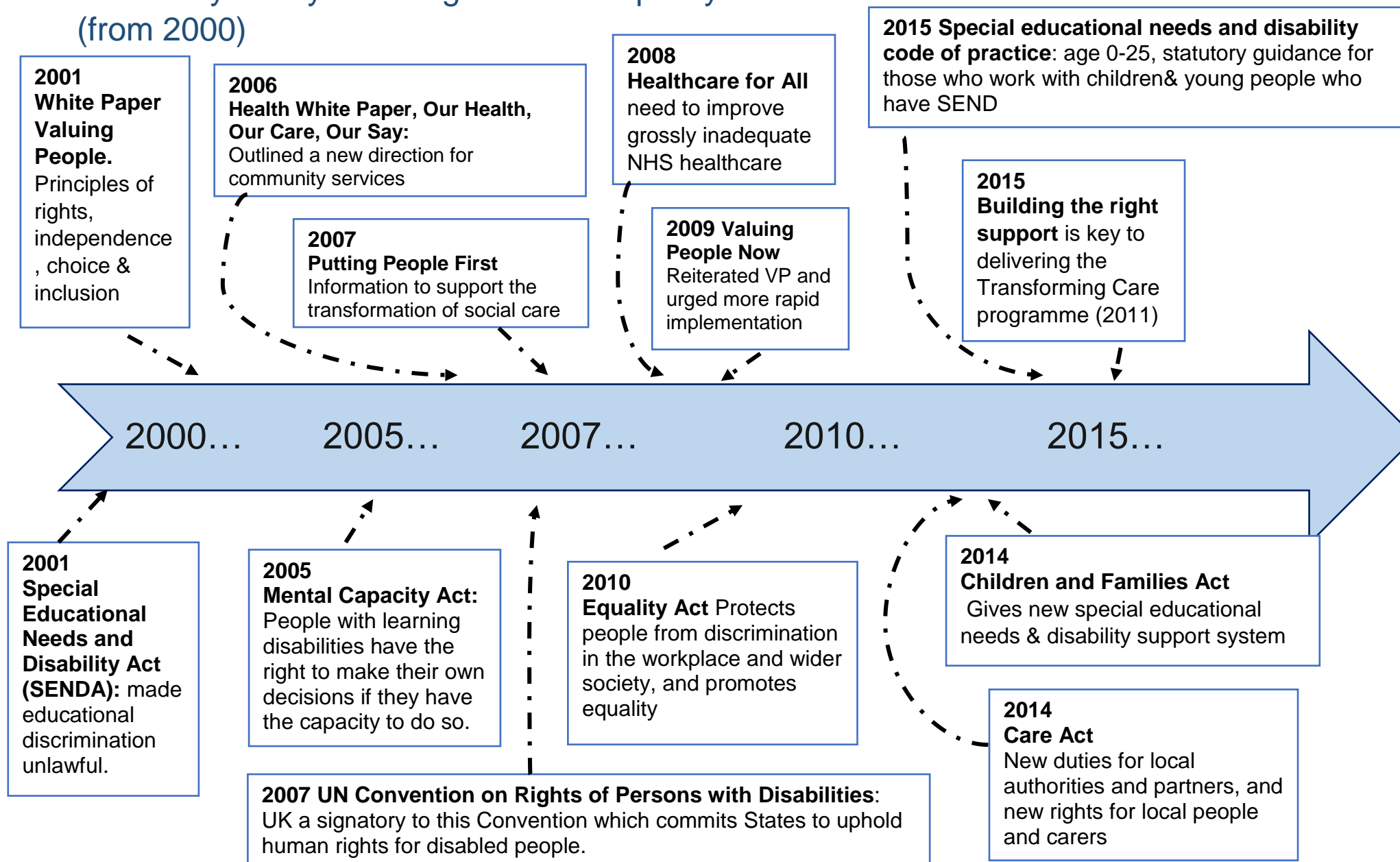
- ✓ The increase in numbers of people with learning disabilities having annual health checks.
- ✓ Health professionals access training in relation to communicating with people with learning disabilities.
- ✓ Collation of evidence of early and appropriate support that is given.
- ✓ People with learning disabilities will access relevant mental health services.

Glossary

Term	Definition
City of York Council (CYC)	The local authority in York which manages social care and other public services.
Clinical Commissioning Group (CCG)	A group of doctors and other health professionals who decide what local health services spend their money on. The CCG for York is the Vale of York Clinical Commissioning Group.
Commissioners	People and organisations that plan services or facilities are sometimes referred to as commissioners. The CCG commissions health services while the CYC commissions social care services
Consultation	Organisations – like the government - sometimes ask for the opinion of other people and organisations when they are deciding what to do, for example, to introduce a new service. This is called a consultation.
Education, Health and Care Plans (EHCPs)	An EHCP details the education, health and social care support that is to be provided to a child or young person who has SEN or a disability. It is drawn up by the Local Authority after an assessment that decides the child or young person's needs cannot be met through the normal delegated resources to education settings
Health & Wellbeing Board (HWBB)	The HWBB brings together a number of agencies to agree priorities and ensure commissioned services meet local needs.
My Support Plans (MSPs)	The My Support Plan is available to use with children and young people who have identified special educational needs and receive SEN Support in school. It can be used for anyone who has a number of professionals supporting them and would benefit from coordinated support.

Term	Definition
Portage	Portage is a service for children with SEND up to three years old and their families. Portage workers visit children in their homes.
Providers	People and organisations that offer services or facilities directly to the people who use them are sometimes referred to as providers. The main provider of health care for people with learning disabilities, apart from primary care (see above) is the Tees, Esk and Wear Valley NHS Trust (TEWV)
Public services	Service provided for the public by the council and other organisations. This includes things like buses, bin collection, adults' and children's social services.
Priorities	The things that you must do first because they are the most important.
Special Educational Needs (SEND)	This refers to children who have learning problems or disabilities that make it harder for them to learn than most children of the same age.
Transition	A word used to describe when something changes in a person's life, as when a child grows up into an adult or an adult marries or changes jobs.

A brief history of key Learning Disabilities policy and law (from 2000)



All Age Learning Disabilities Strategy

Accessible Summary

2019-2024

Introduction



This is the first All Age Learning Disabilities Strategy for York. It was written with the Learning Disability Partnership.



The Learning Disabilities Partnership is a group of partners who include people with learning disabilities, their families/carers, the voluntary sector, and professionals.



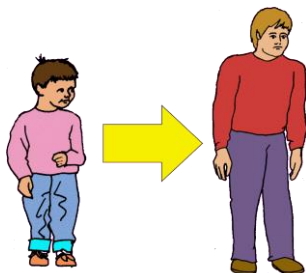
It is for everybody in York with a learning disability as well as those who support them.



The Strategy does **not** try to talk about everything to do with disabilities in York.



In York we want everyone with a learning disability to be as independent and as healthy as possible and to be included in their communities.



As children grow into adults it is important to learn skills which will help them live how they want to.

What we already know



We know that children with more complex needs are living much longer into adult life.



We also know that adults with a learning disability are living much longer.



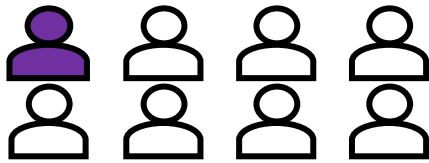
But there is still a gap between how long a person with learning disabilities lives and how long other people live.



In the Strategy there are some facts about people with learning disabilities living in York.



These include:



1 in 8

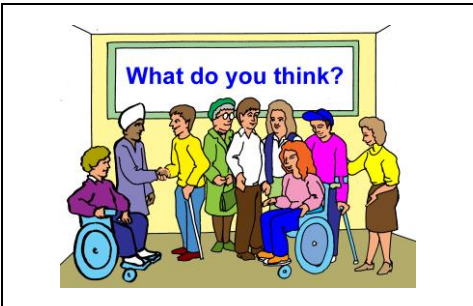
adults who have a learning disability living in York is known to Adult Social Care



8.3%

of adults known to Adult Social Care in York, are in **employment**

Our Strategy



Lots of different people and groups were asked about what things were important to them and what makes a good life.



The Learning Disabilities Partnership talked about all the information from everyone.



