



**Notice of a public meeting of
Health Overview & Scrutiny Committee**

To: Councillors Funnell (Chair), Burton, Doughty (Vice-Chair), Douglas, Hodgson, Jeffries and Watson

Date: Wednesday, 2 July 2014

Time: 5.30 pm

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

AGENDA

1. Declarations of Interest (Pages 1 - 2)

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

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

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

2. Minutes (Pages 3 - 10)

To approve and sign the minutes of the meeting held on 28 May 2014.

3. Public Participation

At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **Tuesday 1 July 2014 at 5:00 pm.**

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4. Attendance of the Cabinet Member for Health and Community Engagement

The Cabinet Member for Health and Community Engagement will be in attendance to give a verbal report on the priorities within her portfolio area.

5. 2013/14 Finance and Performance Year End Report- Health & Wellbeing (Pages 11 - 16)

This report analyses the outturn performance for 2013/14 and presents the financial outturn position by reference to the service plan and budgets for all of the relevant services falling under the responsibility of the Director of Health & Wellbeing.

6. Annual Carer's Strategy Update Report (Pages 17 - 88)

Following a Carers' Review completed by the Health Overview Scrutiny Committee in 2010/11 the Committee recommended that they should receive an annual update report on the Carers Strategy. This is the third annual review to be submitted.

- 7. Plans for an alternative premises for Bootham Park Hospital and a vision for Mental Health services in York**
(Pages 89 - 98)
This report presents the Health Overview & Scrutiny Committee with updated plans for alternative premises for Bootham Park Hospital together with proposals for the relocation of child and adolescent mental health inpatient services in York and the future vision of mental health services across York.
- 8. Vale of York Clinical Commissioning Group Report on a Five Year Strategy for Integrated Health Care in York**
(Pages 99 - 290)
This agenda item includes the full plan for the Vale of York Clinical Commissioning Group's Five Year Strategy for Integrated Health Care in York.
- 9. Safeguarding Vulnerable Adults Annual Assurance**
(Pages 291 - 330)
This is the third annual report to Health Overview and Scrutiny. The report outlines the arrangements in place to ensure that City of York Council is able to discharge its responsibilities to keep vulnerable adults within the City protected from violence and abuse, whilst maintaining their independence and well-being. Members are asked to consider whether the Council can be assured that these arrangements are satisfactory and effective.
- 10. Work Plan Update 2014/15 (including forthcoming Scrutiny Reviews)** (Pages 331 - 334)
Members are asked to consider the Committee's work plan for the municipal year.
- 11. Urgent Business**
Any other business which the Chair considers urgent.

Democracy Officer:

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

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

Contact details are set out above.

This information can be provided in your own language.

我們也用您們的語言提供這個信息 (Cantonese)

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

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

Bu bilgiyi kendi dilinizde almanız mümkündür. (Turkish)

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

 **(01904) 551550**

HEALTH OVERVIEW AND SCRUTINY COMMITTEE**Agenda item 1: Declarations of interest.**

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

Councillor Doughty	Member of York NHS Foundation Teaching Trust. That his partner works at the Retreat.
Councillor Douglas	Council appointee to Leeds and York NHS Partnership Trust.
Councillor Funnell	Member of the General Pharmaceutical Council Trustee of York CVS A Non Executive Member of Be Independent
Councillor Hodgson	Previously worked at York Hospital. Member of UNISON.
Councillor Jeffries	Director of the York Independent Living Network.
Councillor Wiseman	Member and past employee of York Teaching Hospital NHS Foundation Trust.

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City of York Council

Committee Minutes

Meeting	Health Overview & Scrutiny Committee
Date	28 May 2014
Present	Councillors Funnell (Chair), Burton, Hodgson, Jeffries, Richardson (Substitute for Councillor Doughty) and Watson
Apologies	Councillors Douglas & Doughty

1. **Declarations of Interest**

At this point in the meeting, Members were invited to declare any personal, prejudicial or disclosable pecuniary interests that they might have had in the business on the agenda.

Councillor Funnell declared a personal interest in Agenda Item 5 (Be Independent Community Equipment and Response Service) as a non Executive Director. During this item she withdrew from her position as Chair and took no part in the discussion.

Councillor Richardson declared standing personal interests in the remit of the Committee as a patient at Haxby Medical Centre and as a frequent user of Yorkshire Ambulance Services due to ongoing treatment at Leeds Pain Management Unit.

No other interests were declared.

2. **Minutes and Matters Arising**

In reference to Minute Item 96 (Draft Final Report- Personalisation Scrutiny Review), Councillor Jeffries requested that a future review on this topic focus on Learning Disabilities as well as Mental Health.

Regarding Minute Items 95) and 99) (Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) the Chair requested the Committee to nominate another Member to serve on the Joint Health OSC.

In light of Councillor Wiseman no longer being a member of Health OSC, the Chair volunteered to undertake the role of being nominated as the Committee's representative on the Joint HOSC.

Resolved: (i) That the minutes of the Health Overview and Scrutiny Committee held on 23 April be signed and approved by the Chair as a correct record.

(ii) That Councillor Funnell fulfil the role of the Committee's representative on the Joint Health OSC.

3. Public Participation

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

Roger Pierce spoke regarding the minutes of the previous meeting, specifically in regards to the merger between York Medical Group and Minster Health. He questioned why the Committee had formally endorsed the merger. He also made a number of other points, these included;

- He complained to NHS England about the lack of information that had been given to patients about the merger.
- That he had been informed by the current Practice Manager at Minster Health (where he was a patient) that public consultation regarding the merger had been carried out via Facebook and Twitter.

The Chair explained that Members had endorsed the merger as by the time it was presented to the Committee the merger had already taken place. She suggested that the Committee may ask for a progress report at a later date.

4. Presentation by City of York Council's Head of Transformation about her work around Adult Social Care

Members received a presentation from the Council's Head of Transformation about work around Adult Social Care.

Members were told that although they had received a briefing paper on the Better Care Fund to accompany the presentation, the Fund itself was only one national driver in the transformation of Adult Social Care. It was reported that the Council's Public Health programme would try to look at Transformation from the residents' view and would ask what their experiences were in the care they had been given. The programme would look at how to reduce visits to the Hospital's Accident and Emergency (A&E) department and the use of reablement services. The programme was about joined up delivery of care in the city.

In response to a Member's question about Care Hubs, it was reported that an initial pilot between the Council, the Vale of York Clinical Commissioning Group and Priory Medical Group (PMG) had been developed. The Chair added that as PMG had a large patient base this would help the Council to identify why, for example, certain people used A&E.

Members were informed that the start of the pilot would be to map the journey of people from nursing and residential care into A&E and to examine what could be done to prevent regular admittance into A&E. The pilot would then focus on those people who used lots of different care services in the city.

Discussion took place between Members and Officers and the following questions were raised;

- How much patient involvement there would be in the pilot and how would this be publicised?
- How would the pilot identify to Care Services those people who were difficult to engage?
- Would work be carried out with those who lived alone, or those who had not seen in a doctor in a long time but had past medical history?

It was reported that discussions were underway about patient involvement in the pilot, contact had already been established with small groups of people in nursing and residential homes and some had confirmed that they wished to be involved in the pilot. In addition, Priory Medical Group would also write to their patients to inform them of the pilot.

In order to engage with groups who were 'difficult to reach', different formats of the pilot would be used.

It was also reported that an Emergency Care Practitioners (ECP) Pilot would be undertaken. ECPs took calls from the 999 service and often treated lone people. The practitioners involved in the ECP pilot would try to connect those people with the relevant services.

The Chair thanked the Head of Transformation for her presentation and requested that regular reports be presented to the Committee on the progress on the projects mentioned.

Resolved: That the presentation be noted.

Reason: So that Members are made aware of ongoing work around Adult Social Care.

5. Be Independent Community Equipment and Response Service

Following the withdrawal of Councillor Funnell from the Chair, Members were asked to elect a Chair for this item. Councillor Jeffries was duly elected as Chair.

Members received a report which presented them with new information about how Be Independent was developing new ways of delivering services in York. The Chief Executive from Be Independent was present at the meeting to answer Members' questions.

The following questions were discussed;

- How could income be generated through the service?
- Would Be Independent offer equipment repair services for other providers in the city?
- What publicity had been carried out to advertise Be Independent services?
- Was there a way in which people could access other lonely people in sheltered housing through warden call?
- What methods would be use to get feedback and complaints?

The following responses to the questions were received;

- Be Independent had a control room for monitoring those who used their services, for a charge other providers could use this. Equipment could also be sold to those people who did not wish to go through the Council's social services team.
- Be Independent could look at providing an equipment repair system.
- Publicity had been carried out through advertisements in the Local Link magazine.
- If financially viable Be Independent could offer a 'check in' service for users of warden call.
- Equipment assessments would take place via telecare or via the Independent Living Assessment Centre. It was hoped that this centre would have a hub located at the Community Stadium.
- In order to reduce health inequalities, an aim of the service would be to capture those people who wanted a low level of support.
- Feedback and complaints would be captured via postcards with two questions on, every time a warden responded to an emergency they would leave a postcard. The questions included on the postcard would be:
 - How was your interaction with the service?
 - What one thing could have made it better?

The Chair thanked the Chief Executive for attending the meeting to answer Members' questions.

Resolved: That the report be noted.

Reason: To keep Members informed of developments associated with Be Independent.

6. Men's Health Scrutiny Review Topic

During this item Members considered whether they wished to continue with a scrutiny review topic focused around Men's Health in the new municipal year.

The Chair felt that the topic was too wide reaching to start a scrutiny review at the present time. This was due to resources and men being reluctant to talk about health issues.

She clarified with Members that the issue would not be off the Committee's radar but that other bodies such as the Health and Wellbeing Board, Healthwatch or the Council's Public Health Team may look at a Men's Health Topic instead.

Resolved: That the Committee do not continue with the review into Men's Health at the present time.

Reason: It was felt that the topic was too wide and that others may be better placed to carry out this work.

7. Possible Topics for Scrutiny Review during the Municipal Year

Members discussed a number of potential scrutiny topics to undertake a scrutiny review on during the 2014-15 municipal year.

The Chair informed the Committee that at a Scrutiny Work Planning Event there was widespread support to undertake another corporate review carried out across all scrutiny committees during the municipal year. The consensus from that meeting was a corporate review around supporting elderly people.

Following discussion it was agreed that the following topics should be taken forward for review:

- Improving Access to Psychological Therapies
- Personalisation with a narrower remit focused around Mental Health
- A topic based around Older People's Services (subject to confirmation of the topic from (CSMC))

The Chair asked for volunteers for the three task groups to contact her via email so work could begin on scoping the three topics.

Resolved: That the above topics be progressed to review.

Reason: To ensure that the Committee has a planned programme of work in place for the new municipal year.

8. Work Plan 2014-15

Members considered the Committee's work plan for 2014-2015.

Resolved: That the work plan be noted.

Reason: To ensure that the Committee has a planned programme of work in place.

Councillor C Funnell, Chair

[The meeting started at 5.30 pm and finished at 7.00 pm].

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Health Overview & Scrutiny Committee

02 July 2014

Report of the Director of Health & Wellbeing

2013/14 Finance and Performance Year End Report – Health & Wellbeing

Summary

- 1 This report analyses the outturn performance for 2013/14 and presents the financial outturn position by reference to the service plan and budgets for all of the relevant services falling under the responsibility of the Director of Health & Wellbeing.

Financial Analysis

- 2 The new Directorate of Health & Wellbeing comprises the Adult Social Care budgets formerly within the Directorate of Adults, Children & Education, and the new Public Health budget amalgamated with some sport and active leisure and Drug & Alcohol Action Team (DAAT) budgets formerly within the Directorate of Communities and Neighbourhoods. A summary of the service plan variations is shown at table 1 below.

**Table 1 – Health & Wellbeing Financial Projections Summary
2013/14 – Draft Outturn**

	2013/14 Budget £000	Projected Outturn Variation	
		£000	%
Adult Assessment & Safeguarding	26,993	+1,239	+4.6%
Adult Commissioning, Provision & Modernisation	25,233	+256	+1.0%
Public Health	951 *	-104	-10.9%
Total Health & Wellbeing	53,177	+1,391	+2.6%

* Net of £6.641m Public Health Grant

- 3 The draft outturn position shows a net overspend of £1,391k for the year. This is an improvement of £188k since the Quarter 3 report and £357k since Quarter 2.

- 4 In Adult Social Services, demographic pressures continue to be evident in relation to demand for care and have resulted in an overspend on community support (£236k) due to a higher number of customers than forecast, a continued increase above forecast level in the number of customers taking up Direct Payments (£129k), increased use of external placements for emergency and short term breaks (£252k) and a higher than budgeted number of customers in residential nursing placements (£718k).
- 5 There were a number of minor budgetary pressures over the year as well as some areas in which it was not possible to make the whole of the anticipated savings. These include Reablement (£157k), EPH reconfiguration (£175k), Housing Related Support (£132k), Yorkcraft (£122k) and the Night Care team (£130k).
- 6 These pressures are offset by an underspend on External Residential Care (£432k) due to a lower number of required placements than anticipated. Additionally, savings within day services (£210k) and efficiencies resulting from a strategic review of Learning Disability Care (£280k) along with strict budgetary control measures contribute to the overall position.
- 7 The Public Health grant for 2013/14 is £6.641m and has been fully utilised across a range of Public Health services, with increased emphasis on Mental Health prevention.

Performance Analysis

- 8 Performance of the year end shows 8 of the 17 reported indicators meeting or exceeding the year end targets. 4 indicators have missed in year end targets outside of tolerance.
- 9 Adults with learning disabilities in settled accommodation is the most improved performance in the year with 82.6% compared to 63.2% in 2012/13. A different approach (censor approach) of recording data in this area was put in place in 2013 which has allowed capturing of more accurate data.
- 10 Self Directed Support (Individual Budgets and Direct Payments) exceeded our year end target with 4%.
- 11 Timeliness of social care packages and OT/OTA assessments completed within 28 days remained high through out the year.

Code	Description of PI	13/14					Status
			Qtr 1	Qtr 2	Qtr 3	Year End	
A&S1C (NPI 130)	Customers & Carers receiving Self Directed Support (Direct Payments and Individual Budgets)	Target	25.0%	27.0%	29.0%	30.0%	Meets or Exceeds Target
		Actual	25.32%	30.63%	33.21%	33.85%	
A&S1C Part2 (NPI 130)	Customers & Carers receiving Self Directed Support (Direct Payments ONLY)	Target	5%	9%	14%	20.0%	Missed Target
		Actual	6.71%	8.41%	9.13%	9.39%	
A&S1C Part3 (NPI 130)	Customers & Carers receiving Self Directed Support (Direct Payments and Individual Budgets) - ADASS - definition snap shot users from P2f and carers with appropriate services & of those, percentage with DP& Personal budget delivered during the year	Target	70.0%	70.0%	70.0%	70.0%	Meets or Exceeds Target
		Actual	79.75%	-	84.61%	84.13%	
A&S1E (NPI 146)	Adults with learning disabilities in employment	Target	2%	4%	6%	9.0%	Within tolerance at Year End
		Actual	1.7%	2.11%	5.33%	7.74%	
A&S1G (NPI 145)	Adults with learning disabilities in settled accommodation	Target	18%	37%	55%	80.0%	Meets or Exceeds Target
		Actual	4.63%	15.19%	38.89%	82.63%	
A&S2A	Permanent admissions to residential & nursing care homes per 100,000 population	Target	31.00	61.00	92.00	122.00	Missed Target
		Actual	20.60	57.33	104.91	176.27	

Delayed Discharges 1	Average number of Acute delayed discharges (YDH Only)	Target	8.25	8.25	8.25	8.25	Missed Target
		Actual	12.00	11.00	10.78	12.42	
Delayed Discharges 2	Average number of reimbursable CYC delays (people) at period end (YDH Only)	Target	4.00	4.00	4.00	4.00	Missed Target
		Actual	9.00	7.33	6.11	6.58	
Delayed Discharges 3	Average number of CYC bed days	Target	173.81	173.81	173.81	173.81	Within tolerance at Year End
		Actual	188.33	181.00	171.56	181.67	
Delayed Discharges 4	Total CYC bed days cost	Target	£52,500	£105,000	£157,500	£210,000	Within tolerance at Year End
		Actual	£40,400	£108,600	£154,400	£217,400	
132 - part 6	OT/OTA assessments - to be completed within 28 days	Target	90.00%	90.00%	90.00%	90.00%	Meets or Exceeds Target
		Actual	94.5%	94.5%	95.33%	94.65%	
A&SNPI 133	Timeliness of social care packages	Target	90.0%	90.0%	90.0%	90.0%	Meets or Exceeds Target
		Actual	92.86%	92.43%	90.58%	90.24%	
A&S NPI35	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Target	6%	12%	17%	25.0%	Within tolerance at Year End
		Actual	7.4%	15.33%	19.62%	22.34%	
A&SD39	Statement of Needs	Target	95.0%	95.0%	95.0%	95.0%	Meets or Exceeds Target
		Actual	97.61%	97.68%	97.78%	98.68%	
A&SD40	All services Reviews	Target	30%	60%	80%	90.0%	Within tolerance at Year End
		Actual	38.46%	65.13%	78.38%	84%	
RAP A6	Assessments missing Ethnicity	Target	<5%	<5%	<5%	<5%	Meets or Exceeds Target
		Actual	5.29%	4.99%	4.26%	3.75%	
RAP P4	Services missing Ethnicity	Target	<5%	<5%	<5%	<5%	Meets or Exceeds Target
		Actual	3.27%	3.17%	2.98%	2.9%	

- 12 Direct Payment: Evidence suggests that the number of people receiving Direct Payment continue to be low with only 9.39% of customers and carers receiving Direct Payment in the year, a 3% drop from the 2012-13 performance 12.4%.
- 13 Average weekly number of CYC Acute delayed discharges, Bed Days and CYC reimbursable delays: Delayed transfer of care from the hospital remained a challenge in 2013/14 with 17.5 people per 100000 population being delayed from the hospital discharge, of which 11.3 was attributable to adults social care. Non acute days delay were consistently and significantly higher than acute delays though in Q4 acute days delay were slightly higher. People waiting for Nursing home placement, care package in their own home and Patient or family choice were the main reasons for the delays. We remain an outlier in this area both regionally and nationally.
- 14 Permanent admissions: The proportion of people admitted into permanent residential & nursing care homes per 100,000 population has significantly increased to 176.27 compared to 139.42 in 2012/13. This is an area we have before maintained a top performance both regionally and nationally but may not be the case this year.

Council Plan

- 15 The information included in this report demonstrates progress on achieving the council's corporate priorities for 2011-2015 and in particular, priority 4 'Protect Vulnerable People'

Implications

- 16 The financial implications are covered within the main body of the report. There are no significant human resources, equalities, legal, information technology, property or crime & disorder implications arising from this report.

Risk Management

- 17 The overall directorate budget is under significant pressure. This is particularly acute within Adult Social Services budgets. On going work within the directorate has identified some efficiency savings in services that have offset these cost pressures during 2013/14. Further work will be required to manage the on-going implications during 2014/15.

Recommendations

18 As this report is for information only there are no specific recommendations.

Reason: To update the committee on the latest financial position for 2013/14.

Contact Details

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Chief Officer Responsible for the report:

Paul Edmondson-Jones
Director of Health & Wellbeing

**Report
Approved**

Date 19 June 2014

Specialist Implications Officer(s) None

Wards Affected: *List wards or tick box to indicate all*

All

For further information please contact the author of the report

Background Papers

2013-14 Finance and Performance Year End Report, Cabinet 2 July 2014

Annexes

None



ACE Directorate Management Team

2 July 2014

Adults Commissioning and Contracts Team

Carers Strategy Update Report

Summary

1. Following a Carers' Review completed by the Health Overview Scrutiny Committee in 2010/11 the Committee recommended that they should receive an annual update report on the Carers Strategy. This is the third annual review to be submitted.

Background

2. The Carers Strategy Group is a partnership of carers, professionals and provider organisations from social care, health and the third sector. It meets regularly to monitor and oversee the implementation of York Strategy for Carers 2011 – 2015.

Consultation

3. The Carers Strategy Group includes carer representatives from the three carer-led forums in the city: Young Carers Revolution; CANDI; and York Carers Forum. In addition the following specific consultations have taken place:
 - A review of carer commissioned services in summer 2013 included sending out a stakeholder questionnaire and a consultation event for carers was held on 21st June 2013. Feedback was collated and circulated.
(Annex 2 - Review of commissioned services for carers in York 2013 'Feedback from the Review' July 2013)
 - Detailed feedback from carers was collated following a pilot scheme offering small grants to run groups for carers in spring 2013. This demonstrated very positive outcomes for individual carers.
(Annex 3 Carers small grants for support groups Evaluation of pilot scheme 2013)

Carers Strategy Update

4. Achievements

- The waiting list for Carers Assessments has been successfully reduced from 185 in April 2013 to 35 as at 11th March 2014.
- Vale of York Clinical Commissioning Group has actively engaged in raising carer awareness in GP surgeries and primary health care.
- Young Carers Revolution ran a very well attended event in June 2013 for carers week, alongside the Parliamentary Outreach service, engaging in direct discussion with MPs.
- Young Adult Carers work developed at York Carers Centre, including the setting up of a network for professionals.
- York Carers Forum contributed in national, regional and local forums speaking and contributing on End of Life Care.
- Carers members of York Carers Strategy Group gave a successful presentation to the Health and Wellbeing Board in July 2013, who adopted York Carers Charter.
- Contribution to the development of the Carer's Trust, 'Carer Hub Toolkit for Commissioners'.
- The back care project successfully produced a range of factsheets and an online DVD to support carers in maintaining their health.
- Pilot of preventative work to support carers through community groups reported positive outcomes for carers and included specific groups to target 'hard to reach' carers.
- In Adult Social Care York performed very well in the key outcome measure 'Carer reported quality of life' for 2012-13.

Indicator 2012 - 13	York	Family group	Region	England
1D - Carer-reported quality of life score	8.5	8.3	8.3	8.1

5. What still needs to be done

- Ongoing review of Carers Strategy partnership arrangements to ensure effective links with Health and Wellbeing Board, including active sign up and promotion of York Carers Charter.
- Work to implement the Care Bill and Children and Families bill re duties concerning carer assessments and access/provision of services; provision of information; and prevention.

- Health and social care integration: ensure support for carers and access to breaks is integral to work to implement the Better Care Fund requirements.
- Encourage active involvement and identification of a carer's lead at York Teaching Hospital NHS Foundation Trust.
- Review carer involvement arrangements when CYC's Customer Engagement Strategy is established.
- Launch work to implement a 'universal offer' for carers to ensure increased identification of carers and more effective access to information, advice and support.
- Consider further work to identify carers from BME communities, following initial work which did not have a successful outcome.

Analysis

6. The report is provided for information and consideration. Members are also asked to clarify if they wish to continue to receive the report on an annual basis.

Council Plan

7. Carers are York residents, or are supporting York residents and as such are affected by all the five key priorities in The Council Plan 2011. However, the actions and projects under 'protect vulnerable people' are of particular significance in providing services and support to sustain carers in their caring role.

Implications

Financial

8. All actions are accommodated within existing budgets.

Equalities

9. An Equalities Impact Assessment was completed for York Strategy for Carers 2011-15.

The actions arising are:

- Continue to improve accessibility of information for carers and key workers and improve identification of 'hidden' carers.
- Ensure information about carers' ethnicity is appropriately recorded by City of York Council, York Carers Centre and all Carers Strategy partner organisations to inform future service planning.

- Use existing contact mechanisms with BME, multi-faith and multi-cultural groups to identify the numbers of carers from BME communities and take appropriate action.
- Monitor the progress City of York Council makes in implementing the 'Carer Friendly Employer Chartermark' Action Plan.

Other

10. There are no implications relating to Human Resources, Legal, Crime and Disorder, Information Technology or Property arising from this report.

Risk Management

11. No risks arise directly from this report. In a broader sense, however, failure to recognise the importance of carers could lead to the Council failing to comply with its statutory duties under the Equalities legislation, and to additional costs falling on social care budgets.

Recommendation

12. The report is presented for information and consideration.

Reason: In line with the previously completed Carer's Review, to provide the Committee with their annual update report on the Carers Strategy.

Contact Details

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**Report
Approved**

Date 24 June
2014

Wards Affected: All

All

For further information please contact the author of the report

Annexes

Annex 1 - York Carers Strategy 2011- 15

Annex 2 - Review of commissioned services for carers in York 2013
'Feedback from the Review' July 2013

Annex 3 - Carers small grants for support groups
Evaluation of pilot scheme 2013

Annex 4 - York Carers Strategy Action Plan 2011-15 – draft progress
update and forward planner March 2014.

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York Strategy for Carers

2011 – 2015



YORK STRATEGY FOR CARERS 2011 - 2015

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1. Why carers matter

Many of us will be carers at some point in our lives. It is a role that can creep up gradually and for some it can be a life long role. For others it can come unexpectedly and suddenly following a crisis. Supporting carers is in all our interests.

Who are carers?

'A carer is someone who, unpaid, looks after or supports a relative, friend or neighbour who is ill, disabled, frail or in need of emotional support'.



Facts

- There are 6 million carers in the UK.
- Over 1 million carers provide more than 50 hours care per week.
- An estimated 37% of these carers are new to caring every year.
- 58% of carers are women and 42% men.
- Women have a 50% chance of becoming a carer before they are 59.

'Facts about carers' Carers UK, June 2009.

The impact of caring

Carers make a significant contribution in providing health and community care to relatives, friends and neighbours. The impact of caring varies depending on individual circumstances, however it is known that those caring for long hours each week are more likely **not** to be in good health. Caring can also have a financial impact and one in eight workers in the UK combine work with caring responsibilities.¹

Carers are from all walks of life and all backgrounds. Some carers can face particular disadvantage and we may know little about them. These carers are often called 'hidden carers'. They can be 'hidden' due to the circumstances of the person they care for, or their cultural background. For example, carers of people with mental ill health or substance misuse can find it hard to access support.



Equality and social inclusion

Some carers may be less likely to access appropriate information and support. The City of York Council's 'Equality Action Group' provided feedback about the Carers Strategy in 2010² identifying carers who need specific support:

- People with sensory impairments
- Carers with learning disabilities
- Carers from black and minority ethnic communities
- Lesbian, gay, bisexual and transgender (LGBT) carers
- Travellers
- Carers with mental health problems
- Older carers

¹ Carers UK (June 2009) *Fact about carers*

² City of York Council, Equality Action Group (February 2010) *Help us get it right day: feedback report.*

In order to achieve greater equality in supporting all carers, specific approaches should be adopted to reach carers who are currently unknown.

2. National Picture

All public bodies are engaged in a time of major and unprecedented change in responding to the challenges following the Comprehensive Spending Review of 2010, and the new legislative requirements affecting health, social care and many other aspects of local government.

Carers Strategy

'Recognised, valued and supported: next steps for the Carers Strategy' was published by the Coalition Government in November 2010 to outline current priorities for the ten year vision set out in the Carers Strategy of 2008.³

Social care

The Coalition Programme committed the Government to reforming the system of social care in England. *A Vision for Adult Social Care: Capable Communities and Active Citizens*⁴ was published in 2010 and is one a number of key documents⁵ which sets out principles and required actions. The Government plans to publish the Social Care Reform Bill in spring 2012. This follows the Law Commission's review of adult social care legislation and the Dilnot Commission's work on the funding of care and support.

Health

The Health and Social Care Bill was published in January 2011. The Bill provides for significant changes to the health service. This includes the abolition of Strategic Health Authorities and Primary Care Trusts, the transfer of commissioning responsibilities to GPs and the transfer of responsibilities for public health to local authorities.

Performance framework

The national requirements for health and social care are in a process of change. The government describes a vision moving away from top-down performance management, to sector-led improvement and local accountability. New outcomes frameworks for both health and social care have been published in 2010/11, however these have not yet been implemented.

Equality Act 2010

This Act introduces nine 'protected characteristics' replacing what were known as the six equality strands:

- Age
- Disability
- Gender reassignments

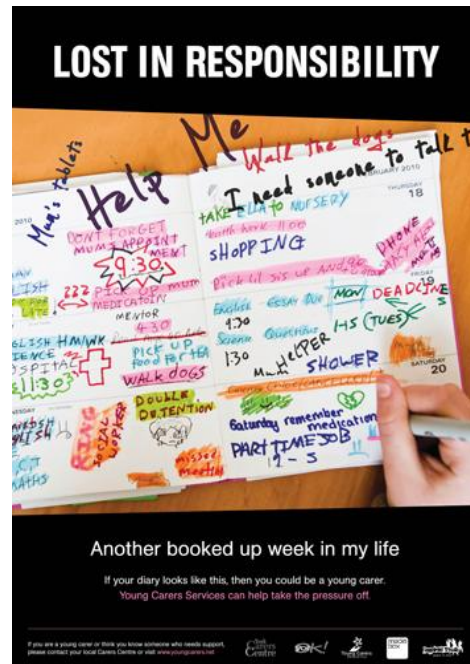
³ HM Government (2010) *Recognised, valued and supported: next steps for the Carers Strategy*; HM Government (2008) *Carers at the heart of 21st-century families and communities: A caring system on your side, a life of your own.*

⁴ Department of Health (2010) *A Vision for Adult Social Care*

⁵ Department of Health (2010) *Think Local, Act Personal* ; Department of Health (2010) *Transparency in Outcomes :a framework for quality in adult social cares*

- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity

The Act also strengthens the protection of carers against harassment and discrimination at work and in the provision of goods and services. This is because a carer is now counted as being 'associated' with someone who is already protected by the law because of their age or disability.⁶



(Campaign Images produced by Young Carers Revolution 2010)

⁶ Government Equalities Office leaflet (2010) *Equality Act 2010: What do I need to know as a carer?*

3. Local picture

Carers in York

Carers in York (2001)	Numbers	%
Total population	181,094	100%
Total population of unpaid carers	17,009	9%

7

Carers make up over 9% of the population in York. The 2001 census records 342 young carers aged 8 –17 years in York, which is likely to be an underestimate, as other research suggests there are as many as 1,600.

An estimate based on the increase in population suggests there were 18,676 adult carers in York in 2010.

Hours of care provided by carers (2001)	Numbers	%
Total population of unpaid carers	17,009	100%
Care provided 1 - 19 hours per week	12,478	73%
Care provided 20 - 49 hours per week	1,520	9%
Care provided over 50 hours per week	3,011	18%

8

Analysis of the 2001 census indicates that 21% of carers caring for 50 hours a week are likely to be in poor health. This is double the percentage of people who are not caring.⁹

Population and demographic change

York's population is rising. A total population of 181,094 was recorded in the 2001 census. The population is predicted to be 202,400 in 2011. A total of 89% of York's population is 'White British', with the BME population rising from 4.9% in 2001 to 11% in 2009.¹⁰

⁷ 2001 Census

⁸ 2001 Census

⁹ Carers UK, (2004) *In Poor Health: the impact of caring on health*.

¹⁰ City of York Council, Business Intelligence Hub Highlight Report July 2011

Older people

There is a significant growth in the population of older people. The Council reported in 2006 an expected 31% growth in the population of older people over 65 in the following 15 years and an estimated 700 additional older people with dementia.¹¹ This highlights the associated increase in mental health and physical and sensory needs as the population ages. It is expected that there will be an increase in both the number of older people being supported by carers, as well as the number of older carers. It is likely that more people will become 'mutual carers' where two or more people, each experiencing ill health or disability, will care for each other.

Strategic planning

Without Walls is the name of a group of people who have worked together since 2003 to jointly develop a shared vision for the city. The Partnership is made up of representatives of public, voluntary and business organisations in York. They have developed a '*Strategy for York*', which sets out the long-term vision for the local area based on what matters most to people. In addition, they have also developed a '*City Plan*' that focuses on a small number of priorities that are critical to address in the next four years to secure York's future.

Partners of the Without Walls Partnership all agreed to include the ambitions of the 'Strategy for York' and 'City Plan' into their own plans and strategies. City of York Council have produced a plan for 2011 – 2015 describing priorities and actions that will be taken to deliver our contribution towards the 'Strategy for York' and 'City Plan'.

Joint Strategic Needs Assessment

This aims to provide a comprehensive analysis of current and future needs in relation to the health and wellbeing of children and adults in the City and to inform future planning and commissioning decisions. The 2010 Assessment included a section about carers which referenced the Carers Strategy Action Plan. The production of a revised Assessment is underway, overseen by the Shadow Health and Wellbeing Board.

Carers Strategy Group

The Carers Strategy Group is a partnership of people from statutory and voluntary organisations as well as carer representatives from the carer led forums. The group meets every three months to monitor progress with the Carers Strategy Action Plan. The group is coordinated by City of York Council's Adults, Children and Education directorate and is working towards increasing carer awareness at all levels of strategic planning.

¹¹ City of York Council (2007) *City of York Commissioning Strategy for Older People 2006 - 2021*

Funding

York Carers Strategy Group supports partnership working between health and social care agencies in the commissioning and provision of services.

City of York Council dedicates funding from the Area Based Grant and NHS North Yorkshire and York uses funding from its core budget to support carers in the following ways:

- Strategic support and direct payments for carers.
- Services commissioned specifically for carers.
- Respite and sitting services.
- Through support provided to the cared for person which allows carers to take a break.
- Specialist services for example Community Mental Health Services that provide advice and support to carers.

As part of the National Strategy refresh the government announced that it is including £400m over four years in PCT allocations and potentially GP consortia subsequently, to spend on supporting carers. This funding is an indicative amount and is included in the PCTs baseline budget and in many cases is already committed against the current service provision. Therefore there is no new separate allocation specifically for Carers on top of the 'core' funding for PCTs.



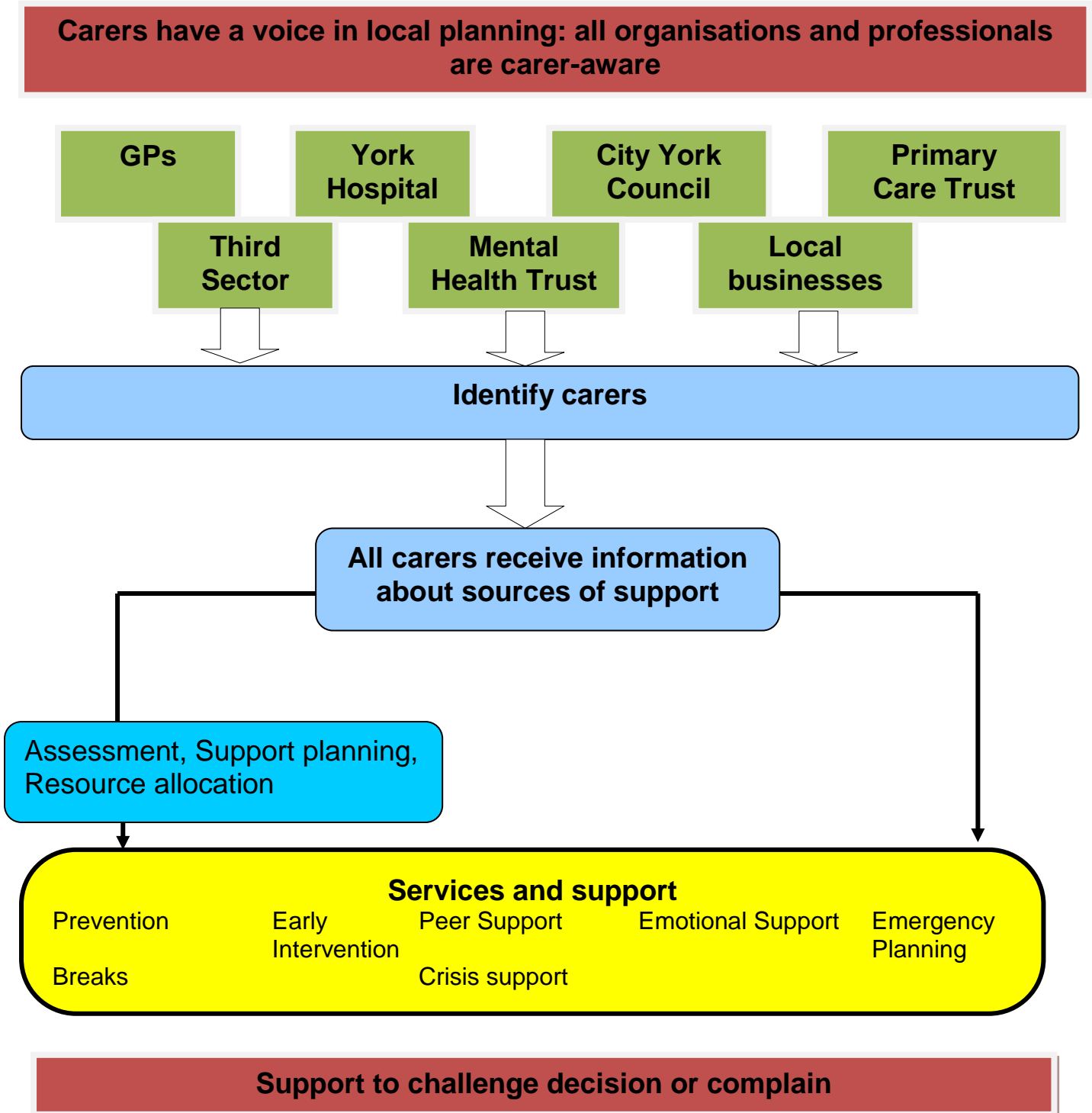
4. Vision and Outcomes Framework

Our vision in York is to work towards developing a local community where carers' needs are identified and supported by all public services and other organisations in the City. In short: 'Carers are everybody's business'.