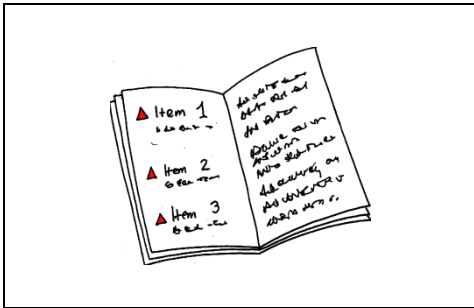
They decided there are 12 important areas but there needed to be priority areas.



Advocacy means that someone with a learning disability's voice and opinions are important and valued.

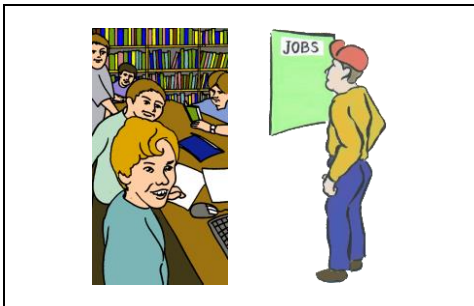


Advocacy is so important that it is in **every priority area** in the Strategy.

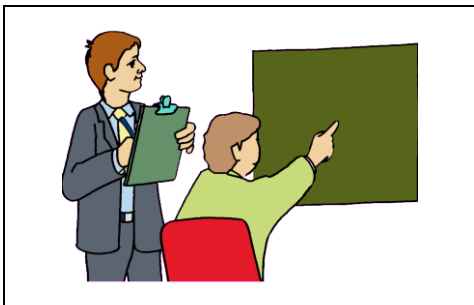


Four main priorities were agreed and the 12 focus areas are all included in the **priority headings**.


The four main priorities





1 Education / life-long learning and employment





2 Independent living – helping people with a learning disability to have choice and control over their lives and the support they get.

	<p>3. Participating in society – having friends and supportive relationships, and participating in, and contributing to the local community.</p>
---	--

	<p>4. Being as healthy as possible.</p>
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	<p>In the Strategy there are four main points in each area.</p>
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	<p>These are the things that are going to be worked on first.</p>
---	---

	<p>There will be an action plan for each priority area.</p>
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Acknowledgements



We thank **Inspired Pics** who provided the images for this publication.

You should seek permission from the image owner if you wish to use any of these images.



Health and Wellbeing Board**13 March 2019**

Report of the Chair of the Ageing Well Partnership

Report from the Ageing Well Partnership**Summary**

1. This report asks the Health and Wellbeing Board (HWBB) to endorse the recommendation of the Ageing Well Partnership to apply to become a member of the UK Network of Age Friendly Communities.

Background

2. The [joint health and wellbeing strategy for 2017-22](#) identifies four principal themes to be addressed. One of these themes is ageing well, with the key priority for that theme being: to reduce loneliness and social isolation for older people.
3. Other aims in the joint health and wellbeing strategy in relation to ageing well are:
 - continue work on delayed discharges from hospital
 - celebrate the role that older people play and use their talents
 - enable people to recover faster
 - support the vital contribution of York's carers
 - increase the use of social prescribing
 - enable people to die well in their place of choice

Context

4. The ageing well part of the joint health and wellbeing strategy covers the so-called 'third age' roughly from 66 onwards, including the end of life. We know that between 2020 and 2035 the number

of people over 65 years of age in York will rise from 39,700 to 52,100 and those aged over 75 from 19,100 to 27,600.

5. When developing the board's joint health and wellbeing strategy 2017-2022, people said they particularly wanted the board to tackle isolation and loneliness and to ensure that in York, no one ever dies alone; hence the board's top priority in the ageing well theme of the strategy is to reduce loneliness and social isolation in older people.
6. Additionally the findings from the [2017 Older People's Survey](#) identified that although the experiences of older people living in York contain much that is positive – they generally feel safe, they are fairly sociable and are in good health – they tell us that there is a lot more that could be improved in the city: things such as providing seating in the city centre; making public transport more accessible and making information and advice more easily available. The survey findings, therefore, led to a number of recommendations for partner agencies. The Ageing Well Partnership will look at how best to take these forward.

Next steps

7. At their most recent meeting in February the Ageing Well Partnership considered a number of items in relation to reducing social isolation and loneliness, these set out some of the positive work that is already happening in the city. Additionally the partnership considered how they might progress the top priority further along with progressing some of the other priorities in the joint health and wellbeing strategy and the older people's survey.
8. They agreed that using a robust nationally recognized framework could be an appropriate way forward and considered that working toward becoming an Age Friendly Community/City could help the city move forward on many of the Health and Wellbeing Board's aspirations for older people. In an Age Friendly Community services, local groups, businesses and residents all work together to identify and make the changes in both the physical environment (e.g. transport, housing, outdoor spaces) and social environment (e.g. volunteering, leisure, employment and services) that are relevant to their own local context and enable people to lead healthy and active later lives. More details are attached at **Annex A**.

9. The partnership also considered the eight domains of Age Friendly Cities/Communities (**Annex A refers**):
 - i. Outdoor spaces and buildings
 - ii. Transportation
 - iii. Housing
 - iv. Social participation
 - v. Respect and social inclusion
 - vi. Civic participation and employment
 - vii. Communication and information
 - viii. Community and health services
10. Additionally the partnership considered the benefits of becoming a member of the UK Network of Age Friendly Communities, currently including 30 cities. The UK network is affiliated to the WHO global network, which has over 700 members worldwide. The Centre for Ageing Better works with the network to share learning about what kinds of approaches work, both in the UK and internationally. They share examples and provide guidance, connect places together and offer support to member communicates in their efforts to become more age friendly.
11. After careful consideration the partnership agreed that an application to become a member of the UK Network of Age Friendly Communities could be progressed. The [Centre for Ageing Better](#) would then help develop York's wider application to become a member of the WHO Global Network of Age Friendly Cities and Communities.

Consultation

12. Consultation with a wide audience took place when developing both the joint health and wellbeing strategy and the older people's survey.
13. Additionally the concept of becoming an Age Friendly City/Community was discussed at the Ageing Well focused Health and Wellbeing Board workshop in November 2018 and also at the

CVS Ageing Well Forum in February 2019, where it was fully supported.

Options

14. The Health and Wellbeing Board are asked to endorse the recommendation of the Ageing Well Partnership to apply to become a member of the UK Network of Age Friendly Communities.

Analysis

15. The approach to making York an Age Friendly City should be an active citizenship approach, applying to the entire population to complement York's 'asset based place' programmes of work. The framework to deliver this is through the eight domains as detailed in paragraph 9.
16. Membership of the UK Network of Age Friendly Cities and Communities is not solely about helping us to identify ways of reducing loneliness and social isolation; but it will provide a robust framework to help us deliver against *all* the priorities in the joint health and wellbeing strategy 2017-2022 and the recommendations in the older people's survey.
17. Joining the network will raise the profile of the older people's agenda complementing the findings of the older people's survey and the aspirations in the joint health and wellbeing strategy 2017-2022. It will recognize our desire to be a great place for people to grow old in.

Implications

18. **Financial:** Membership is free and there are no definitive costs associated with implementing local action plans to become age friendly.

Risks

19. Currently, whilst there is much work happening on the ageing well agenda, there is no strategic framework to support this and ensure that work programmes are joined up. The framework provided through the network will enable this to happen reflecting the domains of age friendly communities

Recommendations

20. The Health and Wellbeing Board are asked to endorse the recommendation of the Ageing Well Partnership to apply to become a member of the UK Network of Age Friendly Communities.

Reason: To progress delivery of the ageing well theme in the joint health and wellbeing strategy 2017-2022 and the recommendations in the older people's survey.

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City of York

**Report
Approved**



Date 25.02.2019

Specialist Implications Officer(s)

None

Wards Affected:

All

For further information please contact the author of the report

Annexes

Annex A – Becoming an Age Friendly Community

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Becoming an Age-friendly Community

What is an Age-friendly community?

Age-friendly communities is a concept developed by the World Health Organisation (WHO) in 2006. In an [Age-friendly Community](#), services, local groups, businesses and residents all work together to identify and make the changes in both the physical environment (e.g. transport, housing, outdoors spaces) and social environment (e.g. volunteering, leisure, employment, and services) that are relevant to their own local context and enable people to lead healthy and active later lives.

What is the Network of Age-friendly Communities?