Carers should be respected and acknowledged. Each carer has a unique perspective, alongside skills and knowledge gained through the experience of caring.

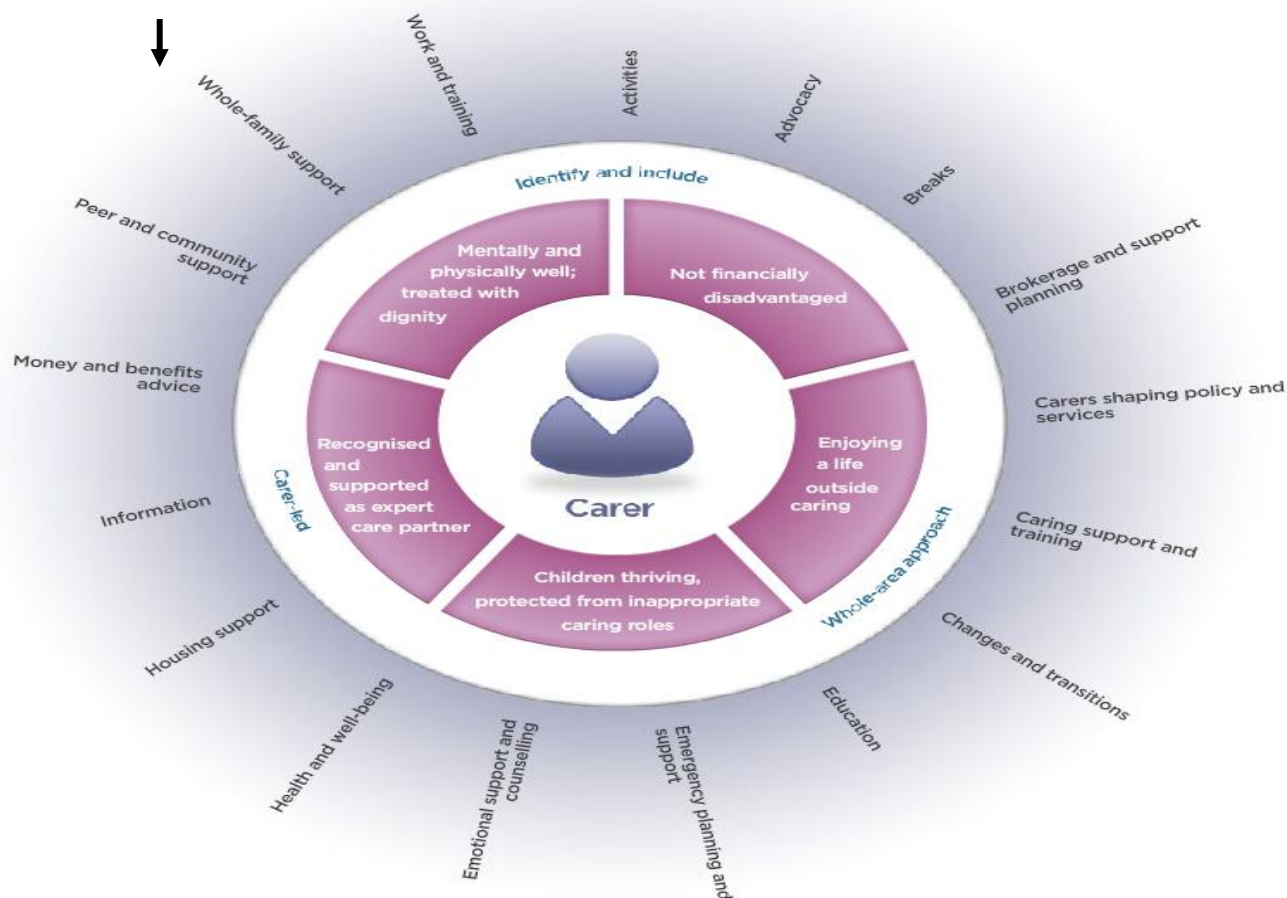
Care pathway for carers support

This has been drafted as a guide for all agencies. The chart below shows how we can work towards making sure carers are always recognised and directed to sources of support .



Outcomes framework

The 'Carers Hub'¹² is a resource developed by the Princess Royal Trust for Carers. It is a model of comprehensive carer support based on the outcomes of the refreshed National Strategy.



The carer is at the centre of the hub. The five outcomes are in the inner section and are universal ambitions for carers. These ambitions underpin the work of York Strategy for Carers.

The middle band states the overarching values:

- 'Identify and include' – we must make sure we reach all carers including those most at risk of being overlooked.
- 'Carer-led' – services and support should be individually tailored, and carers should be part of planning and strategic forums.
- 'Whole-area approach' – effective whole area planning is needed to make sure carers' specific needs are met.

We will use the Carers Hub to help us plan work required to implement the carers strategy in the future.

¹² <http://www.carershub.org>

5. Achievements and what we still need to do

Recognised and supported as expert care partners

What we have achieved

Information

York Carers Centre is now an established local independent charity and a focal point for information and advice.

Carers shaping policy

There are three active carer led forums in York helping to make sure carers voices are heard: CANDI, York Carers Forum and Young Carers Revolution.

Carers Assessments

City of York Council's social work teams have skilled Carers Support Workers carrying out carer assessments.

Carer Awareness Training

Regionally funded training held for library staff, workers in primary care health settings and those undertaking Carers Assessments of Need.

Carer awareness raising

York Carers Centre led the development of the Young Carer and Adult Carer e-learning tools.

Personalisation

Regional conference on personalisation hosted by York Carers Centre, February 2011.

Young adults carers

York Carers Centre successfully provides specialist support to young adult carers aged 18 and over.

Personalisation

York Carers Forum has worked with City of York Council to inform carers about personalisation.

City of York Council Health Overview Scrutiny Committee

Review successfully undertaken 2010/11 focussing on carer identification and information.

Integrated services and better coordination

A 'Care Pathway for carers support' has been drafted. Initial discussions have taken place about some of the implications for City of York Council's adult social care services.

York LINK review

Review completed and recommendations made spring 2011.

Development work at York Carers Centre

Lead agency in work to develop services for Young Carers, whole family support and expanded to incorporate a specialist service for carers affected by substance misuse.

What we still need to do

- Ensure all Carers Strategy partners adopt the 'Care Pathway for carers support'.
- Set up a robust system for update and distribution of accessible information for carers.
- Identify and display information for carers in key places in York.
- Provide public information in these 'key places' which is accessible to people who may not recognise themselves as 'carers'.
- Establish the potential 'trigger points' for carer recognition, so carers can be identified earlier.
- Involve GPs in the provision of information to carers.
- Ensure Adult Social Services provide a coordinated approach to assessment for the 'whole family'.
- Reduce length of waiting list for Carers Assessment of Need.
- Include carer awareness raising in all workforce development strategies.
- Map carer involvement in local health and social care planning networks with attention to the development of Healthwatch.
- Review carer involvement.
- Ensure information about carers ethnicity is appropriately recorded by City of York Council and York Carers Centre to inform future service planning.
- Scope the work needed to identify the numbers of carers from BME communities and assess their needs.
- Ensure City of York Council reviews its equalities framework enabling carers to become part of all equality and inclusion work.

Enjoying a life outside caring

What we have achieved

Carers Discount Card

York Carers Centre launched a free discount card for carers supported by 50 local businesses.

Carers Emergency Card Scheme

Over 400 carers of all ages registered. Launched for Young Carers.

Flexible Carer Support Scheme

Direct payments received by 600 carers in 2009/10 and 680 carers in 2010/11 to support and sustain caring role.

Carers Breaks- York Carers Forum

In response to feedback from carers, new monthly Art and Craft sessions established in addition to monthly social meetings with massages provided; coach trips trialled- enabling carers to take a break with the person they care for; events during carers week.

Young adult carers

York Carers Centre supported 44 young adult carers in 2010/11 with 14 new carers joining. Monthly pub quiz and cinema groups.

Telecare *

Small pilot scheme offered 3 months free trial of equipment to carers 2010/11.

Carer Breaks and Promoting Social Networking - York Carers Centre

Art classes, card making, special events and massage sessions support over 200 carers annually aiming to promote well-being and reduce social isolation.

* see footnote¹³

¹³ "Telecare is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living." It can provide people with electronic equipment such as community alarm systems or falls sensors which makes it possible to live independently and also call for help when needed.

What we still need to do

- Set up a clear framework for provision of breaks for carers which links to self directed support and personalisation.
- Audit existing services and support.
- Agree the concept of what a carers break is.
- Ensure learning from the report of the National Demonstrator Sites is incorporated into future local plans.
- Pursue roll out of Carers Emergency Card to parent carers.
- Ensure telecare services are accessible to carers.

The Carers' Quilt in St Nicholas's Chapel, York Minster



Not financially disadvantaged**What we have achieved****Employment**

York Carers Centre Employment Education and Training service supported carers with writing CVs, training, volunteering, becoming 'work ready'. Work with employers to support carers to stay in work.

Benefits uptake

York Carers Centre achieved an increase of £77,000 in welfare benefits uptake during a ten month period in 2011/11.

York Explore training courses

York Carers Centre has established links with York Library Service to help carers access free courses on computer skills and managing finances.

York Carers Centre – laptops

Funding obtained providing 30 carers with laptops enabling access to digital services to reduce social isolation, access job searches and online shopping, and increase networks.

Young adult carers

York Carers Centre supported 2 young carers to volunteer abroad and provided support to others to enable access to higher education.

What we still need to do

- Audit benefits advice services available to carers.
- Improve the availability of financial information and advice to young people aged 16+.
- Ensure carers can access financial advice when the cared for enters residential care and at end of life.
- Ensure City of York Council implements the action plan linked to the 'Carers Friendly Employer' chartermark.
- Develop links and engage with local businesses.
- Ensure information about carers' employment rights is available to employees and employers in York.

What we have achieved

GP surgeries

York Carers Centre has contacted all GP surgeries in York and distributed information, organised 13 awareness raising sessions for surgery staff and held 13 advice sessions at one GP surgery.

Back care support and training for carers

Proposal developed for 2 year training package utilising new non recurrent DH funding.

Self health checklist

This has been piloted and the feedback is positive. It supports carers to identify their own health needs and acts as a prompt for discussion with their GP practice.

Admissions and Discharge Policy

NHS North Yorkshire and York included carers issues in the principles for the Admissions and Discharge Policies for all Acute Trusts to follow.

Drug and Alcohol Misuse

NHS North Yorkshire and York arranged for the Carers Centre staff to access training on support for carers of those with Substance misuse and alcohol misuse.

Dementia Care Pathway

Carers issues have been included in to the Dementia Map of Medicine to prompt primary care to consider the needs of carers and supportive mechanisms such as the Emergency Carers Card.

End of life

York Carers Forum has worked with York Hospital to ensure carers are recognised, supported and included in the End of Life Pathway.

What we still need to do

- Health commissioners and providers ensure greater consistency around identifying and addressing the needs of carers.
- Health commissioners monitor work towards ensuring that all care pathways provide guidance on the information and advice carers will need.
- To engage with the new NHS Commissioning bodies (Clinical Commissioning Groups) as they develop, to promote carer issues and build on existing work in Primary, Community and Acute Care.



Children thriving, protected from inappropriate caring roles and supported in their caring roles

What we have achieved

Supporting schools

York Carers Centre's Young Carers Service started dedicated work with schools in 2009.

Whole family working

York Carers Centre secured funding for a specialist one year post 2010/11 offering direct support to families and work to support strategic change.

Strategy

City of York Council has identified a lead officer for young carers. A task group has been established to plan and implement actions.

Carers Assessments for Young Carers

A Task Group has begun work to implement young carer assessments in York using the Common Assessment Framework.

Young Carers Forum

Ongoing meetings of Young Carers Revolution have started, leadership of the group has been established and new members attended a meeting in April 2011. DVD promoted locally and nationally. York MP Julian Sturdy praised work of Forum in speech in House of Commons.

Young Carers Service

Support for 95 young carers in 2010/11 and 38 new carers joined due mainly to increased awareness in schools.

Young Carers Awareness Raising

Young Carers Revolution (YCR) DVD promoted locally and nationally. York MPs attended YCR meetings. YCR received standing ovation at No Wrong Doors Conference 2010. Links made with Youth Parliament. Best Community Project in York and Volunteer award in London received.

Breaks for young carers

Monthly sessions held for 3 different age groups, 286 sessions of one to one support, 50 separate activities and 36 groups sessions provided by Young Carers Service 2010/11.

Good practice in schools

Staff at Millthorpe School have been supported to run support groups for young carers. Lessons held at All Saints School for year 11 students to raise awareness re young carers. Feedback from Huntington school deputy head confirms that student and teacher awareness about young carers has increased as a result of work by Young Carers Service.

What we still need to do

- Support the development of the Young Carers task group and action plan.
- Implement the Common Assessment Framework (CAF) as the assessment tool for Young Carers Assessment.
- Ensure all adult services assessment processes and paperwork includes identification of young carers.
- Develop work in schools which identifies the support needs of young carers and ensures this support is made available.
- Young Carers Task Group to consider York LINK report (March 2011) recommendation: 'Young carers should be given help to get home access to computers'.

ONE VOICE ISN'T ENOUGH

Get Involved, Speak Up!

If you need help looking after your family, and feel like no one's listening,
you could be a young carer
Young Carers Services can help take the pressure off.

If you are a young carer or think you know someone who needs support,
please contact your local Carers Centre or visit www.youngcarers.net

The Young Carers Centre OK! The Children's Trust The Children's Trust The Children's Trust

6. Priorities

The Carers Strategy Group agreed the following priorities for the renewed Strategy Action Plan at its meeting in July 2011:

- **Develop work with partner agencies which reaches unknown carers and provides appropriate responses.**
- **Increase access to information for carers and key workers in 'key places'.**
- **Raise carer awareness amongst GPs and all workers in health settings.**
- **Engage with the Clinical Commissioning Group for Vale of York to raise awareness of the support needs of carers.**
- **Ensure the need to provide support for carers is included in all work at a strategic level.**
- **Implement the young carers assessment of need.**

York Carers Forum outing to Yorkshire Lavender (Terrington) – 7th July 2011



APPENDIX 1

Progress summary July 2011

York Carers Strategy Action Plan - Key priorities and targets 2009 - 2011

National Strategic Outcome One <i>Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role.</i>			
	Outcome	Local priority	Achievements: July 2011
1A	Information: Carers will have easy access to accurate information and advice	<ul style="list-style-type: none"> Provision of easily accessible information and signposting 	<ul style="list-style-type: none"> Carers Information Pack produced and annually updated York Carers Centre developing as focal point for information York Carers Centre, CANDI, York Carers Forum, Young Carers Revolution and City of York Council websites provide information for carers
1B	Carer identification: Carers will be recognised and valued for their unique role in supporting the cared for person	<ul style="list-style-type: none"> Increase identification of carers in Primary Care (see 4C) 	<ul style="list-style-type: none"> York Carers Centre contacted all GP surgeries and distributed information in 2010/11 City of York Council Health Overview Scrutiny Committee completed a carer review in spring 2011 focussing on carer identification
1C	Young Adult Carers: Carers will have easy access to accurate information and advice	<ul style="list-style-type: none"> Establishment of support for young adult carers aged 18 years + by York Carers Centre 	<ul style="list-style-type: none"> York Carers Centre provides regular ongoing support to 44 young adults (July 2011)

1D	Integrated services: Services and information will be provided in a coordinated way across and within agencies	<ul style="list-style-type: none"> • Closer joint working and partnerships between health, social care and the third sector • Awareness raising for professionals 	<ul style="list-style-type: none"> • Draft 'Care Pathway for Carers Support' presented to Carers Strategy Group April 2011 • E learning carer awareness raising tools re 'Young Carers' and 'Adult Carers' launched May/June 2011
1E	Personalised services: Carers will have access to a range of flexible services that meet their individual needs	<ul style="list-style-type: none"> • Carer Assessment of Need • Common Assessment Framework <i>(NB not implemented for adults in York)</i> • Personal budgets 	<ul style="list-style-type: none"> • Continued increase in numbers of separate carer assessment and review completed (673 in 09/10 and 857 in 10/11) • Carer's role acknowledged in assessment questionnaire for cared for person's personal budget
1F	Carer involvement: Carers will be involved in planning and monitoring the services they receive	<ul style="list-style-type: none"> • Training for carers – Living for Learning • Carer involvement 	<ul style="list-style-type: none"> • One Living for Learning course held in 2009 • Three active carer led forums established and offered ongoing support

National Strategic Outcome Two			
<i>Carers will be able to have a life of their own alongside their caring role</i>			
	Outcome	Local priority	Achievements
2A	Break provision: Carers should have access to a range of flexible breaks	<ul style="list-style-type: none"> • Joint plans with NYYPCT re new money for breaks • Review current breaks provision • Personal budgets to enable carers to take breaks 	<ul style="list-style-type: none"> • Breaks review presented to Carers Strategy Group April 2010 • Continued increase in numbers of carers benefiting from Flexible Carer Support Scheme (600 in 09/10 and 680 in 10/11)
2B	Emergency Card Scheme: Carers should be better equipped to deal with a crisis and have peace of mind	<ul style="list-style-type: none"> • Emergency Card Scheme 	<ul style="list-style-type: none"> • Card scheme well established for adults, now includes young carers
2C	Technology: Carers should have access to a range of services and support	<ul style="list-style-type: none"> • Telecare 	<ul style="list-style-type: none"> • Small scheme to promote benefits of telecare for carers completed in 10/11
2D	Housing, Leisure and Transport: Carers should have access to a range of services and support	<ul style="list-style-type: none"> • Discount card scheme 	<ul style="list-style-type: none"> • Carers with Carers Emergency Card and those in receipt of Carers Allowance can access discounts at City of York Council leisure classes and swimming pools • York Carers Centre launched a discount card for carers in December 2010 involving 50 local businesses

National Strategic Outcome Three

Carers will be financially supported so that they are not forced into financial hardship by their caring role

	Outcome	Local priority	Achievements
3A	Income: Carers should have access to benefits advice	<ul style="list-style-type: none"> • Welfare benefits advice 	<ul style="list-style-type: none"> • York Carers Centre continues to increase uptake of benefits for carers.
3B	Employment: Carers should have access to employment support and vocational training	<ul style="list-style-type: none"> • Ensure carers in employment are supported • Encourage carer aware employment practice • Make local links with new 'care partnership managers' at Jobcentre Plus 	<ul style="list-style-type: none"> • York Carers Centre Employment Education and Training service established. • York Carers Centre works with employers • City of York Council awarded a Carer Friendly Employer charter mark • Care Partnership Manager a member of Carers Strategy Group

National Strategic Outcome Four			
<i>Carers will be supported to stay mentally and physically well and treated with dignity</i>			
	Outcome	Local priority	Achievements
4A	Prevention: Carers should have access to appropriate medical advice, and support about their own health needs	<ul style="list-style-type: none"> • Self-health checklist distribution and evaluation 	<ul style="list-style-type: none"> • Check list piloted and distributed • Business case for back care support for carers compiled and short term development work planned • Need to give advice to carers on moving and handling included in principles for Admissions and Discharge policies circulated to Acute Trusts
4B	NHS: Carers needs should be addressed in hospital admission and discharge procedures		<ul style="list-style-type: none"> • NHS North Yorkshire and York included carers issues in the principles for the Admissions and Discharge Policies for all Acute Trusts • Health passport piloted for Neurology patients includes pages about carers. • York Carers Forum worked with York Hospital to ensure carer recognition at End of Life Pathway
4C	Primary Care and GPs: Primary care professionals should identify carers ensuring appropriate support, signposting and referrals	<ul style="list-style-type: none"> • Update GP resource pack (<i>Decision made not continue with pack</i>) • Develop work to improve carer identification and signposting in primary care settings 	<ul style="list-style-type: none"> • York Carers Centre contacted all GP surgeries in York and distributed promotional information • Carer issues included in Dementia Map of Medicine to prompt support of carers

4D	Emotional Support: Carers should have support to maintain their well being and reduce stress		
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National Strategic Outcome Five

Children and young people will be protected from inappropriate caring and have the support they need to learn, develop, and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes.

(Every Child Matters outcomes: be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being)

	Outcome	Local priority	
5A	Universal services: Children will have the support they need to learn develop and thrive	<ul style="list-style-type: none"> • Support schools in York to support young carers 	<ul style="list-style-type: none"> • York Carers Centre began dedicated work with York Schools in 2009 • Young Carers Revolution produced and publicised a range of carer awareness raising tools
5B	Targeted support for young carers: Young carers will be able to make a positive contribution and have their views respected	<ul style="list-style-type: none"> • Set up a Young Carers Forum 	<ul style="list-style-type: none"> • Young Carers Revolution established as York’s carer led forum for young carers
5C	Whole family support: Children and young people will be protected from inappropriate caring		<ul style="list-style-type: none"> • York Carers Centre secured funding for a specialist one year post 2010/11 offering direct support to families and work to support strategic change which enabled the development of the e learning carer awareness raising tools.

York Carers Strategy Action Plan 2011 - 2015

Appendix 2

National Strategic Outcome One		
<i>Recognised and supported as expert care partners</i>		
	Outcome	What we need to do
	Information: Carers will have wider access to accurate information and advice available through a range of communication methods	<ul style="list-style-type: none"> • Set up a robust system for update and distribution of accessible information for carers, including electronic distribution methods • Decide which are the 'key places' in York where carers information should be available • Develop and distribute public information which is accessible to people who may not recognise themselves as 'carers' • Involve GPs in the provision of information to carers
	Carer identification: Carers will be recognised and valued for their unique role in supporting the cared for person	<ul style="list-style-type: none"> • Enable professionals to effectively identify carers. • Include carer awareness raising in all workforce development strategies
	Integrated services: Services and information will be provided in a coordinated way across and within agencies	<ul style="list-style-type: none"> • Ensure all Carers Strategy partners adopt the 'Care Pathway for carers support'

	<p>Personalised services: Carers will have access to a range of flexible services that meet their individual needs</p>	<ul style="list-style-type: none"> • Adult and Children’s Social Services to provide a coordinated approach to assessment for the ‘whole family’ • City of York Council will reduce length of waiting list for Carers Assessment of Need
	<p>Carer involvement: Carers will be involved in planning and monitoring the services they receive</p>	<ul style="list-style-type: none"> • Review and increase carer involvement and take appropriate action • Map carer involvement in local health and social care planning networks with attention to the development of Healthwatch
	<p>Equality and social inclusion: All carers will be able to access services and support.</p>	<ul style="list-style-type: none"> • Ensure information about carers ethnicity is appropriately recorded by City of York Council, York Carers Centre and all Carers Strategy partner organisations to inform future service planning • Use existing contact mechanisms with BME, multi-faith and multi-cultural groups to identify the numbers of carers from BME communities and take appropriate action • City of York Council to review its equalities framework to ensure carers become part of all equality and inclusion work

National Strategic Outcome Two <i>Enjoying a life outside caring</i>		
	Outcome	What we need to do
	Break provision: Ensure carers have access to a range of flexible breaks	<ul style="list-style-type: none"> • Set up a clear framework for provision of breaks for carers which links to self directed support and personalisation • Audit existing services and support • Agree and promote the concept of what a carers break is • Research and adopt good practice • Roll out the Carers Emergency Card to parent carers
	Technology: Ensure carers have access to a range of services and support	<ul style="list-style-type: none"> • Provide accessible telecare services to adults

National Strategic Outcome Three <i>Not financially disadvantaged</i>		
	Outcome	What we need to do
	Income: Ensure carers have access to benefits and financial advice	<ul style="list-style-type: none"> • Audit current benefits advice services available to carers • Ensure carers can access financial advice when the cared for enters residential care and at end of life
	Employment: Carers should have access to employment support and vocational training	<ul style="list-style-type: none"> • Monitor City of York Council's implementation of the action plan linked to the 'Carers Friendly Employer' charter mark • Develop links with local businesses • Roll out information about carers employment rights to employees and employers in York

National Strategic Outcome Four
Mentally and physically well; treated with dignity

	Outcome	What we need to do
	<p>Prevention: Carers should have access to appropriate medical advice, and support about their own health needs</p> <p>NHS: Carers needs should be addressed in hospital admission and discharge procedures</p> <p>Primary Care and GPs: Primary care professionals should identify carers ensuring appropriate support, signposting and referrals</p> <p>Emotional Support: Carers should have support to maintain their well being an reduce stress</p>	<ul style="list-style-type: none"> • Health commissioners and providers ensure greater consistency around identifying and addressing the needs of carers • Health commissioners will work towards ensuring that all care pathways provide guidance on the information and advice carers will need • To engage with the new NHS Commissioning bodies (Clinical Commissioning Groups) as they develop to promote carers issues and build on existing work in Primary, Community and Acute Care

National Strategic Outcome Five
Children thriving, protected from inappropriate caring roles

	Outcome	What we need to do
	<p>Universal services: Children have access to the support they need to learn, develop and thrive</p>	<ul style="list-style-type: none"> • Set up the Young Carers task group and action plan • Ongoing development of the work now established in schools which supports young carers • Task group to consider York LINK report (March 2011) recommendation: ‘Young carers should be given help to get home access to computers’
	<p>Whole family support: Children and young people are protected from inappropriate caring.</p> <p>Young adults have access to appropriate advice in relation to their transition into adulthood.</p>	<ul style="list-style-type: none"> • Implement the Common Assessment Framework (CAF) as the assessment tool for Young Carers Assessment. • Ensure adult services identify young carers in their assessment processes and paperwork • Ensure effective sources of advice are available to young carers aged 16-18+

Appendix 3

What carers in York have told us?

National Strategy refresh session – York 2010

25 people attended a consultation meeting on 16th August 2010.

16 were carers, of whom 4 were young carers. Three other carers returned written responses. Nine workers/professionals attended of whom all had specialist roles to support unpaid carers. Carers discussed what the priorities for services and support to carers should be.

KEY MESSAGES (from final discussion at meeting)

“Don’t let money rule it, sometimes have to spend a bit to create a lot.”

Do not cut services to carers. Carers save money, and are value for money. Protect the carers, and the cared for is protected.

“These services are our rights.”

Personalisation and respite is a complex issue.

Third sector equals value for money.

Short breaks are a priority.

Emergency support at short notice.

Development of personal budgets and support to maintain them.

Identification of carers in schools, GPs, hospital and hospital discharge.

Training by carers in carer awareness for professionals/workers.

Carers Allowance: increase and change the rules.

Young Carers need specialist support and support in schools and Further Education.

Carers own health.

Quotes from carers

Peer Support

“The only things that have worked well for me is when I have spoken to other carers....they were the ones who put me on to things that helped me. I would love to say “serviceland” helped me but I can’t.”

“Enabling parent/carers to speak to other parent/carers. People listen and learn best from people that know what they mean without having to explain.”

Health and Well-being

“One of the most important outcomes of the strategy. If the carer doesn’t have support and attention to their physical needs then there would be two people in need of care.”

“For me, the most important priority for the carer strategy is to ensure both the mental and physical well-being of the carer.....in the long term, funds targeted at ensuring carers are mentally and physically able to continue in their supporting roles will pay huge dividends by avoiding significant costs when things go wrong.”

“Emotional support for carers would be very welcome as it is badly needed. The only emotional support I have ever received in my caring role, has come from other carers. Funding carer led support groups should be a priority.”

Health Overview Scrutiny Report 2011

In November 2010 the City of York Council's Health Overview Scrutiny Committee set up a Task Group to carry out a Carer's Scrutiny Review.

Aim: to promote the valuable work done by carers and to improve the way City of York Council and its key partners identify carers and ensure they have access to information and the support available.

Key objectives:

- 1) To raise awareness of carers
- 2) To improve access to information for carers

20 carers and 10 care workers contributed information in person or via a questionnaire.

Analysis of information from the Public Event and questionnaires

The importance of early identification of carers

Key professionals, especially GPs need to be aware of carers from an early stage and identify them as soon as possible.

Recognising you are a carer

People do not always immediately recognise themselves as a carer. Steps need to be taken to encourage early carer self-identification so that the right information can be provided at the right time. Carer needs to have access to information immediately that they recognise themselves as a carer.

"Many comments were received (at the public event and in returned questionnaires) that recognising that you are a carer was a gradual process, however it often became very clear at a point of crisis (such as hospital admission or diagnosis or a particular condition.)"

Provision of Information

Information would need to be proportionate to the needs of each individual carer.

Carers own needs

Comments at the public event were backed up by questionnaires that identified that frequently more support is given to patients/customers than to carers. This meant that the carer's health often suffered as a consequence and carer didn't always get enough time to spend on their own needs especially if they were caring for more than one person.

York LINK Report 2011

The LINK Steering Group held a Public Information and Awareness Event on Carers Rights on September 8th 2010. Evidence about services for carers in York was provided by a total of 48 individuals and York Carers Centre staff.

Recommendations from “Report on Carers Rights – March 2011” were made on the following themes:

Young Carers

- City of York Council to help fund York Carers Centre to promote young carers awareness in schools
- Implementation of a Young Carers Card Scheme and funding for York Carers Centre for a young carers event
- GPs should keep a record of young carers
- City of York Council provide support to help young carers to find ways of funding home computers

Employment

- City of York Council organise support and advice to help carers combat discrimination in the workplace
- Local organisations to offer work experiencing placements to carers

Parent carers

- City of York Council should improve access for disabled children to social services
- Jointly commissioned (by NHS North Yorkshire and York and City of York Council) posts to help parent carers liaise with community, social services and health services

City of York Council

- Congratulations to City of York Council for the amount of support provided for carers and carer organisations and request that high standards are maintained.

Carers Assessments

- Increased resources from City of York Council to reduce waiting times for Carers Assessments

GPs

- GP surgeries in York should adopt the model used in Somerset called the Carers Champions Scheme, with training delivered by York Carers Centre and York Carers Forum.

York Carers Centre Survey 2011

In January 2011 York Carers Centre sent out a survey to 650 adult carers registered on its database. In total 183 surveys were returned: a response rate of 28%. The following is a summary of feedback from carers.

To view the full survey results go to:

<http://www.yorkcarerscentre.co.uk/content/carers-survey-2011>

Current services

- 47% of carers heard about York Carers Centre from a social worker or carer support worker.
- 13% of carers heard about York Carers Centre from their GP surgery.
- 57% of carers responded that one of the reasons they initially contacted the Centre was to find information about services, and 42% to register for the Carers Emergency Card.
- 58% of carers usually contact the Centre by phone.
- 94% of carers felt able to speak to someone at the Centre at a convenient time.
- 95% of carers fed back very positively about all aspects of home visits from Centre workers.
- 88% of carers agreed that information in York Carers Centre newsletter was useful and relevant.
- 95% of carers felt that leaflets in the Carers Information Pack were useful and relevant.
- 79% of carers agreed that York Carers Centre helps them with the stresses of being a carer.

What carers would like to see in the future

- 80% of carers would like to have regular advice surgeries in their local area.
- 74% of carers felt it would be useful to have a telephone helpline for emotional support.

Appendix 4

Carers Scrutiny Review March 2011 – summary of recommendations

City of York Council Health Overview Scrutiny Committee Carers Review Task Group met between December 2010 and March 2011.

For further details and the full final report see:

<http://democracy.york.gov.uk/ieListDocuments.aspx?CId=718&MIId=6313&Ver=4>

Carers Scrutiny Review March 2011 – summary of recommendations

To raise awareness of carers:

- Health commissioners and providers ensure that there is greater consistency around how carers are identified and once identified their needs addressed.
- That the Multi-Agency Carer's Strategy Group identifies where it would be helpful to provide public information about what it means to be a carer and how to access support to enable carers to identify themselves earlier.
- That City of York Council reviews its Equalities Framework to ensure that carers become an integral part of all equality and inclusion work.

To improve access to information for carers

- That health commissioners ensure that all care pathways provide guidance on the information and advice carers will need.
- That Adult Social Services develop a clear pathway, which provides an integrated approach to assessment for the whole family.
- To continue to promote carer awareness an annual update on the Carers Strategy for York be presented to the Health Overview and Scrutiny Committee and thereafter to the Executive Member for Health and Adult Social Services.

York Strategy for Carers

Compiled and agreed by York Carers Strategy Group August 2011.

For more information contact:

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Acknowledgements

Thanks to Young Carers Revolution for the campaign images page 5 and 19, to see their campaign please visit www.youngcarersrevolution.wordpress.com

Thanks to York Carers Forum for photos page 14 and 20.

Other photos from local and national library sources.

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Review of commissioned services for carers in York 2013 'Feedback from the Review' July 2013

Background

Aim of the Review: to review provision of commissioned services for carers in York to ensure we provide the best support possible within available budgets.

The Review Process:

- Annual review meetings have been completed by Adults Commissioning and Contracts Team for the commissioned services for York Carers Centre; Crossroads; Age UK – In Safe Hands; York MIND Carers Counselling Service; and York Alzheimer's Society.
- A questionnaire was circulated through contacts and networks to carers and professionals; discussions held with key people including York Carers Forum; and a get together for carers 'Conversation and Cake' held on 21st June to discuss initial findings. A survey monkey questionnaire was circulated to GP practices. A total of 59 responses were received during this process.

What we found out

What works

There was overwhelmingly positive feedback about the value to carers of **all** the services above which are commissioned for carers in York. This quote gives a flavour of how much carers value the services that are in place:

"I have had much help....over the years, without this service I would not know how I would have coped".

York Carers Forum and CANDI (both carer led forums) were named as good sources of information, advice and support to local carers and positive comments were made about statutory support from health and social care services.

Young carers

There was positive feedback about the current services and sources of support for young carers in York.

What does not work and gaps in services

The following themes emerged about where there is a need for development, or where gaps exist:

- **Carer identification**

“Finding the right way into the system and services is the hardest thing”

There was particular concern about the need to be identified as a carer in hospital and health settings.

- **Information, advice and support**

Carers need information which is appropriate to their specific needs. Some feel bombarded by information and others feel they have none.

“The right information in the right place at the right time for the life stage of the carer”

- **Breaks for carers**

Opportunities for breaks of all sorts, including services and support to the cared for person including respite and day support, were very much valued. However, there was a general view that current provision does not meet the overall demand and that there are gaps. Carers can find it hard to take up the opportunity to attend support groups and events because they are unable to find alternative arrangements for the person they care for.

- **Carer assessments**

A Carer’s Assessment was viewed as a valuable source of support particularly for those people new to the caring role, or where the impact of the caring role increases.

“Carers need a timely Carers Assessment of Need”

There was significant concern expressed that there has been a long

waiting list for carer assessments in York for a number of years. City of York Council is currently investing resources in this area of work, on a short term basis to clear the waiting list. There were concerns expressed about the need to change how carer assessments are carried out to ensure, once cleared, the waiting list does not grow again.

- **Support for carers of people with mental ill-health**

When a person with mental ill-health is discharged from statutory services and goes on to receive support through primary care services, a carer can no longer access support from the Carer Support Workers in the Community Mental Health Teams.

“Carers still have to support someone with mental ill-health and do so without support themselves”

Carers also find difficulties in accessing support when a person with mental ill-health refuses to engage with mental health services.

- **Emotional support for carers**

There is a gap in provision of emotional support for carers, with some service providers looking creatively at how existing provision could be enhanced by use of telephone support and increased use of volunteers in this area.

- **Access to services and waiting lists**

Some feedback highlighted that statutory services could be difficult to access and that the existence across many services (e.g. benefits advice) of waiting lists or delays in support being available can cause difficulties for carers.

- **Joined up' services**

Generally, carers would like better coordination across organisational boundaries, less demand in terms of assessments and paperwork and a more holistic approach.

“There should be better integrated working between adult, children’s social services and health”

A more specific point was that there could be an increase in coordination between organisations in York who provide direct support to carers so as to avoid duplication and improve collaborative working.

What next?

Services specifically commissioned to support carers

The aim was to review and assess if these services are providing the best possible support for carers within existing budgets. The conclusion is that these services are all well used and valued by those who benefit from them. There is pressure on many of these services and some hold a waiting list. During this time of financial restraint all providers have reviewed their services and implemented or plan to implement efficiencies to ensure as many carers as possible benefit from the resources that are invested.