The [WHO Global Network of Age-friendly Cities and Communities \(GNAFCC\)](#) has over 700 members worldwide. Established in 2012, the [UK Network of Age-friendly Communities](#) is affiliated to the WHO Global Network and has members across England, Scotland, Wales and Northern Ireland. Founding members include the cities of Manchester, Newcastle, Nottingham, Leeds, Belfast and Glasgow.

The Centre for Ageing Better works with the network to share learning about what kinds of approaches work, both in the UK and internationally. We share examples and provide guidance, connect places together and offer support to member communities in their efforts to become more age-friendly.

How does my community become Age-friendly?

To become officially recognised as Age-friendly, with the [WHO Global Network of Age-friendly Cities and Communities \(GNAFCC\)](#), the leadership in your town, city or county must make a written commitment to actively work towards becoming a great place to grow old in, for **all** of its residents. This is done with the support and engagement of older people and relevant stakeholders.

How much does being age-friendly cost?

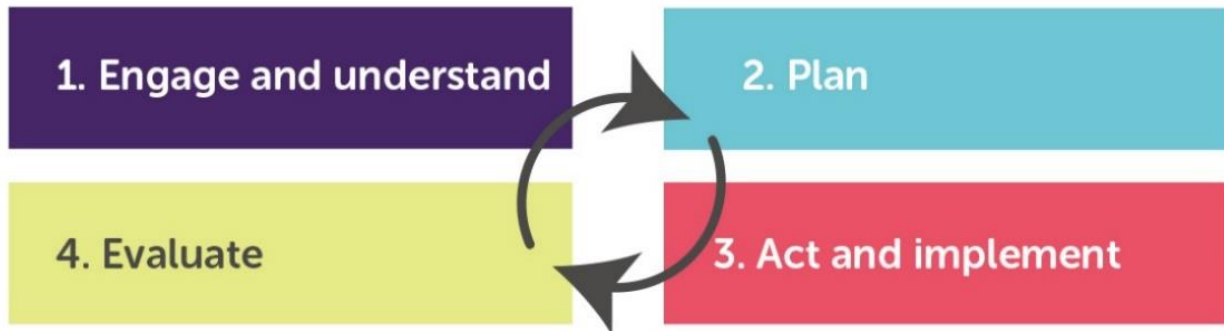
Membership is free.

There is no definitive set of costs associated with implementing your action plan to become age friendly and the scale and pace of improvements are determined by what is needed in your place. Experience has shown that resource is most required to coordinate the collaboration, as partnership working and involvement of older people, underpins the approach. Often no new money is needed for projects; age-friendly can be about using existing resources better.

How long does it take?

Becoming age-friendly is an ongoing process, with most places starting with an initial 5-year commitment, incorporating up to 2 years to deliver a baseline assessment and action plan. From there, progress is assessed, and the work continues.

Once signed up, communities carry out the following programme cycle:



Step 1: Engage and understand	The first step on the age-friendly journey is to engage with older people and stakeholders, creating a baseline assessment of the age-friendliness of your place. The eight domains of age-friendly provide a framework for understanding needs and preferences as well as barriers, local priorities, and opportunities for healthy, active ageing.
Step 2: Plan	This stage is where all stakeholders develop a shared vision, to determine the priorities for action and to plan and resource how your community will achieve its age-friendly outcomes.
Step 3: Act and Implement	Implementing an age-friendly action plan is at the heart of creating an age-friendly community. Even small steps can go a long way.
Step 4: Evaluate	Monitoring and evaluating progress of your age-friendly journey will help to identify successes and challenges and serve as the basis for defining priorities for future improvements.

What impact will being age-friendly have?

Age-friendly is built on the evidence of what supports healthy and active ageing in a place, allowing more people to live independent lives and contribute to their communities for longer. In addition, by committing to becoming age-friendly:

- Older residents are engaged in shaping the place that they live
- The potential for greater equity within the current older population is better understood
- Multi-agency and multi-level collaboration is strengthened, connecting the social and built environment across departments and reducing siloed working

What are the eight domains of age-friendly communities?

The eight domains of age-friendly are all the aspects of community life that need to be considered when making your plans.



Outdoor spaces and buildings	The outside environment and public buildings have a major impact on the mobility, independence and quality of life of people in later life.
Transportation	Transportation, including accessible and affordable public transport, is a key issue for people in later life.
Housing	Housing and support that allows people in later life to age comfortably and safely within the community to which they belong are universally valued.
Social participation	Social participation is strongly connected to good health and wellbeing throughout life. Enabling accessibility, particularly for those with mobility issues, is also key.
Respect and social inclusion	Older people from all backgrounds are valued and respected.
Civic participation and employment	An age-friendly community provides options for people in later life to continue to contribute to their communities.
Communication and information	Staying connected with events and people and getting timely, practical information to manage life and meet personal needs is vital for active ageing.
Community support and health services	Community support is strongly connected to good health and wellbeing throughout life, alongside accessible and affordable health care services.

What are the benefits of joining the UK Network?

- **Being part of a growing movement** of communities, giving you access to contacts, ideas and expertise from the UK and across the globe
- The opportunity to **share your own learning** about what works to create the conditions for ageing better with a UK and international audience
- Access to support to build the **evidence of your impact and build the case for an age-friendly approach**
- **Practical support** to become more age-friendly, including examples of **good practice** on how to develop your age-friendly initiative
- Peer-to-peer insight to tackle emerging challenges across both the ‘how to’ and the ‘what’ of age-friendly, e.g. involving older residents, implementing age-friendly transport, or monitoring progress / measuring change
- **Guidance and support** to help you become a member of the WHO’s Global Network
- **Member-only** events, webinars and training, including access to travel bursaries for place-to-place learning exchanges with other age-friendly communities.

How can my community join the UK Network?

To join the UK Network, you need to be ready and able to demonstrate your commitment to and understanding of age-friendly. You will have some commitment from one or more stakeholders/sectors, and either have or be looking to gain, political commitment and broader stakeholder involvement.

How can I find out more?

To find out more about becoming an age-friendly community, either:

Go to: <https://www.ageing-better.org.uk/afc>

Email: AFC.Network@ageing-better.org.uk

Phone: 020 3829 0113



Health and Wellbeing Board

13 March 2019

Report of the Chair of the Health and Wellbeing Board Steering Group

Update on the work of the Health and Wellbeing Board Steering Group**Summary**

1. This report provides the board with an update on the work that has been undertaken by the Health and Wellbeing Board (HWBB) Steering Group. The board are asked to note the update and:
 - confirm the Steering Group's proposal and timetable to lightly refresh the joint health and wellbeing strategy;
 - and
 - ratify the decision that the recommendations in the JSNA needs assessment about people who fund their own adult social care in York be progressed through the Ageing Well Partnership.

Background

2. The HWBB Steering Group has met twice since it last reported to the Health and Wellbeing Board. There is a commitment from the group to meet at least once every two months.
3. The paragraphs below provide an update on some of the recent work of the HWBB Steering Group.

Main/Key Issues to be Considered**Care Quality Commission – Local System Review Progress Report**

4. In response to the recent local system review, in particular around ownership of the joint health and wellbeing strategy and an agreed shared vision, the Steering Group discussed what action they felt

the Health and Wellbeing Board should take. They agreed that the joint health and wellbeing strategy, including the vision, should be lightly refreshed with the aim of presenting the refreshed strategy to the HWBB at their June 2019 meeting.

HWBB Work Programme and Workshops

5. As part of their remit HWBB Steering Group manage the business on the HWBB's work programme. This ensures the board receives and considers the most appropriate material at its meetings. The Steering Group has very recently started to think about the work programme for 2019/2020. The pattern of themed quarterly meetings will continue with workshops taking place in most of the months when the HWBB do not meet formally. A draft of the work programme and a timetable of workshops will be shared with Health and Wellbeing Board members at the June 2019 meeting.

Developing a Carer's Strategy for York

6. The Steering Group have received and discussed a briefing paper on the development of a new carer's strategy for York. Engagement on content for the strategy is coming to a close and the next step is for the strategy to be drafted. The HWBB Steering Group discussed how the strategy would fit with the priorities in the joint health and wellbeing strategy. They also discussed the possibility of the strategy being owned by the Health and Wellbeing Board and the board receiving an annual update on strategy delivery.