Other support and services

The experience of carers is influenced by services and support which are far wider than the services which are specifically commissioned to support carers. Feedback received as part of the review highlighted a wide range of other sources of support that benefits carers. The three carer led forums in the City: Young Carers Revolution, York Carers Forum and CANDI are much valued and demonstrate the strengths and benefits of peer support. These organisations need to be supported to continue.

Issues raised by the review

A number of issues were raised by stakeholders with particular concern about the ongoing Carer Assessment of Need waiting list; the need to effectively identify carers in health settings; and concern that the demand for breaks for carers is in excess of what is currently available.

The issues raised in the review will be fed back to the appropriate organisation/forum. The Carers Strategy Group will be informed about the issues raised in order to monitor progress in addressing them.

Frances Perry, Carers and Strategic Policy Manager, City of York Council, July 2013



Carers small grants for support groups Evaluation of pilot scheme 2013

Aim of the pilot

To fund a small grants scheme enabling groups for carers to be run in York. The scheme will include some outcome based evaluation to find out how effective groups are in supporting local carers.

“Both York Carers Forum and York Carers Centre are of the view that providing group based support and activities is a valuable and cost effective way of carers accessing support e.g. through massage treatments at York Carers Forum meetings, or craft and art classes. Often the FCS grant provides a one off break only and does not specifically promote peer support and contact.” (Minutes of Carers Strategy Group meeting, July 4th 2012)

The proposal was to fund carer support sessions for adults, which will aim to meet a one of more of the following outcomes from the York Carers Strategy Action Plan bearing in mind the perceived benefit of peer support:

- Ensure carers have access to a range of flexible breaks.
- Carers will have wider access to accurate information and advice through a range of communication methods.
- Support to maintain mental and physical well-being.

Overview of groups receiving funding

Five local voluntary organisations or carer led groups applied successfully for funding and thirteen grants were approved in spring 2013 offering a diversity of opportunities including:

- A series of sessions teaching yoga and meditation skills.
- One off sessions requested particularly by young adults carers to have a break and develop new skills eg chocolate making and flower arranging.
- Support groups for specific carers eg a social event for carers of people with mental health problems and groups sessions for carers of people with dementia.
- Support for a carer led group to provide mini-massage sessions at regular meetings as well as mini-workshops at a event during Carers Week.

Numbers of carers

191¹ carers in total were in attendance at the 13 groups that were funded by the grant. There were 274 attendances recorded at all the sessions funded by the grants and 160 completed evaluation forms returned and collated. Not all carers returned an evaluation form and of those who did, some did not answer all the questions.

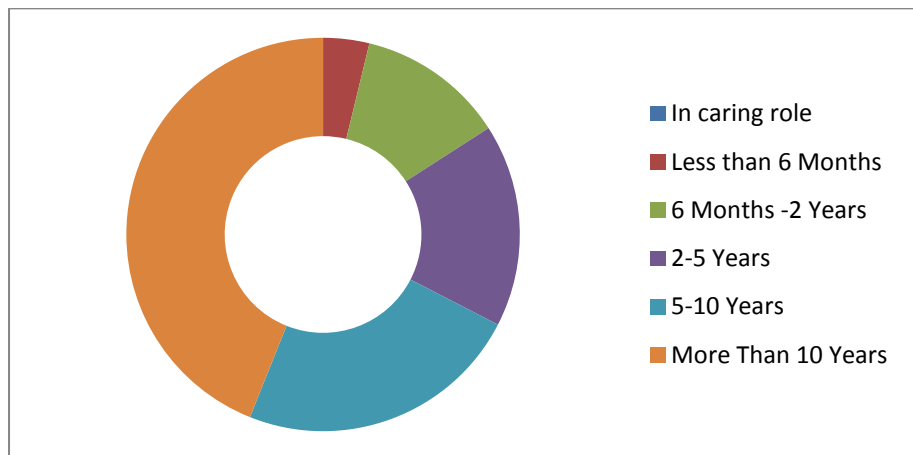
Profile of carers

This is a summary of information from the evaluation forms completed by carers who attended the events/groups funded by the grants.

¹ Some carers attended more than one of the 13 events organised through the small grant support so will be counted more than once.

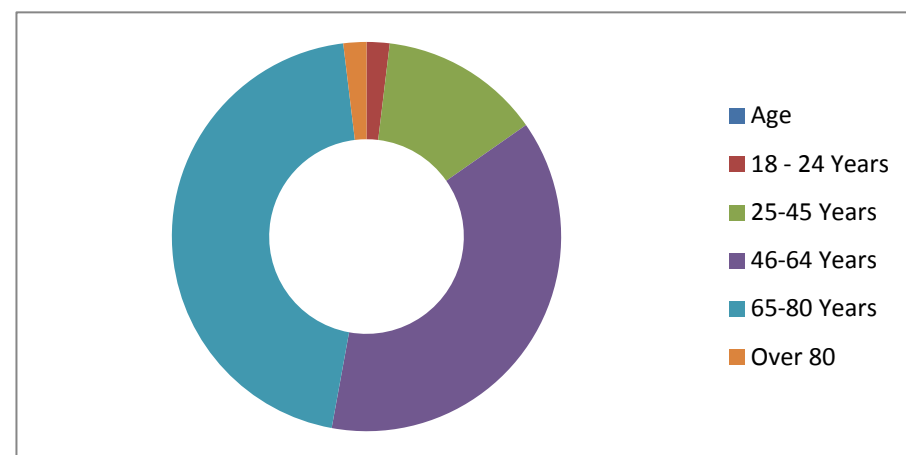
‘How long have you been in the caring role?’

132 carers provided information.



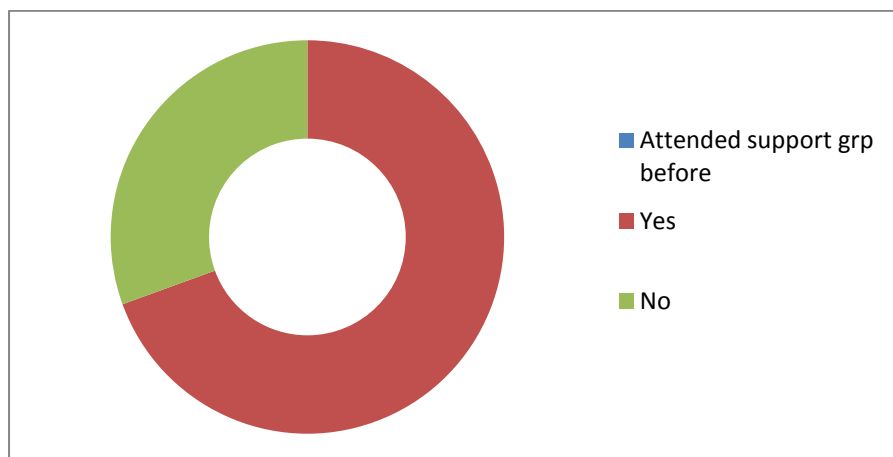
‘What is your age?’

157 carers provided information.



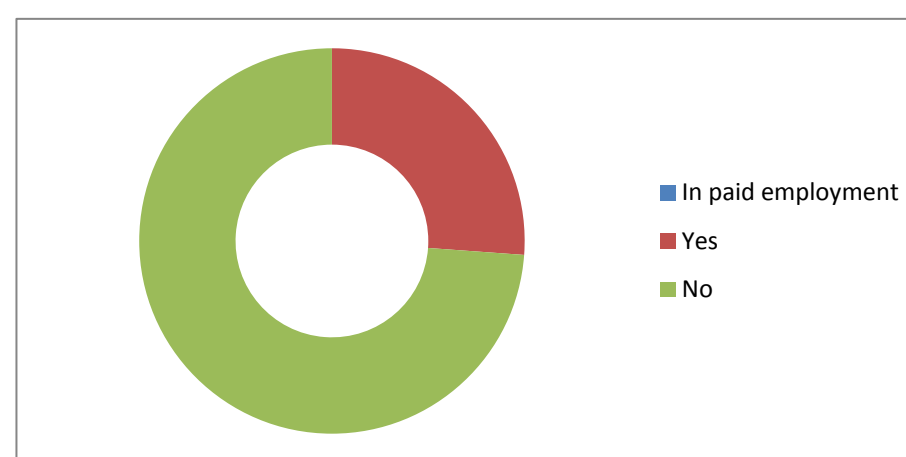
‘I have attended support groups for carers before’

180 carers provided an answer.



‘I am in paid employment’

130 carers provided an answer.

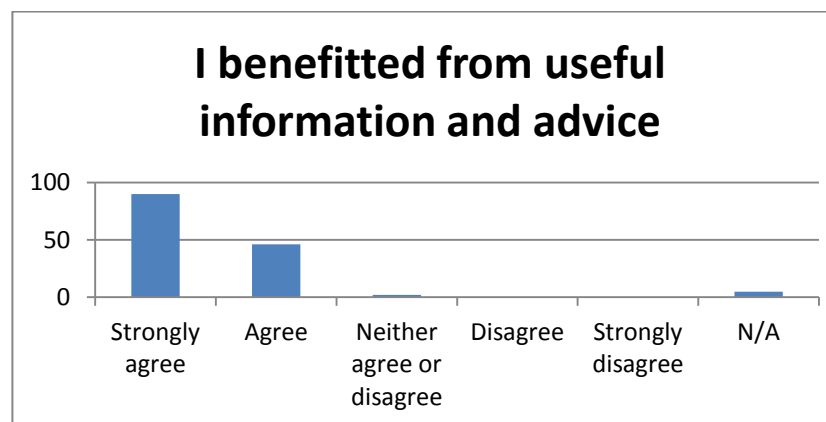
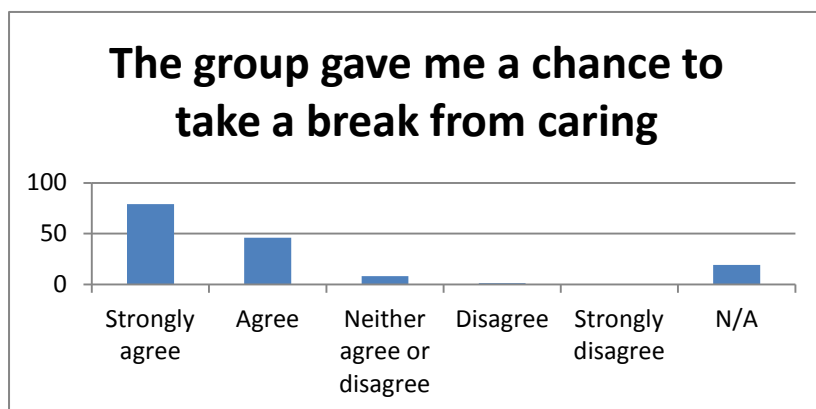


Key points:

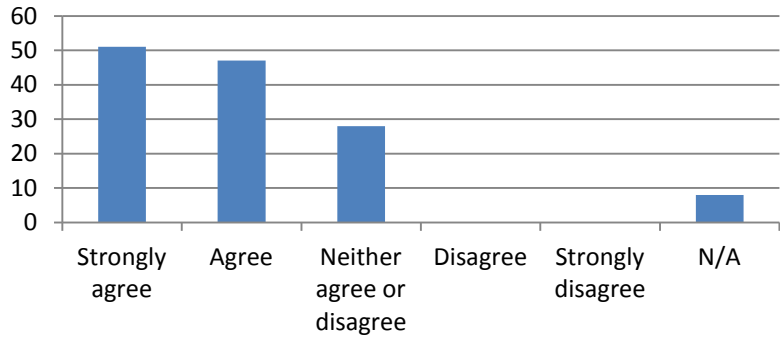
- Carers from across the age range attended sessions, though few were under 25 or over 80.
- A significant proportion of carers, 30% of the total, had never before attended a support group before.
- Over a quarter of carers who attended are in paid employment.
- 16% of carers who attended had been caring for 2 years or less and 44% for over 10 years.

Outcomes for carers

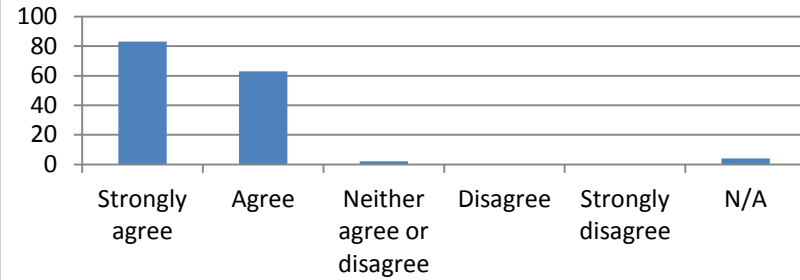
Carers were asked to give individual feedback about the impact of their attendance at a group. This has been collated across all the groups:



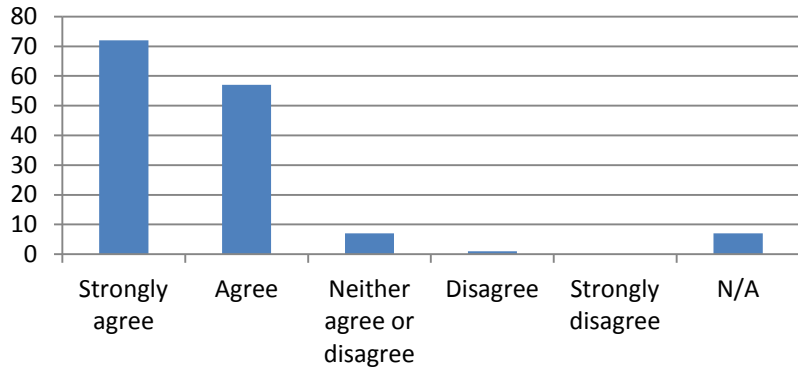
Attending the group has helped me maintain my physical health



My emotional wellbeing has benefitted from attending the group



I feel supported in my caring role



The feedback is overwhelming in demonstrating how a range of outcomes for carers were met across all the groups that were funded.

Benefits for carers identified by the organisations who received grants

- Helped to lower carer stress levels.
- Carers set up their own peer support group after the sessions.

I watched one carer change from saying she had no choice but to cope....to actually recognising her own strengths and ability to cope.

More detailed evaluation ...revealed significant improvements in wellbeing and social relationships for this group.

Carers talked really openly about their home situations and supported each other despite having only just met.

What carers said

- “Having some quiet me time”
- “I’d recommend this as a great way of de-stressing from the daily routines. Feel emotionally and physically refreshed”
- “I felt very supported by other people”
- “The pamper evening was a really good idea, just what we needed as carers of relatives with dementia as we didn’t have to think and could just enjoy ourselves”
- “Talking to other people in the same position, I don’t feel so isolated”
- “Learning new stress relief and pain relief skills”
- “Learnt a lot of information that I wasn’t aware of”
- “Getting to know more about the stages of dementia”
- “Making a start meeting people in my same situation”
- “There are always speakers on subjects which are needed by carers and good advice can be had”

- “Meeting people like myself and having massages”
- “Friendships made, information shared, distractions from the tiring and relentless daily struggle”
- “A lovely treat”
- “Fantastic, learned new skills, lovely to create something and have a sense of pride in what you have made. Relaxing, calming and enjoyable”
- “Meeting other people and exchanging thoughts on similar problems”
- “Receiving information – we are at the very start...and are looking for as much information as possible to help us as carers”

Learning for the future from organisations

- The grant did not cover the full costs of running a number of the groups and some organisations underestimated the costs of running the groups they organised.
- More time to use the funding.
- Carers do not always find it easy to attend events due to working full-time and caring commitments.
- Thinking differently to meet the needs of male carers in the future.
- Need to take into account cost of printing the evaluation forms.
- Costs of completing applications and cost of promotion of events.
- Being able to offer events that reach young adult carers.
- Would like to offer events again and build up a core of carers who spread the word to help welcome new carers.

Outcomes for carers

The evaluation gives evidence of positive outcomes for carers:

(Percentages are based on the total number of carers who responded to the question)

Breaks

- 82% of carers said that the group gave them a chance to take a break from caring.

Information and advice

- 95% of carers said they benefitted from useful information and advice.

Physical health

- 73% of carers said attending the group helped maintain physical health.

Emotional wellbeing

- 96% of carers said their emotional wellbeing benefitted from attending the group.

Supported in my caring role

- 90% of carers said they felt supported in their caring role.

Carers who attended the groups and gave feedback report high levels of benefit from the group they attended. The evidence suggests that peer support is extremely helpful to many carers alongside being a cost effective way of offering support and access to information.

There have been concerns expressed in York about the limited availability of breaks for carers and the lack of opportunities for emotional support. This pilot scheme demonstrates that funding a range of groups for carers successfully contributed to carers being enabled to take a break and a very high proportion of carers reported benefits to their emotional wellbeing.

DRAFT York Carers Strategy Action Plan 2011 – 2015 (Progress update March 2014)

National Strategic Outcome One Recognised and supported as expert care partners				
Outcome	What we need to do	Achievements	Lead officer	Actions to c/f
Information: Carers will have wider access to accurate information and advice available through a range of communication methods	Set up a robust system for update and distribution of accessible information for carers, including electronic distribution methods	Information in factsheet format and available on line. 'Universal offer' being developed to launch June 2014. New York Carers Centre website being developed.	Carers Info Group Chair YCC	Continue
	Develop and distribute public information which is accessible to people who may not recognise themselves as 'carers'	As above	Carers Info Group Chair YCC	Continue
	NEW Monitor implementation Care Bill re duty to provide information as it affects carers.		Frances Perry CYC	
	Involve GPs in the provision of information to carers	CCG continues to commission training for GPs	Sarah Kocinski VOYCCG	Further training planned by CCG

<p>Carer identification: Carers will be recognised and valued for their unique role in supporting the cared for person</p>	<p>Enable professionals to effectively identify carers.</p> <p>Include carer awareness raising in all workforce development strategies</p>	<p>Universal offer as above</p>	<p>Carers Info Grp Chair</p> <p>CYC WDU and health workforce</p>	<p>Launch 'universal offer June 14</p> <p>Work needed with health workforce development Units.</p>
<p>Integrated services: Services and information will be provided in a coordinated way across and within agencies</p>	<p>Ensure carers voice is represented and heard in Health and Wellbeing Board and partnership groups.</p> <p>NEW Better Care Fund and health and social care integration (BCF)</p> <p>NEW Prevention: Care Bill implementation: monitor and review availability of 'preventative' support to carers.</p>	<p>Carers Charter and Carers Champions agreed by HWBB July 2013.</p> <p>York Carers Forum sit on Older People and Long Term Conditions Partnership Board..</p> <p>Work in progress re ensuring support for carers integral to integration plans.</p>	<p>Frances Perry/Sarah Kocinski/Helen Sikora</p>	<p>Review April 2015</p> <p>Review June 2015</p>

	<p>Personalised services: Carers will have access to a range of flexible services that meet their individual needs</p>	<p>Adult and Children’s Social Services to provide a coordinated approach to assessment for the ‘whole family’</p> <p>NEW Engage in implementation of Care Bill guidance when issued re carer assessments and rights to services.</p> <p>City of York Council will reduce length of waiting list for Carers Assessment of Need</p>	<p>Ensure holistic approach in implementation of Care Bill changes.</p> <p>Achieved. Ensure waiting list does not develop in future.</p>	<p>TBC CYC</p> <p>TBC CYC</p> <p>Ralph Edwards, CYC</p>	<p>Review June 2015</p> <p>Ongoing monitoring</p>
	<p>Carer involvement: Carers will be involved in planning and monitoring the services they receive</p>	<p>Review and increase carer involvement and take appropriate action</p> <p>Map carer involvement in local health and social care planning networks with attention to the development of Healthwatch</p> <p>NEW Liaise with Healthwatch re raising carer awareness and promoting carer involvement in monitoring services.</p> <p>NEW Support for carer led forums – review : York Carers Forum and CANDI</p>	<p>Carers Strategy Group role and membership reviewed and revised..</p> <p>Achieved and ongoing – Healthwatch Manager member of Carers Strategy Group..</p>	<p>Frances Perry CYC</p> <p>Frances Perry CYC</p> <p>Frances Perry CYC/Sian Balsom Healthwatch</p> <p>Frances Perry</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>September 2014</p>

<p>Equality and social inclusion: All carers will be able to access services and support.</p>	<p>Ensure information about carers ethnicity is appropriately recorded by City of York Council, York Carers Centre and all Carers Strategy partner organisations to inform future service planning.</p> <p>Use existing contact mechanisms with BME, multi-faith and multi-cultural groups to identify the numbers of carers from BME communities and take appropriate action</p> <p>City of York Council to review its equalities framework to ensure carers become part of all equality and inclusion work</p>	<p>Carers ethnicity now recorded by CYC and York Carers Centre</p> <p>Work completed but no response to request to complete questionnaire.. Needs funding to complete targeted work.</p> <p>York Carers Centre has place on Fairness and Equality Board.</p>	<p>Frances Perry CYC</p> <p>Frances Perry CYC</p>	<p>Review September 2014</p> <p>Review September 2014</p>
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National Strategic Outcome Two
Enjoying a life outside caring

	Outcome	What we need to do	Achievements	Lead officer	Action required
	<p>Break provision: Ensure carers have access to a range of flexible breaks</p>	<p>Continue monitor supply and demand re all carers breaks schemes</p> <p>NEW Establish plans for Better Care Funding stream highlighted for carers breaks.</p> <p>Support additional breaks through small grants to carer support groups.</p>	<p>Review of commissioned services completed summer 2013 – highlights demand for breaks is high and supply for funded breaks not met.</p> <p>See above</p> <p>Successful pilot spring 2013, further funding spring 2014.</p>	<p>Frances Perry CYC</p> <p>Frances Perry CYC</p> <p>Frances Perry CYC</p>	<p>Review April 2015</p> <p>Review June 2015</p> <p>Review September 2015</p>

<p>Technology: Ensure carers have access to a range of services and support</p>	<p>Ensure telecare services are accessible to adults</p> <p>Ensure carers are aware of availability of and access to telehealth services and support</p>	<p>Warden Call aware of carers as host the Carers Emergency Card.</p> <p>Ask Sarah</p>	<p>Frances Perry CYC</p> <p>Sarah Kocinski VOYCCG</p>	<p>Sept 2014 Request monitoring information from Be Independent re telecare and carers</p> <p>Review telehealth with regard to carers</p>
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National Strategic Outcome Three
Not financially disadvantaged

Outcome	What we need to do			
<p>Income: Ensure carers have access to benefits and financial advice</p>	<p>Audit current benefits advice services available to carers</p> <p align="center">http://www.yorkcvs.org.uk/benefitsinyork</p> <p>NEW: Review impact of welfare benefits changes and access to advice.</p> <p>Ensure carers can access financial advice when the cared for enters residential care and at end of life</p>	<p>List about how to access benefits available on YCVS website</p> <p>No specific work completed</p> <p>No specific work completed.</p>	<p>Sian Balsom YVCS</p> <p>Frances Perry CYC</p>	<p>Review June 2014</p>
<p>Employment: Carers should have access to employment support and vocational training</p>	<p>Monitor City of York Council's implementation of the action plan linked to the 'Carers Friendly Employer' charter mark</p> <p>Develop links with local businesses</p> <p>Roll out information about carers employment rights to employees and employers in York - NEW YCC looking at good practice in Gateshead and roll out of similar in York. Liaison with CYC around 'Good Growth' agenda.</p>	<p>Last review March 2012 and this is no longer 'active'.</p> <p>Factsheet for employers produced</p> <p>Ongoing</p>	<p>Frances Perry CYC</p> <p>YCC</p> <p>YCC</p>	<p>Review all June/Sept 2014</p>

National Strategic Outcome Four -Mentally and physically well; treated with dignity

Outcome	What we need to do	Achievements	Lead officer	Action required
<p>Prevention: Carers should have access to appropriate medical advice, and support about their own health needs</p> <p>NHS: Carers needs should be addressed in hospital admission and discharge procedures</p> <p>Primary Care and GPs: Primary care professionals should identify carers ensuring appropriate support, signposting and referrals</p>	<p>Health commissioners and providers ensure greater consistency around identifying and addressing the needs of carers</p> <p>.</p> <p>Health commissioners will work towards ensuring that all care pathways provide guidance on the information and advice carers will need</p> <p>To engage with the new NHS Commissioning bodies (Clinical Commissioning Groups) as they develop to promote carers issues and build on existing work in Primary, Community and Acute Care</p>	<p>Vale of York CCG actively promoting carer awareness in GP surgeries.</p> <p>Back care project developed factsheets and a DVD: www.youtube.com/watch?v=dHxzxXoEeyM to support carers around back care and moving and handling</p> <p>No success in identification of Carers Lead in acute trust.</p> <p>Active engagement with Vale of York CCG. Decision in 2013 that health task group does not meet as current projects overseen by Carers Information Group.</p>	<p>Sarah Kocinski VOYCCG</p> <p>YCC and YCF</p> <p>Sarah Kocinski VOYCCG</p>	<p>PRIORITY Review actions and best way forward re health outcomes in light of BCF/health and social care integration</p> <ul style="list-style-type: none"> • April 2014

Emotional Support: Carers should have support to maintain their well being and reduce stress

Gap analysis did not produce useful information.

Work completed to confirm carer access to Mental Health Support line and clarify referral process.

Sarah Kocinski
VOYCCG

Review
April 2014

National Strategic Outcome Five				
<i>Children thriving, protected from inappropriate caring roles</i>				
Outcome	What we need to do	Achievements	Lead Officer	Action required
Universal services: Children have access to the support they need to learn, develop and thrive	Set up the Young Carers task group and action plan NEW Identify new lead from Children' Services and review membership of Task Group.	Task Group set up September 2011 but not met since 2012 due to long term sick leave of lead officer.	TBC CYC	Review April 2014
	Ongoing development of the work now established in schools which supports young carers http://ycrtinytreasures.wordpress.com/ Information about Primary School Project	Carers Card rolled out in X secondary school and Young Carers Revolution engaged in active work re Primary School Project.	CYC	
	Task group to consider York LINK report (March 2011) recommendation: 'Young carers should be given help to get home access to computers' NEW Support Young Carers Revolution to continue and develop	Not achieved.		

<p>Whole family support: Children and young people are protected from inappropriate caring.</p> <p>Young adults have access to appropriate advice in relation to their transition into adulthood.</p>	<p>NEW Ensure strategic links to implementation of Children and Young People’s plan action: <i>‘(25) Further identify, and respond to, the needs of young carers’</i></p> <p>Implement the Common Assessment Framework (CAF) as the assessment tool for Young Carers Assessment: PRIORITY</p> <p>NEW ensure successful monitoring of FEHAs and young carers</p> <p>Ensure adult services identify young carers in their assessment processes and paperwork</p> <p>NEW Monitor guidance re implementation of Children and Families Bill and Care Bill in young carers accessing assessments and support of whole family approaches.</p>	<p>CAF – ‘Family Early Help Assessment’ is the assessment tool. Monitoring initially not recording young carers</p> <p>Agreement that question to identify young carers is included in CAAT team first contacts</p>	<p>TBC CYC</p> <p>Ralph Edwards CYC</p>	<p>Link with YorOK Board’s work</p> <p>Monitor young carers assessments</p> <p>Promote progress in whole family working</p>
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Ensure effective sources of advice are available to young carers aged 16-18+

Promote support to all young adult carers

Successful development of young adults service at YCC and young adults network for professionals

Continue support of work with young adult carers.



Health Overview & Scrutiny Committee**2 July 2014**

Report of the Assistant Director Governance and ICT

Plans for alternative premises for Bootham Park Hospital and a vision for mental health services in York.**Summary**

1. This report presents the Health Overview & Scrutiny Committee with updated plans for alternative premises for Bootham Park Hospital together with proposals for the relocation of child and adolescent mental health inpatient services in York and the future vision of mental health services across York.

Background

2. The Care Quality Commission has deemed that Bootham Park Hospital (inpatient services for adults) and Lime Trees (inpatient services for children and young people) were no longer suitable for modern day mental health care and there was a need to vacate these premises as soon as alternatives can be found.
3. Patients are to move out of Bootham Hospital's wards 1 and 2 to Peppermill Court off Huntington Road. The Elderly Assessment Unit (ward 6), at Bootham will move to Cherry Tree House in Tang Hall. Inpatients at Lime Trees are to move into Mill Lodge in Huntington Road.

Consultation

4. Leeds and York Partnership NHS Foundation Trust has prepared the report at Annex 1 – Relocation of Child and Adolescent Mental Health Tier 4 Inpatients Services in York - and officers will be at the meeting to answer any questions Members may have. The Vale of York Clinical Commissioning Group will give a verbal report on the future vision for mental health services across York and the interim solutions for Bootham Hospital to date.

Analysis

5. The report at Annex 1 and the verbal presentation to the meeting are for information only.

Council Plan

6. This report is directly linked to the Protect Vulnerable People element of the Council Plan 2011-2015.

Implications

7. There are no implications associated with this report. The report from Leeds and York Partnership NHS Foundation Trust details some implications related to equalities issues, including wheelchair access, and these will be addressed accordingly.

Risk Management

8. There are no risks directly associated with this report.

Recommendations

9. The Health Overview and Scrutiny Committee are asked to receive and comment in the information provided in Annex 1 and the verbal presentation to be made to the Committee.

Reason: To keep the Committee informed on plans mental health services in York.

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Chief Officer Responsible for the report:

Andy Docherty

Assistant Director Governance and ICT

**Report
Approved**

Date 23 June 2014

Wards Affected:

All

For further information please contact the author of the report

Annex

Annex 1 – Relocation of child and adolescent mental health inpatient services

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Relocation of Child and Adolescent Mental Health Tier 4 Inpatient Services in York

1. Introduction

Child and adolescent mental health services (CAMHS) cover a wide range of services for young people up to the age of 18. About one in 10 young people will have emotional or behavioural problems at some time in their lives.

CAMHS is split into four tiers:

- The first three tiers are delivered in the community and provide a wide variety of assessment and support for mild to moderate mental health conditions. These range from common problems of childhood such as sleeping difficulties or feeding problems up to assessment of development or behavioural problems, autism, hyperactivity, eating disorders, depression and early onset psychosis. Services in Tiers 1 to 3 are commissioned by clinical commissioning groups.
- Tier 4 services consist of specialised day and inpatient units, where children and adolescents with more severe mental health problems can be assessed and treated. Tier 4 services are commissioned directly by NHS England specialist commissioners.

2. CAMHS provision in York and Selby

Tier 4 CAMHS is provided to young people up to the age of 18 in the York and Selby area by Leeds and York Partnerships NHS Foundation Trust (LYPFT).

The service is known as Lime Trees and is based in a building of the same name, which is located in the Clifton area of York. The building is owned by NHS Property Services. Whilst most service users are supported by the outpatient (community) team, which provides a range of assessment and treatment interventions including one-to-one, group and family therapy, some young people with severe conditions require more intensive assessment, care and support in an inpatient service.

Lime Trees provides mixed gender inpatient accommodation for up to nine service users. The majority of inpatients are female, which is in line with national trends. The most common conditions experienced by inpatients are anorexia nervosa (28% of cases) and self-harming behaviour (26%).

At present, demand for inpatient CAMHS beds for York and Selby is variable but at any one time there can be up to 14 service users who need an inpatient admission.

At Lime Trees only nine beds are currently available (with the unit having closed two of its beds at the request of NHS England due to the serious constraints of the physical environment of the unit). When demand is high, service users are admitted to other specialist units in other parts of the country and in some cases there is a waiting list for places.

In Yorkshire and Humber, up to 40% of patients are admitted to Tier 4 services outside of the region due to high demand for existing specialist services in the region. The closure of the two beds at Lime Trees will inevitably add more pressure on this.

3. Challenges of the current environment

The physical environment of the current Lime Trees inpatient building is not fit for purpose, and creates a number of challenges to the delivery of safe and effective care to children and adolescents requiring 24-hour care. LYPFT has, for some time, been working with NHS Property Services to find alternative premises for inpatient CAMHS at Lime Trees. The challenges of the physical environment were then highlighted in a recent (February 2014) Care Quality Commission (CQC) inspection report relating to the service, and have also required NHS England specialist commissioners to issue an agreed derogation against national standards for Tier 4 CAMHS services.

The latest CQC inspection report highlighted that generally the care received by service users at Lime Trees is good. They found the service to be fully compliant in meeting standards for:

- Treating people with respect and involving them in their care
- Providing care, treatment and support that meets people's needs
- Staffing (providing skilled staff and the appropriate staffing levels).

The CQC highlighted some very positive feedback in their report. They said:

- Staff were interacting with patients in a positive, respectful and caring manner
- There was documented evidence which demonstrated that patients were provided with written and verbal information about their rights
- Each patient had a comprehensive risk assessment in place which included exploitation, vulnerability, nutrition, social isolation, self-harm, aggression and violence
- Patients they spoke with told them they thought they were cared for well by staff and felt safe on the ward.

However, as a result of the challenges posed by the clinical environment, Lime Trees was only partially compliant against two required standards in the CQC inspection:

- People should be cared for in safe and accessible surroundings that support their health and welfare (outcome 10)
- The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care (outcome 16).

An inspection of inpatient facilities found a number of potential ligature (hanging) points in bedrooms and bathrooms, and the CQC noted that the ward did not have risk assessments in place to manage the ligature risks identified. In addition, the bedrooms were found to present a risk in enabling service users to barricade themselves into rooms, and there were concerns relating to adequate ventilation. These were identified as serious concerns that needed prompt resolution.

The CQC concluded that the building is not compliant with the Disability Discrimination Act (DDA) because the corridors and some rooms are not accessible for wheelchair users.

A number of issues relating to the provision of separate services for male and female service users also meant that the inpatient service was not compliant with the Department of Health Single Sex Accommodation (SSA) requirements, and the environmental layout may compromise the privacy and dignity of patients. The accommodation is such that the number of male inpatients is therefore limited to two at any one time.

A number of these concerns are equally reflected in the feedback given by both service users and families/carers as part of the annual Quality Network Peer Review process. Last year, the comments raised included concerns relating to the size and layout of the bedrooms, a lack of adequate visiting space, a lack of bathrooms, poor ventilation, and a general sense of the whole unit feeling very small and cramped.

Although a number of short-term actions have been taken to reduce the risks identified, it is fully agreed by LYPFT and NHS England specialist commissioners that the current unit cannot remain open due to the environmental challenges and an inability to ever fully comply with national standards and other legal requirements (such as the DDA).

4. Proposed solution

LYPFT has worked closely with NHS England specialist commissioners and NHS Property Services to identify optimum solutions for enabling Lime Trees to meet CQC standards and deliver high quality, safe inpatient care in line with national guidelines. Due to the urgency of the need to relocate the service, a current property was identified that could be adapted to meet the required standards, and this was proposed as a temporary interim solution.

LYPFT, NHS England specialist commissioners and NHS Property Services have therefore planned to relocate inpatient services to an alternative NHS building in the Huntingdon area of York. The Mill Lodge building is currently unoccupied, although was previously designated as a 20 bedded inpatient unit for older adults. Outpatient services will remain at Lime Trees.

Subject to refurbishment, the Mill Lodge building will provide suitable accommodation for young inpatients and will enable the service to:

- Increase bed capacity, which would reduce the number of local young people receiving their inpatient care out of the York area
- Develop a high dependency area as part of the inpatient service, which would enable the unit to care for more acutely ill young people
- Minimise ligature risk and make bedrooms, bathrooms and other facilities safer
- Make the inpatient wards single sex and improve dignity by introducing washing facilities in all the bedrooms and separate facilities for male and female patients
- Ensure that the service is wheelchair user-friendly and compliant with the DDA
- Provide more relaxation space and space for family visits, which is not currently available at the Lime Trees building
- Increase space at the Lime Trees building for outpatients and other community services.

Mill Lodge has previously received capital investment from the former North Yorkshire and York PCT and is therefore of a high internal and external standard already. By utilising this existing inpatient space, LYPFT will be able to reduce costs and make the best use of resources whilst ensuring a prompt transition to the new premises.

Based upon the work that has been undertaken to date to develop plans for Mill Lodge, NHS England specialist commissioners have given their support to a business case to proceed with refurbishment of the building; and we expect (a different part of) NHS England to give approval to the capital funding for the refurbishment shortly. A specification for the refurbished building – based upon the identified needs of the service user group and the national standards related to Tier 4 CAMHS units – has been developed, and is currently going to tender.

NHS England specialist commissioners have been clear that failure to implement an urgent resolution to the relocation of the service would inevitably result in a closure of the service; and a loss of a local Tier 4 CAMHS service to the young people of York and North Yorkshire.

5. Service user involvement

LYPFT and NHS England have been working closely with service users, families and staff to ensure that their views have assisted in – and continue to inform - the development of these proposals. Some current inpatients were involved in a site visit to the proposed new premises. During the visit the young people were very positive about the potential and in particular commented on the space throughout the unit, both internally and externally. They liked the fact that there would be better visiting space and more 'chilling out' areas. They wanted the lounge to remain as one room but liked the different zones in the room – a sense of being together but having some space apart. The young people advised on furniture choices and wanted a combination of sofas and chairs in the lounge, citing how challenging it feels in the current unit when everyone has to 'squash into the sofas' in the lounge.