Joint Strategic Needs Assessment (JSNA)

7. Health and Wellbeing Board Steering Group receive regular updates from the JSNA Working Group. The paragraphs below are a summary of some of the key pieces of work the group has undertaken over the past 6 to 7 months.
8. Mental Health Inequalities Report: This report looks at which specific population groups are more likely to experience mental ill health and considers if the service access is equitable across these population groups. The report has been presented for discussion at the Mental Health Partnership and the final version is due to be considered by the HWBB Steering Group at their March meeting. the final report will be presented to the Health and Wellbeing Board at their meeting in June 2019.

9. People Who Fund Their Adult Social Care in York: This report (**attached at Annex A**) has recently been completed by the JSNA Working Group and approved by the Health and Wellbeing Board Steering Group. The report uses what is known locally and nationally about people who self fund their care in order to provide a best estimate of the number of people who fund their care in York; their experiences of navigating the care system, the over or under use of care and the perspectives of those who advise them.
10. The report contains four recommendations under the following headings:
 - Move to a community asset approach of prevention and living well in older age
 - Develop a system wide vision for ageing well in York
 - Make it easier for people to access good quality information and advice
 - Explore opportunities to further understand people who self-fund care in York
11. At the February meeting of the Steering Group it was agreed that the natural place for the recommendations in this report to be progressed would be at the newly formed Ageing Well Partnership. Health and Wellbeing Board are asked to ratify this decision.
12. Falls Prevention: the JSNA Working Group are working on a report in relation to falls prevention in older adults which looks at falls risk across York, summarises best practice guidance and highlights existing evaluative work produced by falls prevention services.
13. Ageing Well Inequalities Report: this report focuses heavily on loneliness and social isolation, both looking at population level risk and the experiences of older people who live in York. A draft of this report will be considered by the HWBB Steering Group in the next few months.
14. Other Activity: The JSNA Working Group have redesigned the prioritisation and scoping tools to support better project initiation. The prioritisation tool is used to quantify the scale and impact of a topic on health and wellbeing, and identify strategic or legal reasons for considering the project. It considers the following factors:

- proportion of residents directly affected
 - impact on wellbeing
 - scale of inequality
 - impact on wider population
 - how is the topic evolving
 - how York benchmarks
 - views of professionals
 - economic impact
 - legal mandate
 - strategic mandate
15. Reviewing this matrix has meant the JSNA Working Group are better able to emphasise the type and scale of health inequalities, and also to give due weight to where the scale or impact of a topic is not readily understood and use this as part of the rationale for advocating to proceed with a project.

Pharmacy Applications and Notifications for Changes to Community Pharmacy Provision

16. On 6th November 2018 officers acting on behalf of the HWBB received notice of an application for a new pharmacy '*offering to meet an identified current need at Kimberlow Hill*'. Primary Care Support England's (PCSE) market entry team also issued this notice to a number of interested parties. The notice gave all named parties 45 days to respond to the application.
17. Officers from the public health team drafted a response on behalf of the board. Approval on this draft was gained from the HWBB Steering Group and the Chair and Vice-Chair of the HWBB, and was submitted on 26 November 2018.
18. The HWBB has not yet been notified of PCSE's decision in connection to this application to open a new pharmacy.
19. Additionally on 7th January 2019 an officer acting on behalf of HWBB received notification from PCSE regarding change of ownership of the pharmacy at 18 Bishopthorpe Road. On this occasion, NHS England considered that the new owner had fitness to practice, and that services and opening hours will remain unchanged with no interruption in services. Because of this assurance, NHS England granted the application for change of ownership without consultation.

Consultation

20. Consultation and engagement around specific projects and topics is ongoing. The current HWBB Steering Group is a multi-agency group with the ability to co-produce, engage and consult on specific areas of work.
21. in more recent months representatives of the JSNA Working Group have been to several CVS forums, health management meetings, the primary care home steering group specifically to promote the opportunities of joint working with the JSNA. The group is also currently developing a formalised communications template to use on all needs assessment projects. Additionally a representative of the York JSNA presented the York approach at a regional public health network to highlight good practice.

Options

22. The Board are asked to note the contents of this report and:
 - confirm the Steering Group's proposal and timetable to lightly refresh the joint health and wellbeing strategy;
 - and
 - ratify the decision that the recommendations in the JSNA needs assessment about people who fund their own adult social care in York be progressed through the Ageing Well Partnership.

Strategic/Operational Plans

23. The Health and Wellbeing Board have a statutory duty to produce a Joint Strategic Needs Assessment; a Joint Health and Wellbeing Strategy and a Pharmaceutical Needs Assessment.

Implications

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

Risk Management

25. The production of a JSNA, a Joint Health and Wellbeing Strategy and a PNA are statutory responsibilities for the HWBB. Delivering against these is resource intensive and needs to be managed to ensure they are fit for purpose and subsequently delivered.

Recommendations

26. The Board are asked to note the contents of this report and:

- confirm the Steering Group's proposal and timetable to lightly refresh the joint health and wellbeing strategy;

and

- ratify the decision that the recommendations in the JSNA needs assessment about people who self fund their own care in York be progressed through the Ageing Well Partnership.

Reason: To update the Board in relation to the work of the HWBB Steering Group.

Contact Details

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City of York Council/NHS
Vale of York Clinical
Commissioning Group

Chief Officer Responsible for the report:

Sharon Stoltz
Director of Public Health
City of York

**Report
Approved**



Date 27.02.2019

Tel: 01904 551714

Specialist Implications Officer(s) None

Wards Affected:

All

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A – Needs Assessment: People Who Fund Their Adult Social Care in York

People who fund their adult social care in York

DRAFT

A report by the York JSNA, 2019

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1. Introduction

Most people in York can expect to live the majority of their lives in good health. However, many of us will need support with day to day activities towards the end of life.

The industry surrounding the professional paid-for care of older people in the UK is estimated to be worth £22.2 billion¹ (2013 values). Some of this care is paid for by local authorities, or through the NHS through the continuing care fund for people with complex long term conditions. The remainder is funded by individuals themselves.

This report uses what is known locally and nationally about people who self fund their care in order to provide a best estimate of the number of people who fund their care in York; their experiences of navigating the care system, the over or under use of care and the perspectives of those who advise them.

DRAFT

¹ Laing and Buisson, (2013). *Care of Elderly People Market Survey 2012/13*.

2. Planning for older age

Most people in York can expect to live much of their lives in good health and to maintain independence into older age. However, it is also true that many of us will need some support with daily activities in the final years of life. This can include getting washed, dressed, using the toilet, preparing meals and eating.

In 2018, 208,000 people live in York, 18.5% are aged 65 or older.

65+ years	38,600 people
75+ years	18,000 people
85+ years	5,500 people
90+ years	2,000 people

A publication in the Lancet (2017)² compared life after the age of 65 for people between from 1991 onwards and made projections for future decades. The chart below shows the life course of an average man and women after the age of 65.

Average life trajectory for people after the age of 65 (in years)		
	Men	Women
Life expectancy after 65	17	21
Full independence	11	10
Low care needs (i.e. help with housework or cutting toenails)	4	8
Medium care needs (i.e. help preparing meals, and needing help every day)	1.1	1.1
High care needs (i.e. help dressing or using the toilet, or eating)	1.1	1.9

The Lancet publication projects that over the coming decades life expectancy after 65 will continue to increase, and so will the number of years spent with medium and high care needs.

² Kingston A et al, (2017) Is late-life dependency increasing or not? A comparison of the cognitive function and ageing studies. Lancet, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31575-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31575-1/fulltext)

A similar pattern is found in ONS projections of life expectancy and overall health of people who are currently 65 years old.

	Men	Women
Life expectancy ^{3,4}	84.2	86.4
Healthy life expectancy ⁵	77.3	77
Disability free life years ⁶	75.8	76.3

Among people who are currently aged 65 in York; men will live 7-8 years in ill health, and women will live 9-10 years in ill health. People who live in the least deprived parts of the country have, on average, longer lives and live slightly fewer months in poor health, but most people will still have some care needs in the final years of life. For future generations, it is projected that the number of years spent in living in ill health will increase.

Increasing the number of years people live in good health is an important part of the prevention agenda both for York and the whole country. In 2018 Public Health England and the Centre of Better Ageing have signed a joint agreement to promote evidence based approaches to healthy ageing over the next five years.