In addition, a session was held with the York Youth Council, asking them to comment on the requirements they would want from an inpatient service. The general feedback included:

- Homely feel with a place to lock personal belongings
- Own bedroom and own bathroom
- Community area and opportunities to watch TV, read books, play games and listen to music
- Warm colours
- A safe place
- A gardening area to grow vegetables
- Stationery to keep a diary
- Good food (and possibly a tuck shop)

The feedback is being used to shape the plans for developing the Mill Lodge site; and young people and their families/carers will be invited back to further inform the next stage of the development, including the choice of colours used in the unit and the general look and feel of the decor.

6. Next steps

Assuming that the current specification for refurbishment is successfully tendered and the timescales anticipated within the work programme are achieved, the intention is for the Tier 4 CAMHS inpatient services to relocate to Mill Lodge by early November 2014. This will provide an interim solution to the environmental needs of the service. It is anticipated that the refurbishment project will cost around £1m inclusive of fees, contingency and VAT.

It was originally proposed that NHS Property Services might provide a new entirely fit-for-purpose development on the Lime Trees site at an estimated cost

of around £3m. However, due to both the urgency of the need to relocate the service and a planned national procurement exercise by NHS England for the provision of Tier 4 CAMHS this was not a viable solution in the short term. It is anticipated that this will need to be explored further, in particular depending upon the outcome of the national procurement process for Tier 4 CAMHS provision across Yorkshire and Humber.



Integrated Operational Plan 2014-19



Foreword

Dr Mark Hayes, Chief Clinical Officer

What will healthcare look like in five years from now? Will it be better and how would we know if it was?

In this plan we will try to answer these questions and to set out a clear vision for the future. We will draw upon the shared values of both patients and care givers, rallying them to the common purpose of creating a high quality and sustainable health and social care system.

We have spent the last 6 months in conversation with our community and we have learned about their priorities, wants and needs for a health and social care system. A number of interlocking themes emerged; such as services being involved and engaged with the patient at all times, ensuring care is coordinated across all community based services, continuity of care (including seven day working) and improvement in the provision of mental health services. There was also a desire to see the GP practice find a role at the centre of the health system of the future.

We have taken this knowledge and have used it to produce a plan that can deliver services to meet the aspirations of the community from within the available resources.

We have been actively researching various models of care provision both within this country and internationally. We have come up with a vision which we are describing as the “Care Hub Model”. We believe that with the support of our partner organisations we could develop this in a staged approach.

Whilst the model of ownership has yet to be finalized there are a number of possibilities under consideration including social enterprise, federated GP partnerships or hospital / GP partnership. However, the model is provided we believe that the most important task is to determine the nature of the services that will be offered. Once this is known we can think about the structures required to support the identified services.

The Care Hub (s) will serve a population of between 100,000 – 350,000, initially a virtual network based in existing premises, providing a comprehensive range of services including both health and social care. This will include an extended range of primary care services over a longer working day, seven days a week. Hubs may eventually provide the out of hours services, ensuring that continuity of care is maintained through a shared care record thereby reducing any unnecessary hospital admissions.

With the addition of community services and some out-patient services, the Care Hub will move towards merging primary care, secondary care,

community care and mental health and learning disability services into a single, integrated system of “care”.

Our partner organisations have given the CCG the role of system leader and working closely with them we have gained wide ownership of this plan. Conversations with partners have been important in laying out the scope of change that will be required across the system. From secondary care to primary care, community care to urgent care and from mental health to social care our partners are signed up to bring about this profound shift in the way that care will be delivered in the future.

There are a number of enablers that will support this change process in the future, including the potential to co-commission primary care with NHS England, the Better Care Fund across health and social care, and the promise of new and innovative funding mechanisms from NHS England.

There is a clear alignment of our plans with national requirements, more so than ever with the vision that Simon Stevens, Chief Executive Officer of the NHS England, has recently mapped out for local health systems. The levers and local flexibilities he advocates will provide additional momentum and focus on driving our plans for transforming integrated community and primary care.

As such we are currently bidding to be one of four national NHS Accelerate sites which would provide us with significant additional capacity and expertise to drive our integration pilots as well as trial some of increasingly innovative and sophisticated commissioning and contracting approaches.

The future offers us a range of possibilities and it is up to us to choose wisely. We believe that the plan we are presenting here is cohesive, deliverable and most importantly supported across our entire system.




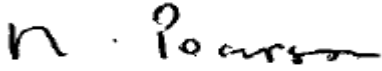




I am pleased to present our Five Year Strategic Plan and associated Integrated Operational Plans which map out how we are delivering the changes required to achieve a sustainable healthcare system for the future.



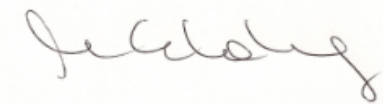
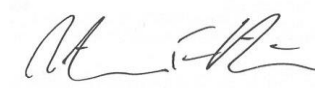


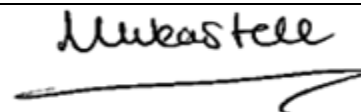
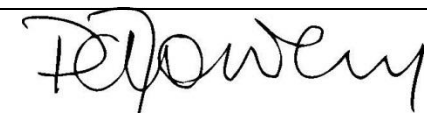

Our team, and our relationships with our key stakeholders, has never been stronger and our successes in 2013-14 provide us with a strong foundation for our challenging programme of work for the next five years.



Dr Mark Hayes
Chief Clinical Officer
NHS Vale of York Clinical Commissioning Group

Partners and Signatories*

Kersten England Chief Executive, City of York Council	
Linsay Cuninghame-Cross Chair, City of York Health and Wellbeing Board	
Jonathon Owen Chair, East Riding Health and Wellbeing Board	
Nigel Pearson Chief Executive, East Riding of Yorkshire Council	
Philip Morton Chief Executive, Hambleton District Council	P. Morton.
Richard Ord Chief Executive, Harrogate District Foundation Trust	
Richard Davies Chair, Healthwatch East Riding of Yorkshire	
David Ita Partnership Co-ordinator (Lead Officer) Healthwatch North Yorkshire	
Chris Butler Chief Executive, Leeds and York Partnership NHS Foundation Trust	

<p>Ian Gordon BDS MFGDP Chair, North Yorkshire Local Dental Committee</p>	
<p>John Crompton Chair, Local Medical Committee</p>	
<p>Liz Colling Chair, Local Pharmaceutical Committee</p>	
<p>Richard Flinton Chief Executive, North Yorkshire County Council</p>	
<p>Julia Mulligan North Yorkshire Police and Crime Commissioner</p>	
<p>Janet Waggott Chief Executive, Ryedale District Council</p>	
<p>Mary Weastell Chief Executive, Selby District Council</p>	
<p>Pat Crowley Chief Executive, York Teaching Hospitals NHS Foundation Trust</p>	
<p>David Whiting Chief Executive, Yorkshire Ambulance Service</p>	

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Who we are

NHS Vale of York Clinical Commissioning Group (the CCG) brings together all GP practices in the Vale of York area to enable patients and primary care clinicians to have a greater say in how health services are delivered locally.

On 1st April 2013, we officially became the statutory body responsible for commissioning the vast majority of healthcare services for patients across the Vale of York. This includes hospital care, mental health and community services.

Led by a number of local GPs and other health professionals, we work with the community and our local partners to understand the needs of our patients. We are dedicated to working with local people to ensure they have access to the right services, in the right place, at the right time.

Remit

Our main areas of responsibility are:

- Planned hospital care
- Urgent and emergency care
- Community health services
- Mental health and learning disability services
- Tackling inequality including children's health and wellbeing

CCG Structures

We are a membership organisation overseen by the **Council of Representatives**, comprising a member from each GP practice in the Vale of York. The work of the CCG is led by the **Governing Body**, which consists of:

- Chair (lay member)
- Chief Clinical Officer,
- 8 GPs, (6 Clinical leads and 2 representatives from the Council of Representatives)
- Chief Financial Officer
- Chief Operating Officer
- Additional lay member representation
- Practice Manager representative
- Secondary care doctor
- Chief Nurse
- 2 Directors from relevant local authorities

The Governing Body monitors and challenges the delivery of work across the CCG, quality and health performance outcomes for the residents of the Vale of York, financial and risk management.

To find out more about the CCG go to

<http://www.valeofyorkccg.nhs.uk/about-us/>

What We Do

In order to deliver our five year vision of “**Achieving the best health and wellbeing for everyone in our community**” our teams are working daily to drive four main activities:

<p>1. Quality assurance and improvement</p>	<ul style="list-style-type: none"> ▪ Ensuring patient safety first and foremost ▪ Delivering the NHS Constitution ▪ Performance improvement ▪ Patient experience and dignity ▪ Safeguarding ▪ Quality Premium ▪ CQUINs ▪ Seven day services ▪ Response to Francis, Berwick and Winterbourne Review ▪ Compassion in practice ▪ Staff satisfaction 	<p>3. Improving outcomes (Our five year ambitions)</p>	<p>Meeting our local trajectories and targets (health and quality outcomes) Meeting our local priorities Meeting our Better Care Fund Measures Tackling health inequalities Addressing unwarranted variation</p>
<p>2. Financial sustainability</p>	<ul style="list-style-type: none"> ▪ Ensuring value for money ▪ Delivering productivity improvements and savings which contribute to our financial target Quality, Improvement, Productivity and Performance plans (QIPP) ▪ Prioritisation of funding and cost pressures ▪ Investment 	<p>4. Transforming services (Our five year strategic initiatives)</p>	<ol style="list-style-type: none"> 1. Integration of Care 2. Person-centred care 3. Primary care reform 4. Urgent Care reform 5. Planned Care (Productive Secondary Care including specialised services) 6. Transforming Mental Health and Learning Disability Services (and achieving Parity of Esteem) 7. Children’s and Maternity 8. Cancer and End of Life Care

Laying the Foundation: Key Successes in 2013/14

The first year of the CCG's existence has seen the foundations for future success being laid down with the achievement of some fundamental objectives, including:

- CCG received full authorisation
- Achieving financial turnaround
- Provision of a Section 136 Suite to provide a place of safety for people with mental health needs
- Investment in autism assessment services
- Work with Neurological Commissioning support to improve services to patients
- Development of a new community model of Diabetes Care in partnership with patients and Hospital clinicians
- Development of a Referral Support Service to support primary care in the way they refer patients for on-going treatment and to standardise referral guidelines
- Development of collaborative working across primary care to improve links between practices and opportunities to develop services
- Improvement in relationships between the commissioner and partner organisations, in particular providers and Local Authorities (as evidenced through the 360 Stakeholder Survey)
- Excellent engagement strategy and programmes embedded within every piece of work undertaken
- Development of a great CCG team that has innovation and improvement embedded as core values
- Strengthening of assurance gained from internal and external audit
- Clinical engagement and support for the Care Hub future model of care
- Strong aligned and jointly agreed goals for Integration across health and social care via the Better Care Fund and establishment of a number of integration pilots to test the vision
- Collaboration and common purpose across both our local Unit of Planning and wider planning footprint, which are driving our improvement interventions, QIPP initiatives, the Better Care Fund and specialised services commissioning
- Clear patient navigation and access to range of interventions with patients empowered and engaged across all their needs and the system
- Working collaboratively with primary care to improve services and redesign pathways
- Review of neurology pathways and development of community based pathways to support care closer to home
- Establishment of an Urgent care working group with representation from all key partners to implement system-wide solutions to managing demand in urgent care services

Already in early 2014-15 we are building further on this foundation with:

- All our contracts agreed with our providers, including Service Development Improvement Plans which map out the programmes of review and transformation
- Recommencing IVF treatment
- £290,000 of additional funding for delivering IAPT services
- Additional CCG experts to scope and drive transformation and address core areas such as ensuring safeguarding and focusing on patient experience
- Commencement of the redevelopment of mental health inpatient unit at Bootham Hospital (interim solution) by Leeds and York Partnership Foundation Trust
- Further engagement with voluntary sector as a critical enabler for delivering our transformation programmes
- Development of a CCG prioritisation framework to support challenging decision-making
- Ensuring all our service developments and transformation work can demonstrate VFM and clear impact of on improving health outcomes and/or addressing health inequalities and parity of esteem
- Roll out of improvement training and support for primary care to develop services



Vision, Mission and Values

Our Vision

“Achieving the best health and wellbeing for everyone in our community”

Our Mission

- Commission excellent healthcare on behalf of and in partnership with everyone in our community.
- Involve the wider clinical community in the development and implementation of services.
- Enable individuals to make the best decisions concerning their own health and wellbeing.
- Build and maintain excellent partnerships between all agencies in Health and Social Care.
- Lead the local Health and Social Care system in adopting best practice from around the world.
- Ensure that all this is achieved within the available resources.

Our Values

- **Communication** – Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.
- **Courage** – We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.
- **Empathy** – We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.

- **Equality** – We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality.
- **Innovation** – We believe in continuous improvement and we will use the creativity of our stakeholders and staff.
- **Integrity** – We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.
- **Measurement** – Successful measurement is a cornerstone of successful improvement.
- **Prioritisation** – We will use an open and transparent process to arrive at value driven choices.
- **Quality** – We strive to be the best that we can be and to deliver excellence in everything we do.
- **Respect** – We have respect for individuals, whether they are patients or staff colleagues; we respect the culture and customs of our partner organisations.

Our Health and Wellbeing Principles

The CGG also forms part of our three local **Health and Wellbeing Boards** and as such we are committed to delivering our plans in line with their main principles. Our City of York Council principles are outlined below:

1. Making York a great place for older people to live
2. Reducing health inequalities
3. Improving mental health and intervening early
4. Enabling all children and young people to have the best start in life
5. Creating a financially sustainable local health and wellbeing system
This last principle is the over-arching aim of this five year strategic plan.

Our Objectives

People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life.

People will have more opportunities to influence and choose the healthcare they receive and shape future services.

People will continue to have good access to safe and high quality healthcare services.

When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible .

Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life.

When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.

A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services.

High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.

A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.

Access to world class highly complex and specialist care provided through specialist centres across the country.

Opportunities for accessing and leading research to improve healthcare systems for all.

Equality

Equality is a core principle of the NHS Constitution and embedded into the Health and Social Care Act 2010. What is more, as a public sector organisation we have a duty under the Equality Act 2010 to promote equality, eliminate discrimination and foster good relations.

For more information please see our Equality, diversity and Human Rights strategy and implementation Plan 2013-2017, which is available on our website at <http://www.valeofyorkccg.nhs.uk/about-us/equality/>

Our equality objectives are:

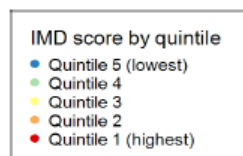
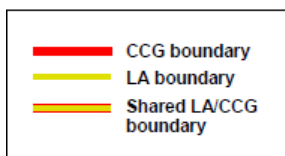
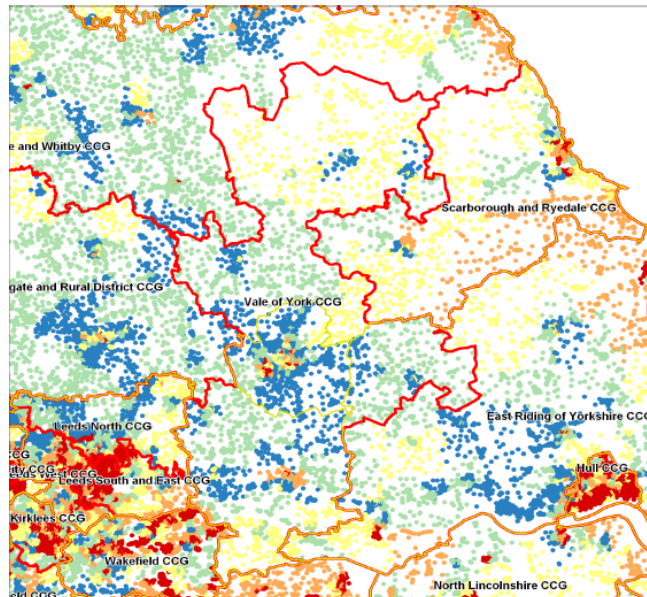
1. To provide accessible and appropriate information to meet a wide range of communication styles and needs
2. To improve the reporting and use of equality data to inform equality analyses
3. To strengthen stakeholder engagement and partnership working
4. To be a great employer with a diverse, engaged and well supported workforce
5. Ensure our leadership is inclusive and effective at promoting equality



The Vale of York

Our Geography

We represent patients registered with 32 GP Practices located in places such as York, Selby, Tadcaster, Easingwold, Pocklington and parts of Ryedale. Through these GP practices we represent a population of 336,330 residents.



The population is comparatively affluent; however, there are pockets of significant deprivation in parts of York and Selby and surrounding Sherburn-in-Elmet. We cover the urban city centre and rural surrounding areas, the complexity of working across different partner agency boundaries and geographic areas requiring a flexible approach to the provision of services across the area.

Our partners

We span 3 local councils, North Yorkshire County Council, City of York Council and East Riding of Yorkshire Council and work to three Health and Wellbeing Boards for each of these local authority areas. We work closely with NHS England Direct Commissioning (covering GPs, Pharmacies and Dentists), Public Health England, NHS England Specialist Commissioning, our neighbouring CCGs as well as our local Partnership Commissioning Unit (PCU) who commission mental health, learning disability services and children's services for our population.

Collaborative Improvement Board

To achieve the degree of change necessary all key partners and stakeholders need to work together in a 'whole system' approach to meeting the needs of the population within the resources available across the whole local health and social care system.

We have successfully initiated a high level Collaborative Improvement Board consisting of the Executive Directors of the York Hospitals Foundation Trust, East Riding CCG, Scarborough and Ryedale CCG and

Vale of York CCG to ensure alignment of commissioning for the majority of patients attending the shared acute provider, York Hospitals Foundation Trust.

The Collaborative Improvement Board has an agreed set of shared objectives and commits the partner organisations to close collaborative working to transform services across the health and social care system to deliver sustainable change to achieve maximum benefit for its populations.

Strategic Collaborative Commissioning Groups

We work closely with the other three 'North Yorkshire' Clinical Commissioning Groups and all the CCGs across North Yorkshire and Humber through two strategic collaborative commissioning groups. Through these arrangements we set out lead commissioners and risk-share arrangements to commission services for our local populations.