Beyond thinking about care, people in England typically do not plan well for declining health and the end of life. Only 60% of adults aged 55+ have written a will which would give them control about what happens to their home and savings after death⁷. The number of people who establish a lasting power of attorney is still small but is thought to be growing, this enables people to nominate a trusted family member or friend to make decisions about their healthcare or finances on their behalf if they became unwell and unable to do this themselves.

³<https://fingertips.phe.org.uk/search/life%20expectancy#page/4/gid/1/pat/6/par/E12000003/ati/102/are/E06000014/iid/91102/age/94/sex/1>

⁴<https://fingertips.phe.org.uk/search/life%20expectancy#page/4/gid/1/pat/6/par/E12000003/ati/102/are/E06000014/iid/91102/age/94/sex/2>

⁵<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/healthylifeexpectancyhleandlifeexpectancyleadage65byregionengland>

⁶<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/disabilityfreelifeexpectancydflandlifeexpectancyleadage65byregionengland>

⁷ Financial advice website www.unbiased.co.uk

3. Self-funding care in older age

3a. Who is eligible for funded care?

Adult social care funding is means tested. People are required to meet the costs of their own care if they have savings in excess of £23,250. The value of a person's home is not included in this assessment unless the person moves from their home into a residential care setting.

The UK Home Care Association (2016)⁸ report that access to local authority funded domiciliary care is being restricted to those with the greatest levels of care and support needs. Similarly, Age UK⁹ estimate there has been a 25% reduction in people who are eligible for state funded care since 2010. This is correlated with an increase in people receiving care from family, friends and neighbours.

As a result of these changes to eligibility for local authority funded care a growing proportion of people will pay for their own care. These people are commonly referred to as 'self-funders'. The Kings Fund in 2016¹⁰ identify that changes to the nationally defined programs of care have meant that people who would have previously been eligible for state funded care are now longer so. They argue that 'more older people are falling outside the social care system, either because their financial means are too high for publicly funded help or their care needs are not high enough, yet knowledge about what happens to them is limited'.

3b. Transitioning from self-funding care to local authority funded care

If a person's savings fall to below the funding threshold, and they have defined care needs, they typically become eligible for local authority funded care.

This information is not routinely reported on in York, but a specific review of 2017/18 and 2018/19 case note indicates that fewer than 1 in 10 of York's self-funding cohort deplete their savings to a level that they become eligible for local authority funded care. This appears to be lower than the national rate, but reliable information is scarce.

⁸ UKHCA, An Overview of the Domiciliary Care Market in the United Kingdom (2016)

⁹https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care--support/RB_mar18_social_care_campaignreport.pdf

¹⁰ Kings Fund (2016) <https://www.kingsfund.org.uk/publications/social-care-older-people>

Local authority funding rates

The Care Act requires that local authorities ensure that the fee level they pay for care is reasonable and allows care providers to operate sustainably whilst also ensuring value for public money.

For 2018/19 City of York Council set the weekly care home rates at:

£505.36 for residential care

£543.72 for residential care for people with dementia

The care market in York is thought to be more competitive than other parts of England. In order to secure residential placements for residents with high care needs, City of York Council will sometimes need to meet the cost of fees which are in excess of the calculated standard rate.

In the year 17/18, City of York Council reported that the average residential care placement funded by the local authority was nearer £700, this means that York ranks high against both the regional and national figures. This figure is for all City of York Council funded care placements in that year, not just those for people who were previously self-funded.

A publication by LSE¹¹ found that the median amount of time people live in care homes is 15 months, however this varies significantly as 27% of people were still living in their care home three years later. Length of stay in nursing care was shorter.

For some people, the transition to local authority funded care can be complicated. The national money advice service¹² says: "Some care providers will let you stay while you apply for funding, and they might accept a lower rate from your local authority so you wouldn't have to move out. These days, the amount local authority's pay is usually a lot less than care homes normally charge. If you do qualify for local authority funding, you're not allowed to top up your care home fees yourself from your capital. If you can't make up the shortfall in some way, such as getting friends or family to top up your contribution, or there might be a charity or benevolent fund that can help you out. Failing this, you might have to move to a cheaper or shared room, or into another care home which accepts the local authority funding as full payment."

The national money advice service also highlights that for home owners who are receiving care in their own homes there are a range of other options such as equity release schemes

¹¹ Forder, J. & Fernández, J. (2011) *Length of stay in care homes*. PSSRU, London School of Economics and Political Science <http://eprints.lse.ac.uk/33895/>

¹² Money Advice Service <https://www.moneyadvice.org.uk/en/articles/paying-your-own-care-costs-but-the-moneys-run-out>

or agreements with the local authority to defer the payments for care. The best option will depend on the type of care the person needs, how much the home is worth, and whether any one else is living in the home.

3c. The cost of care for self-funders

The cost of care varies dependant on who is paying. Laing Buisson¹³ identified that 96% of self-funders paid more than local authorities did for the same type of room in the same home. Nationally, Age UK¹⁴ report “It is well established that these so-called ‘self-funders’ pay more than a local authority would if it was funding an identical care home placement ... The reason, of course, is that in many areas councils can use their buying power as block purchasers to drive down the prices they pay. The IPC (2015)¹⁵ comments that most care providers would find it very challenging to have a viable business model through the local authority tariffs alone; and therefore need to attract self-funders to be a viable business.

In York, a greater proportion of the care market is comprised of self-funders than is the case in other areas of England. Some care providers in York work exclusively with people who are self-funding their care and do not have any local authority funded places. This creates a different market to other parts of England where the local authority is a much more dominant provider, and can have a greater degree of purchasing power.

3d. Home care costs

The costs of care for self-funders can also vary. UK Home Care Association (2018)¹⁶ identify that the minimum cost of domiciliary care would in 2018 is £18.01 an hour. This is the minimum required for staff to be paid the living wage and for the business to operate sustainably. The UKHCA report references a statement from the Low Pay Commission which found that domiciliary care is not always charged at this rate.

To illustrate, if a person organised two hours of care a day this would amount to £13,200 annually. As a result, for many self-funders, arranging for care in their own homes represents a more cost effective option than moving to a residential setting.

¹³ Laing and Buisson (2015); “Care of Older People Market report 2015.” Referenced in http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2017.pdf?dtrk=true#page=29

¹⁴ Age UK (2016) Behind the headlines: ‘stuck in the middle’ self-funders in care homes. <http://www.ageuk.org.uk/latest-news/older-people-who-pay-way-their-own-way-in-care-homes-struggling-to-get-a-fair-deal/>

¹⁵ IPC 2015 Understanding the self-funding market in social care: a toolkit for commissioners second edition https://ipc.brookes.ac.uk/publications/publication_824.html

¹⁶ UKHCA (2018) A Minimum Price for Homecare v5.1

4. Estimating the number of self-funders in York

It is difficult to identify the true numbers of people who fund their own care in York. Care providers are not required to report this information, and there is a commercial sensitivity which dissuades many from doing so. Another option is to ask individuals themselves, however, it is widely understood that many people organise care directly with a care provider, and therefore there is no opportunity to ask this group. City of York Council does collect information about funding status for those who approach the council for advice, but these questions are voluntary and the data collected provides an incomplete picture. Therefore, the best information comes from local estimates produced by the City of York Council adult social care team who have an in-depth understanding of the local context, and a broad range of information sources.

Nationally, the IPC¹⁷ estimate that between 40% and 50% of older adults receiving care are self-funders. Prof. John Bolton¹⁸ identifies that the wealth of the local population has a significant influence on the proportion of the care market that is targeted at self-funders. York is among the most affluent local authorities in England, and therefore is likely to have a large self-funder market.

4a. Residential care

In York there are 27 residential care homes which provide support to older people, 14 of which are registered to provide nursing care to some residents. It is estimated this is a 1,218 residential bed capacity; this figure is taken from CQC inspection reports and information held by CYC adult social care.

The ASC commissioning team estimate that approximately **800 residential care** places are self-funded. This would equate to **65%** of the total residential care capacity in York.

CYC adult social care identify that residential care providers in York are averaging a 98% filled capacity. This indicates a high level of demand for services, and therefore a less competition in the system. This means that there is less incentive for care homes to accept the lower local authority care fees than there might be in other parts of the country with less demand for care home services.

Local intelligence suggests that some of the self-funders in York have moved into the city from the surrounding area.

¹⁷ IPC (2015) Understanding the self-funding market in social care: a toolkit for commissioners.

https://ipc.brookes.ac.uk/publications/publication_824.html

¹⁸https://webcache.googleusercontent.com/search?q=cache:fj0iJmp2NZEJ:https://ipc.brookes.ac.uk/publications/Predicting_and_managing_demand.html+&cd=2&hl=en&ct=clnk&gl=uk

4b. Home care

Despite the growth in the care home market, many older people live in their own homes. Among people aged over 85 years old, 80% are thought to live in their own home. Of the remainder, 15% live in residential or nursing care, and 5% live in specialist retirement communities. Among people who fund their own care, home ownership rates are very high.

Nationally, the UK Home Care Association¹⁹ report that of the 874,000 people in the UK receiving care at home, 228,000 people were funding their own care (26%) This finding is echoed in a research estimate²⁰, which indicated 25% of the home care market was made up of people who self-fund their care. This would not include where people arrange care through family, friends, neighbours or other informal support structures.

There are 30 home care providers in York that support older adults, plus a smaller number who are registered in North Yorkshire but who deliver care services to people who live in the York area.

There is no centralised data set of people who receive domiciliary care. The CYC adult social care commissioning team estimate that there is a little over 1,000 people in York receiving domiciliary care from a registered organisations. Of these between 300 and 400 are thought to be people who self-funded their care.

4c. Home adaptations

Making changes to the home can be an effective way for people to continue to live independently for longer. When asked as part of the York older people's survey²¹ 51% of respondents said they had fitted adaptations or aids. People who were widowed were more likely to say yes, than people who were married, as were people over the age of 90 in comparison to younger retired adults. It is not clear how many of these people have other forms of support at home, and what proportion fund their own care.

4d. Reablement Services

The reablement service offers short term intensive support over a maximum of six weeks. It is designed to help people find new ways of doing things in order to stay more independent for longer. It is particularly helpful after a stay in hospital or a period of ill health. In York, a smaller proportion of older people are offered reablement after leaving hospital than other parts of the country.

¹⁹ UKHCA Summary (2016) v.35 An Overview of the Domiciliary Care Market in the United Kingdom

²⁰ <https://www.york.ac.uk/inst/spru/pubs/pdf/sscrSelfFundSR11.pdf>

²¹ York Older People's Survey (2017) <http://www.healthyyork.org/media/62045/older-peoples-survey-2017-publication-ready.docx>

5. What do we know about self-funders in York?

Experian Mosaic combines information household characteristics to produce modelled estimates of household types. This tool has been used to estimate household demographics for self funders in York.

- Half of self-funders were aged 85-94
- The ward with the most self funders was Haxby and Wiggington, this is an affluent ward with an older population.
- 1 in 3 households were receiving 'community support' and one in 6 had received 'OT equipment and adaptations'
- Self funders most closely align with the experian profile of 'Senior Security'; suburban home ownership, at least one employment related pension, an overall moderate income, late adopters of technology.

5a. Discharge from hospital

When older people leave hospital some will find they have a greater need for care than they did before they were admitted. In some instances, older people can find that although they are medically well enough to leave hospital they are delayed because of reasons to do with needing to organise care at home or in a residential or nursing home. This is formally known as a delayed discharge.

In the three months of October to December 2018, there were 141 patients who experienced a delay in discharge. Of these, 52 were self-funders, this is 37% of the total. Within this cohort, 22 were still in hospital due to a delay in organising a package of care in their own homes, 23 were waiting for residential care, and 7 for nursing care.

5b. What else do we know about self-funders nationally

- Self-funders tend to be older; half of all self-funders are thought to be over 80.
- More self-funders are women than men. In one study looking at people aged over 75; 4% of men were self-funders compared with 10% of women.
- Despite most of the research focusing on care home places, most self-funders are home owners and live in their own homes.
- Typically self-funders live in more wealthy areas.
- Self-funders are also more likely to live alone than the general population. This may be connected with age and the likelihood of being widowed²².

²² <https://www.york.ac.uk/inst/spru/pubs/pdf/sscrSelfFundSR11.pdf>

- 68% will only visit one or two residential care homes before moving in. Although not discussed directly, this may indicate that this cohort did not fully explore their home care options before deciding to move to adult social care.
- 33% of residents reported not needing help with any aspect of daily living before moving into a care home
- 60% of people didn't have any formal care at home before moving
- 25% of self-funders received help with four or more aspects of daily living when they were at home

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6. The care needs of self-funders

Regardless of a person's financial situation, everyone is encouraged to have a care assessment if they feel they need care. This care assessment is available to everyone free of charge, and is delivered by the local authority. It gives a formal understanding of a person's care needs²³ and the options available to them. Although everyone is entitled to an assessment, people who fund their own care may choose not to have this assessment.

In York, if self funders choose to have an assessment, they can subsequently opt to have their care coordinated by City of York Council. The person will be given information about the care providers which are available and can meet their care needs and are asked which provider they prefer. In York, this coordination incurs a charge of £500 annually, but the care is payable at the reduced price that the local authority has negotiated with the providers.

Alternatively, self funders may choose to co-ordinate their care package themselves by micro-commissioning directly from a care provider.

6a. Evidence of care needs

Nationally, self-funders living in care homes were less likely to have received care in their own homes before making the transition, additionally those who did organise care at home reported fewer hours than local authority funded residents²⁴. This may reflect an informed preference to move into residential care, but may also reflect a limited awareness of home care options.

Similarly, a publication by LSE²⁵ found that people who self-funding their residential care home place had a longer average length of stay than people whose care is funded by the local authority. This may suggest that self-funders were in generally better health at the time of their move than people who had their places funded by the local authority. This might also reflect the trend for local authorities to strongly preference providing care in a person's own home wherever safe and practical to do so.

²³ The Care and Support (Eligibility Criteria) Regulations 2014 <http://www.legislation.gov.uk/ukdsi/2014/9780111124185>

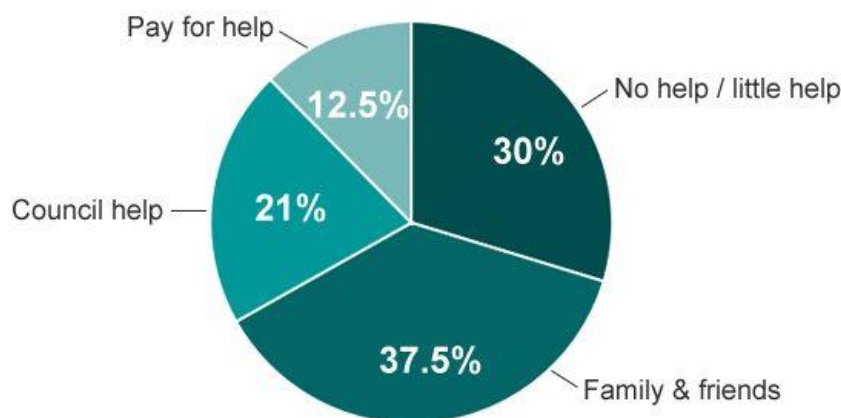
²⁴ <https://www.york.ac.uk/inst/spru/pubs/pdf/sscrSelfFundSR11.pdf>

²⁵ Forder, J. & Fernández, J. (2011) *Length of stay in care homes*. PSSRU, London School of Economics and Political Science <http://eprints.lse.ac.uk/33895/>

6b. Care from family, friends, and neighbours: community assets

A Laing Buisson²⁶ report found that among people with care needs, the majority rely on 'family and friends', or 'no help' at all in older age. It also indicated that only a third of older adults with care needs are in receipt of formally organised professional care.

Where older people in England with care needs get help



Source: Age UK, Laing Buisson, NHS Digital, Carers UK

BBC

This information emphasises the importance of community led support, and the strengths of a person's social networks through family, friends, neighbours, and community groups. For many people, the strengths of the community can delay the need for paid-for formal care, or reduce the amount of paid-for care that they need. The information above emphasises that for many people, the strengths of their social connections are a key source of support in older age.

Additionally, the best available information from Age UK²⁷ estimates that 1.4 million people nationally are not getting the support they need for day to day tasks, and the report asserts that most of these are self-funders.

Care from family and friends

Nationally, informal unpaid care is significant; involving 6.5 million people, nearly 1 in 8 of the general population. Around half of this cohort are also in paid work. In York specifically, 1,160²⁸ people claim carers allowance, this means they are caring for a person full time and are not in employment as a result of their caring responsibilities; half are over the age of 50.

²⁶ Coverage in BBC, by health correspondent Mark Trigg, 8th October 2018

<https://www.bbc.co.uk/news/health-45750384>

²⁷ Age UK (2018) care in crisis <https://www.ageuk.org.uk/our-impact/campaigning/care-in-crisis/>

²⁸ <https://www.nomisweb.co.uk/reports/lmp/la/1946157112/report.aspx?town=york>

York Carers Centre is commissioned to provide support to carers of all ages in York. In particular, the Carers Hub is designed be to a single point where carers can access information and advice, as well as assessment and signpost on to other agencies as required. There have been a growing number of carers registering with and using the service each on year, and this is projected to continue to rise.

Ageing without children

The national ageing without children charity²⁹ (AWOC) estimates that 9% of people aged 65 or older in England do not have children (data source: ONS). For York this would mean that over 3,000 older people do not have children. In addition to this central cohort, there will be further people who have outlived their children or who are estranged from their children.

Nationally, AWOC identify that adult children take on many tasks to support elderly parents; for example housework or gardening, household administration, shopping, and providing social companionship.

AWOC note that people who do not have children are 25% more likely to move into a residential care setting than their peers with children; and also to make this move with lower care needs.

²⁹ <https://awoc.org>

7. Financial information and advice

The cost of care can be significant. City of York Council and other local authorities publish information and make it available to everyone. Despite this, there is some evidence that people who self-fund their care are not, or do not feel, well informed about the options available to them.

Nationally, The Independent Age chief executive (2011) commented, “We get a lot of calls to our Helpline about paying for care, and many people don’t realise that social care is means-tested and that there are costs involved. When you think about it in the context of a deposit, wedding, or family holiday, you start to realise how high and confusing care costs can be. We know that a lot of people don’t think about care in advance, but there are things you can do even if you haven’t planned ahead.

A systematic review³⁰ of available evidence reported one study that 60% of self-funders did not feel well informed about the financial impact of their care decisions. The best estimate for York would be that this is in excess of 500 people³¹. It is probably that there is a further larger cohort with care needs who are receiving informal care from family and friends; these people may also benefit from financial advice³².

The York older people survey (2017) asked people about their information needs, and whether they felt they were lacking information on any particular topic; around one-fifth of respondents thought there was a lack of information about adult care services.

Nationally, organisations such as Independent Age, Age UK, and the Money Advice Service, money saving expert and others all provide good quality information about how to make informed decisions about care and finances in older age.

York Carer’s Centre: Self-funders of care

The York Carers centre receive a small number of queries each a week about self-funding care, mostly from carers who are themselves in retirement. They recognise a steady increase in the rate of calls over the last two years.

Carers typically seek advice about finding suitable care; including care homes, home care, and respite care. The centre recognises that people ‘don’t know where to start looking for care’. The centre feels that people are often not aware that self-funders are still entitled to a care assessment. Additionally they report that “most people are not aware that the council can commission care on their behalf, that a personal account can be set up with the council

³⁰ <https://www.york.ac.uk/inst/spru/pubs/pdf/sscrSelfFundSR11.pdf>

³¹ Based on the City of York Council adult social care estimates

³² BBC, health correspondent Mark Trigg, 8th October 2018 <https://www.bbc.co.uk/news/health-45750384>

rather than a care agency and that there may be financial benefit in doing so.

The carers centre recognise that family and friends often feel a weight of responsibility about making decisions on behalf of someone else. The centre feels it is difficult for people in York to make informed decisions because of the lack of information. The centre notes that coordinating care with providers from both care homes and home care organisations can be very time consuming and onerous for the person arranging it. A resource that specifically listed providers with current vacancies would significantly improve this process in York. The carers centre does not feel that it is sufficient to leave carers and families to 'just get on with it' particularly without the information they need.

The centre also gets requests for information about the nationally defined financial assessment rules. The centre recognises a lack of local and clear information about other funding routes such as the continuing care fund.

From time to time the centre is contacted by people after their family member's savings have been exhausted and they are no longer able to pay for care. This demonstrates that, for at least some families, there is little awareness of the means testing thresholds in care. Additionally, some people who contact them do not feel there is enough information about the potential implications of arranging care in a residential placement in York with fees that are far in excess of City of York Council's funding limits. These cases are small numbers, but have significant impact for the individual and family.

The lack of financial information is also identified in a recent systematic review of the available evidence³³. The review estimates that two in three people who self-fund their care didn't feel well informed about the financial implications of the decision they were making. Other studies included in the review found that carers and relatives held similar views about the quality of the written information available.

Age UK³⁴ say that older people moving to self-funded care home places are particularly vulnerable, in part "because the decision to enter a care home is usually taken in a rush, following a health emergency such as a fall and a spell in hospital, after which it becomes clear that they are no longer able to live at home. At such an emotional time, scrutinising the fine print in a care home contract is probably the last thing on anyone's mind. Yet few legal documents will have a greater impact on an older person's quality of life, or involve larger sums of money."

³³ https://www.york.gov.uk/downloads/file/6438/care_and_support_fees_charges_allowances_and_ratespdf

³⁴ Age UK (2016) Behind the headlines: 'stuck in the middle' self-funders in care homes. <http://www.ageuk.org.uk/latest-news/older-people-who-pay-way-their-own-way-in-care-homes-struggling-to-get-a-fair-deal/>

One study in the review³⁵ found that “40% of people in care homes would benefit from an existing financial product, but that only 3% of councils provided a list of independent financial advisors would could give advice about products for funding” and 17% referred self-funders to independent financial advisors before a care assessment.

Access to clear and comprehensive financial advice can help self-funders to make the best decisions for their circumstances and relieve stress on families, and in the longer term provide savings to the local authority.

Age UK in York information service: Firstcall

In York, Age UK run a phone based information and signposting service ‘firstcall’. Annually the service receives nearly 3,000 requests for information. This figure does not include the potentially large number of people who visit the Age UK website or other information and advice websites such as Live Well York. Age UK recognise that some people value a conversation when seeking information, and do not want to use these resources.

The team are often asked about the details of the local authority financial assessment. Age UK give printed information and also recognise that City of York Council. The team also receive a number of requests for information about financial benefit entitlements, as well as requests for information about what to do once person comes to the end of their funds.

There is also recognition that whilst many older people in York live in high value homes, they have limited savings and find it difficult to downsize. The most commonly requested leaflet was the home services directory, which provides a list of CYC vetted tradesmen for home improvements.

Requests for information about care agencies were common. This included concern about the capacity or organisations to help, waiting time for support, and difficult with top-up provision.

Age UK York recognises that older people in York want to remain independent for as long as they can, and often hear from people who are seeking information with urgent care needs.

In 2017/2018 citizens advice in York only saw 5 people for information and advice specifically relating to self-funding care.

The national audit office³⁶ in 2014 also reported concerns about the degree of local support offered to self-funders: “Local authorities have had little involvement with self-funders. Few

³⁵ https://www.york.gov.uk/downloads/file/6438/care_and_support_fees_charges_allowances_and_ratespdf

³⁶ Adult social care in England overview (2014) National audit office <https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf#page=17>

have known about, or used, their entitlement to free care assessments. Without appropriate guidance and financial advice, adults may make poor, expensive or unsustainable choices about their care and risk running out of funds or losing independence earlier, leading to greater impacts on local authorities or the NHS. The Local Government Information Unit estimated that authorities spent £425 million in 2011-12 on care home residents who had run out of private funds.

7a. Sources of information for people in York

There are many information and advice organisations in York that are able to offer advice on community led support and care in older age; there are yet further organisations in York who work alongside older people and who may be seen as trusted sources of information³⁷.

City of York Council predominantly publishes information for self-funders on both the council website www.york.gov.uk and the Live Well York website www.livewellyork.co.uk. In both instances, the information which directly mentions self-funders focuses on residential care. On the livewellyork page for self-funders, there are five sub-pages; 'what is a self-funder', 'support for self-funders' (continuing healthcare), 'deferred payment scheme', 'residential care' and 'independent financial advice'. Information on the other support options such as home adaptations, care at home, independent living communities are available on both platforms, but are not directly presented as information for self-funders.

In addition, national organisations; Age UK, Independent Age, Money Advice Service, Citizen's Advice and other similar organisations produce information on ageing well, personal care, and finances.

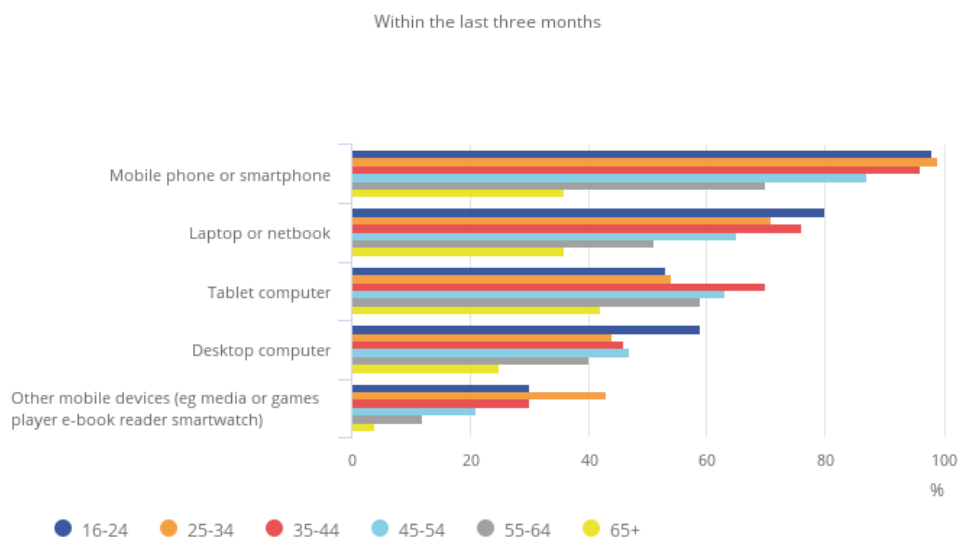
³⁷ York 50+ festival <http://www.yorkassembly.org.uk/y1/Festival>

8. Access to information

8a. Internet use

The internet remains an incomplete way at targeting older adults³⁸. The number of older adults (75+) who use the internet at all is rapidly increasing, and has doubled between 2011 and 2017, this still only accounts for around half of older adults. ONS³⁹ show the proportion of people aged 65+ who had accessed the internet within the last three months is 40%.

Figure 4: Devices used to access the internet, by age group, in Great Britain, 2018



Additionally, the York older people survey⁴⁰ in 2017 reports that almost two-thirds of older people said that they prefer to be contacted by post, and a third of people prefer to receive information in a face-to-face manner. Finally, the Experian Mosaic profile 'senior security' which most closely aligns with the known characteristics of self-funders are in part defined by the late adoption of technology, and the preference for written information.

³⁸ *Internet Users in the UK 2017* ONS, 2017 <https://www.ons.gov.uk/releases/internetusersintheuk2017>

³⁹ Internet access by household and individuals in Great Britain (2018) <https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2018>

⁴⁰ York Older People Survey 2017 <http://www.healthyyork.org/media/62045/older-peoples-survey-2017-publication-ready.docx>

9. Recommendations

9a. Move to a community asset approach of prevention and living well in older age

- Encourage the use of community hubs and the future focus network to support people to maximise their use of community resources
- Support the development of volunteering opportunities for older people
- Use existing information platforms to promote the role of community led support, and ensure it is given sufficient weight against more traditional care approaches
- Find new ways to promote the equipment that allows people to retain a greater degree of independence for longer

9b. Develop a system wide vision for ageing well in York

- Develop a system planning approach for meeting the need of people in older age
- Seek out and incorporate the voices of older people, and opportunities for coproduction, when developing information resources and service models
- Identify and support innovative approaches for people to talk about and plan for older age. This would include the community base support, the options for personal care, financial planning, and use of power of attorney.

9c. Make it easier for people to access good quality information and advice

- Work collaboratively to ensure that people can access good quality information and advice about their care and funding options, irrespective of which organisation they approach
- Make full use of national resources which offer information and advice about personal care and financial planning in older age
- Recognise that most people have a preference for how they receive information; ensure that the same quality of information is available through websites, information phone lines, and in print media

- Highlight the importance of being able to make informed choices about care, including the financial impact of care. Offer practical information about the accreditations that a professional financial advisor would be expected to have

9d. Explore opportunities to further understand people who self-fund care in York

- Explore options to work with the ICG and partner organisations to share additional information indicating how many self-funders use residential and home care services in York.
- Explore approaches to building a richer understanding of the experience of self-funders through working directly with older people in York who are currently funding their own care.

DRAFT



Health and Wellbeing Board

13 March 2019

Report of the Head of Corporate Strategy and City Partnerships

Brexit Update**Summary**

1. This report is intended to assure the Health and Wellbeing Board (HWBB) that preparations are being made in anticipation of the United Kingdom (UK) leaving the European Union (EU).
2. The UK is scheduled to leave the EU on 29 March 2019. However, at present, the Withdrawal Agreement negotiated by the UK and EU has still to secure the support of Members of Parliament.
3. As such, there is a possibility that the UK will leave the EU without a deal – a so called ‘no deal scenario’.
4. CYC has worked with partners at a local, regional and national level to identify appropriate responses in a no deal scenario.
5. These arrangements, developed within organisations and with the Local Resilience Forum and North Yorkshire Local Health Resilience Partnership (LHRP), seek to mitigate against any challenges presented by a no deal EU Exit.

Recommendations

6. The HWBB are asked to note that discussions and activities are under way to prepare for EU Exit and to mitigate against the challenges of a no deal scenario.

Background

7. In a referendum on 23 June 2016, a majority of voters supported the UK leaving the EU. The Government committed to leave the EU on that basis and Article 50 was triggered on 29 March 2017. The UK is scheduled to leave the EU on 29 March 2019.

8. Negotiations and parliamentary processes have not yet resulted in clarity on how the UK will exit the EU. It has been announced that the House of Commons will have another chance to vote on the Withdrawal Agreement on 12 March 2019.
9. If the Withdrawal Agreement is approved, there will be a two year transition period in which European legislation and mechanisms are transferred across to the UK. This will ensure a relatively smooth exit from the EU.
10. However, without parliamentary approval for the Withdrawal Agreement, a no deal scenario remains the default option. This will come into effect at 11pm on 29 March 2019.
11. In the eventuality of a no deal scenario, there will be no transition period for the UK to leave the EU – that is to say, EU law, regulations and trade agreements will cease to apply to the UK immediately after 11pm on 29 March 2019.
12. While the Government has said that a no deal scenario remains unlikely, it has continued to prepare for all eventualities. The Council has continued to take its lead from the Government in this respect and considered how the city should respond in the event of a no deal.

Main/Key Issues to be Considered

13. A main focus for planning has been to consider the immediate impacts of a no deal outcome which would need to be responded to in order to ensure the wellbeing of York's residents.
14. This has included consulting with city partners at a local, regional and national level including community groups, the CCG and NHS England.
15. There is a continued level of confidence that areas of potential risk could be addressed by organisations in the city.
16. Work has been undertaken by the Local Resilience Forum and the North Yorkshire Local Health Resilience Partnership to ensure the escalation mechanisms are in place to respond to any emerging challenges emanating from a potential no deal scenario.
17. The Council has also assessed the Government's technical notices and information packs which provide information to allow

businesses and citizens to understand the technical and regulatory changes that would follow a no deal outcome.

18. This assessment has been made following consultation with relevant Heads of Service within the Council and with the Council's city partners.
19. Communication to residents, businesses and communities is the priority from this point onwards, although this is challenging given the continuing uncertainty in respect of the process by which the UK will exit. All individuals and organisations are advised to refer to gov.uk/euexit for the latest information.

Next steps

20. Officers continue to maintain a watching brief on the emerging information provided by the Government, communicating it through as wide a range of channels as possible.
21. CYC will also continue to liaise with partners to prepare for EU Exit and to share information on the potential pressures that may arise from the UK leaving the EU.
22. The Local Resilience Forum and North Yorkshire Local Health Resilience Partnership will continue to prepare robust plans in the eventuality of a no deal scenario.

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 City of York Council

**Report
 Approved**



Date 28/02/19

Wards Affected:

All

Glossary

CYC – City of York Council
 EU – European Union
 HWBB – Health and Wellbeing Board
 UK – United Kingdom

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