Urgent Care Working Group

We work in partnership through the Urgent Care Working Group to manage demand and capacity within the urgent care system. The group comprises representation from Vale of York, Scarborough and Ryedale and East Riding CCG's; Yorkshire Ambulance Service; City of York Council and North Yorkshire County Council; Mental Health Trusts from Tees, Esk and Wear Valley and Leeds and York Partnership Foundation Trust; Healthwatch and NHS England. This group leads on the implementation of the Urgent Care Strategy and the improvements set out in the Improvement and Intervention section.

Providers

There is one main provider of hospital and community care (York Teaching Hospitals Foundation Trust) and one main provider of mental health services (Leeds and York Partnership Foundation Trust). Specialist healthcare services are primarily provided by Leeds Teaching Hospital for our area. The population is also served by the Yorkshire Ambulance Service and a range of other public, private, voluntary and independent health care providers across the range of services.

Specialist Services

National thinking around hospital based care has been influenced through high profile reviews such as the Keogh review of Mid-Staffs, and the Berwick and Cavendish Reviews. In his review of hospital services Sir Bruce Keogh recommended that serious or life threatening care should be delivered from centres of excellence, with the best expertise and facilities to maximise chances of survival and recovery. This has led to national recommendations moving towards commissioning of serious, life-threatening emergency care and rare services from centralised locations to ensure clinical and cost efficiencies are maximised.

Examples in the North Yorkshire and Humber region of centralised services include major trauma, procedures relating to Primary Percutaneous Coronary Intervention and vascular interventions already commissioned through specialist commissioned services.

Major Trauma Centres in the area are shown below:



James Cook University Hospital	Adult and Children's
Hull Royal Infirmary	Adult
Leeds General Infirmary	Adult and Children's
Sheffield Children's Hospital	Children's
Northern General Sheffield	Adult

Locally the Specialised Commissioning Team is undertaking consultation to establish their five year plan which is due to be published by the end of spring. Within the priorities being consulted on there is focus on the following:

- Complex Cardiology Services, with the view to full scale reconfiguration
- Morbid obesity surgery where there is a need for CCGs to commissioning Tier 3 weight management services to support this priority and in line with the national requirements Vascular Surgery

Commissioning Support

We are supported by the North Yorkshire and Humber Commissioning Support Unit, who provide a range of 'back office' functions and clinical policy support for the CCG. We also work in collaboration with our neighbouring North Yorkshire CCG's on areas, including Continuing Health Care, Mental Health and Learning Disability, Children's services and both children's and adults safeguarding through the Partnership Commissioning Unit (PCU). We work closely with these partners to meet the health needs of our population.

Demographics

Our population is comprised of 51.3% women and 48.7% men, with a higher proportion of people over age 50 than the national average and a significant transient student population (30,000 swell). Over the next five years we anticipate that our population will grow by 3.9% to 356,360 people; within this we expect that the percentage of people over 65 will increase by 10% and the percentage of people over 85 will increase by 18%. As we celebrate people living longer, we need to ensure that we have planned to meet their more complex needs and support quality of life in the later years.

In the 2011 census, 9% of our population reported that their day to day activities are a little bit limited by their health and 6.8% of people report that their day to day activities are limited a lot by their health. This shows that

for many residents (approx. 53,000) managing health conditions can be an issue.

The population is majority white British (95%) and report their religious beliefs as Christian (64%) or of no religion (26%). The Vale of York has a number of other significant ethnic groups including, Asian (2.2%), mixed race (1%), black (0.4%) and travellers and Roma Gypsy communities. There is also a diverse range of religious beliefs, including Muslim (0.7%), Buddhist (0.4%), Sikh (0.1%) and Jewish (0.1%). We need to plan effectively for the different cultural, social and health needs of our community to everyone to achieve the best health and well-being.



The Case for Change

NHS Call to Action

The national 'Call to Action' identified that the current investment levels and growing population may lead to a £30billion funding gap nationally. This is being driven across all CCGs by:

- the challenge of an aging population – we now look after more pensioners than children
- the growing challenge of obesity, dementia and multi-morbidity (the co-occurrence of two or more chronic medical conditions in one person)
- more expansive and more expensive treatments

To ensure the sustainability of the NHS we need to work across our community and local partners to do things differently and to transform the current system. The transformation of services will include the 6 characteristics of a high quality and sustainable system outlined by NHS England in its planning framework 'Everyone Counts: Planning for Patients 2014-15 to 2018-19'.

This five year plan clearly identifies how we will address each of these areas:

- Citizen inclusion and empowerment
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

The CCG's delivery against these areas will be monitored and assured by NHS England quarterly and the assurance reports are available on the CCG website.

Our Local Population Needs

Joint Strategic Needs Assessments (JSNAs) outline a range of performance information, quality outcomes, financial data and feedback from the local population.

We use these <http://www.healthyyork.org/lifestyles-in-york/alcohol.aspx> and <http://www.nypartnerships.org.uk/index.aspx?articleid=26753> to understand the health needs and issues for the Vale of York. These are compared to other similar areas in the UK to help prioritise work and drive improvements in health across the local area.

The four key points that emerged from the JSNA 2014 were:

- Our population is ageing and will place increasing demands on health and social care services
- Health and wellbeing inequalities exist in the city and must be tackled
- We need to know more about the mental health needs of our population
- The importance of intervening early and give children and young people the best possible start in life

Successes and things working well

The CCG and local providers performs better than the national average on a range of services and outcomes. Compared to the average for England, our population reports:

- Greater patient satisfaction with their GPs
- A higher quality of life for people with Long Term Conditions (LTCs)
- More people feel supported to manage their condition
- The health and wellbeing of children and young people is better than the England average

Overall the population is comparatively healthy, the CCG area scores significantly better than the England average on 18 out of the 32 national health indicators. None of the areas commissioned by the CCG perform significantly worse than the England average. Particular areas of success for Vale of York CCG compared to the England average are:

- Fewer emergency admissions for alcohol related liver disease;
- Fewer unplanned admissions for asthma, diabetes and epilepsy in under 19s;
- Fewer emergency re-admissions within 30 days.

Overall the performance is robust against the commitments in the NHS Constitution, which includes the national timescales for access to treatment and appropriate care.

We have also seen significant organisational improvements in our first year of operation. We have had our conditions and directives from CCG authorisation removed and achieved a balanced budget after years of historical deficit in the local area. We are leading a collaborative approach to service improvement and have strong clinical engagement in all areas of our work. We have grown our staffing capacity, including apprenticeships and development opportunities for clinical trainees.

Areas for improvement

Despite the successes, there are some areas where we have lower outcomes than comparator and the national average. These areas are:

- Higher mortality rate for those with cancer under 75 years of age;
- Higher emergency admission for children with lower respiratory tract infections;
- The Selby area scores significantly worse than the England average for adult obesity;
- Higher than average spend on emergency admissions than comparators and national average;
- Higher than average growth in the number of emergency admissions than comparators and national average;
- Faster than average growth in the number of GP referrals to services than comparators and national average;
- Higher than average disease prevalence on Depression, Atrial Fibrillation, Dementia, Cancer, Hyperthyroidism, Stroke and Coronary Heart Failure;

- Top 20% of 55 ONS comparators for spend on Circulation, Neurology;
- Number of bed days for mental health problem significantly higher than average (England value: **4686**, Vale of York: **4976** per 100,000 population);
- People in contact with mental health services Significantly Higher than average (England value: **2176**, Vale of York: **2345** per 100,000 population);
- Carers of mental health clients receiving of assessments Significantly Lower than average, England value: **69**, Vale of York: **31%**).

We recognise that there are areas where current performance against the NHS Constitution commitments could be improved and strengthened, including:

- The prevalence of healthcare acquired infections (e.g. MRSA, C.difficile);
- Ambulance response and turnaround times;
- Accident and Emergency waiting times;
- Access to psychological therapies (IAPT);
- Cancer waiting times;
- Delayed transfers of care;

The CCG and its providers work closely to address any pressures on capacity in different care areas during each year and new System Resilience Groups are currently being established to ensure there is sufficient capacity for our population throughout the year in order to meet all NHS Constitution targets.

The services we have, as well as investment required for new treatments and services, also create financial pressures. The cost of healthcare activity in-year can exceed the planned budget and we are working hard to change this situation to make our services sustainable in the future.

Engagement and Collaboration

Listening to our Community and Citizens

Patients, carers and the public are at the heart of health services and we are committed to the philosophy of 'no decision about me - without me'. Delivering a sustainable and successful NHS in the local area is a collective challenge, and we will work with the public to put them at the centre of their care.

Engagement is at the root of everything we plan and do and our stakeholders have reported that our engagement is 'excellent'. We are committed to working in partnership with patients and the public to co-design changes in the health and social care system, and have a wide ranging engagement programme.

The CCG has a now well-established a platform to engage with the Vale of York community called '**Let's talk health**' which allows everyone to contribute to the conversation and be heard. Details of forthcoming engagement events are available at <http://www.valeofyorkccg.nhs.uk/get-involved/> .

Our improvement interventions and comprehensive engagement with public, patients and stakeholders including clinical leadership from both our GPs and provider. We recognise that partnership working in all our interventions will be critical to success.

We work closely with Healthwatch organisations in our local area, and have held a number of joint engagement events on a wide range of health issues. A lay member for the CCG Governing Body is currently being co-opted from Healthwatch to further strengthen our focus on empowering our citizens in all our delivery and governance.

Our work with Healthwatch is supported by a more formal engagement structure through the Patient and Public Engagement Steering Group (PPE), Patient and Public Groups (PPGs) in primary care with LAY representation. The Chairman of the Governing Body provides the lead for engagement on the Governing Body. During our first year we have taken different approaches to engagement, including forum events, world café sessions, open space events and online consultations on service improvements including diabetes, mental health and out of hours.

In 2014-15 we also want our local citizens to undertake a greater role in making challenging decisions alongside us and we are currently considering how our new prioritisation framework can be used by citizens with the CCG to support decisions around investment and commissioning.

Throughout the development of this plan we have reviewed consultation information, held workshops on specific conditions and held local engagement events.

The Vale of York community has told us:

'We only want to tell our story once'

'Care needs to be individualised to match our needs'

'To improve support for patients, services need to communicate better'

'We need more open access GP appointments'

'It would be better if regular services could be provided in the community'

'We want more time with consultants'

'We want to wait less time for our hospital treatment'

'We need to be provided with reliable, relevant information to allow us to make informed decisions, particularly about our medications'

'Carers need to be considered and included'

'Mental health needs to be a main focus'

The full detail is available in the Annex 3 'You Said, We Did' including a summary of key stakeholder engagement activity the CCG has undertaken to date and some patient feedback from specific care areas which is guiding the improvement and transformation work we are now delivering and gives a clear vision of where we need to be in five years time.

We are currently undertaking a significant engagement programme to support the review of mental health services that is underway and which

will inform the future procurement of our mental health and learning disability services.

DISCOVER!

28th April 2014 saw the launch of the DISCOVER! engagement programme. DISCOVER! is designed to support and complement existing engagement processes, bringing together stakeholder views from all sources to inform commissioning decisions – initially around mental health. The intention is to work with existing communications colleagues, service users, carers and relevant stakeholders to establish a new approach to engagement around mental health, ensuring that the people we serve have a real voice at all stages of the commissioning cycle.

The need to understand better the mental health needs of our population is critical. The launch event was attended by representatives from the CCG, Leeds and York Partnership FT, the local authority and voluntary sector organisations, MIND and Converge.

The intentions were to:

- Build a shared approach and shared sense of purpose for engagement across the 4 CCG localities.
- Develop the skills, capabilities and behaviours which will support a relational approach to engagement.
- Learn about how to lead this kind of engagement in our CCG Localities and use learning to develop a sustainable future approach.
- Generate immediate feedback about what matters to patients, carers,

service users and communities about mental health to help shape 2014 commissioning decisions.

- Generate feedback about mental health and about maternity services.

Using an Appreciative Inquiry approach, DISCOVER! is focusing upon the question “**What is your best experience of mental health services and what is your dream for how we can do more of that?**”

During June themed café-style events have taken place, one focusing on dementia and the other on general mental health. In between events, work has continued with the DISCOVER! network to gather further intelligence from as many places as possible. This will be developed into themes and fed back to the community and everyone involved in the DISCOVER! programme.

The CCG has also recently:

1. Recruited a **Patient Experience Lead** who will monitor the results of the Friends and Family test and Patient Experience information, and work with Health Watch, the CCG communications and engagement team and CCG clinicians to roll out the test in other areas (e.g. primary care) using digital technology
2. Started to develop clinical soft intelligence to further triangulate patient concerns within the economy.

Planning in collaboration with our commissioning partners

This Five Year Plan is based around a geographical footprint now commonly known as the CCG ‘Unit of Planning’ which includes all our providers, our commissioning partners in Leeds, East Riding, Scarborough and Ryedale and Hull; our three local authorities in City of York Council, East Riding County Council and North Yorkshire County Council, as well as the NHS England (NHSE) Direct Commissioning team in relation to the commissioning of specialised services, primary care and veterans care.

There is joint system-wide leadership across this Unit of Planning through a variety of collaborative groups supporting our programmes and all local CCGs in the North Yorkshire and Humber region including:

- Health and Wellbeing Boards of City of York, North Yorkshire and East Riding of Yorkshire
- Mental Health and Learning Disabilities Partnership Board
- North Yorkshire Collaborative Transformation Board
- City of York Collaborative Transformation Board
- Collaborative Improvement Boards for York, East Riding and Scarborough and Ryedale CCGs (CIB)
- Integrated commissioning group (NYCC)
- Collaborative Transformation Group (CYC)
- Strategic Collaborative Commissioning Group (all local CCGs)
- Urgent Care Working Group (alongside the emerging Systems Resilience Group)

- Safeguarding Children Boards for City of York, North Yorkshire and East Riding of Yorkshire
- Safeguarding Adults Boards for City of York, North Yorkshire and East Riding of Yorkshire
- PPE Steering Group
- Healthwatch Assembly – York
- Local Dental Committee
- Local Ophthalmic Committee
- Police and Crime Commissioner

These represent highly effective and inclusive membership and the result has been increasingly aligned plans and joint work programmes. We welcome more and more collaborative work being led across more than one CCG where there are benefits to planning and redesigning models across this wider footprint, and to achieve economies of scale and deliver change at pace.

We work closely with the NHS England Area Team in relation to assurance as well as improvement planning when focusing on managing issues in the system or misalignment in planning between CCGs and providers. There is a high level of transparency and mutual support in addressing areas of significant challenge and mitigation.

There is also continuous engagement and planning with NHSE around services which they direct commission:

Primary care: the CCG is working closely with Area Team to deliver the transformational programme for primary care reform. The CCG has clearly indicated its interest in co-commissioning primary care with NHS England from 2014-15, including opportunities around community dentistry, community pharmacy and ophthalmic services which would support the delivery of the Care Hub Approach. This would include workforce planning and estates infrastructure required to deliver primary care at a greater scale in the future.

Public Health (with Public Health England [PHE] and our local authorities): delivering national immunisation and screening programmes; children's services years 0-5 and the healthy child programme (family nurse partnerships, health visiting, school nursing); there is also currently an on-going re-procurement of the 5 to 19 year old service across two of our local authorities.

Military health: the CCG is working with the Area Team to improve care co-ordination for military staff upon discharge, particularly access to specialist mental health services (IAPT, crisis services, post-traumatic disorder services) and ensure a Care Programme Approach is adopted between services and clear sign-posting to appropriate services. This will enable us to deliver our Armed Forces Community Covenant for York and to ensure equitable access for our military and veterans.

Offender Health: all services for offenders in custody including public health programmes.

Specialised services: the CCG is working closely with NHSE, York Teaching Hospitals NHS Foundation Trust and the Academic Health and Science Networks to understand and embed the implications and requirements from the Specialised Services Commissioning Operational Plan for 2014-16.

The national Planning Framework outlines a drive to deliver specialist services from a smaller number of centres of excellence in order to ensure high quality and more cost effective services. The aim of all partners is to ensure that there is no destabilisation of any service or provider and that the CCG can respond to the requirements of the commissioning plans rapidly this year to ensure all our transformation work captures the key issues.

There are a number of specific issues (including consistency in standards of care, clinical sustainability, financial sustainability, derogations from national service specifications) across a range of specialist services identified for our providers in York, Leeds, Sheffield and Hull which we are currently discussing:

- Hyper-acute stroke
- Neuro surgery
- ENT
- Children's surgery
- Children's centres and neonates
- Cancer (sarcoma)
- Major trauma
- Complex disability equipment
- CAMHS Tier 4

Planning and transforming services in collaboration with our providers

We recognise that partnership working in all our interventions will be critical to success and every improvement intervention includes dedicated clinical leadership for each intervention from both our GPs and provider. The CCG works closely with its providers to agree changes, plan and transform services as required, whether that is short-term action planning, identification of cost improvement plans, or undertaking fundamental service review and redesign work, including the retendering of services.

The CCG is committed to working with our current providers to strengthen their organisational health and sustainability, recognising their own specific organisational challenges and ensuring alignment in both current and future transformational plans. To this end there are regular discussions with providers through Board-to-Board sessions, Executive team meetings and at Contract Management Boards, as well as the many joint working groups established across the area driving specific improvements.

The **Urgent Care Working Group** has been highly effective in driving the national urgent care agenda locally. The new emerging Systems Resilience Group will build on this established group to plan and commission the appropriate volumes of activity required in both unplanned and planned care services throughout the year.

The contracts with our main providers have now been agreed and there is on-going discussion to agree the set of service developments and improvements which impact on our providers over the period of the

contracts and beyond, and which will require joint working and delivery. These will be captured in a Service Development Improvement Plan (SDIP).

Joint working is already well-established between the CCG and **York Teaching Hospitals Foundation Trust** with the Trust leading one of the integration pilots as part of the Care Hubs approach. There is also joint work on-going to address delivery of a joint medical and surgical assessment pathway.

Likewise, the CCG is actively supporting the redevelopment programme for Bootham Park Hospital inpatient accommodation and the review of mental health and learning disability services with **Leeds and York Partnership Foundation Trust** and our **Partnership Commissioning Unit**.

Voluntary Sector partners: we recognise the huge contribution that the voluntary sector plays in supporting the community and services to optimise outcomes for patients and their families. The role of the voluntary sector will become increasingly important as we move towards more integrated care pathways and service provision. The CCG is committed to continuing and developing our partnerships with the voluntary sector and further exploring how the services they offer may complement and enhance provision in line with our strategic plans.

We will work closely with providers in the voluntary sector to ensure all our initiatives consider the opportunities for voluntary sector to support and deliver change and future services. Indeed these organisations are sometimes critical to delivering the capacity required in the system, for

example we are exploring how the voluntary sector can help us improve access to IAPT services and transport home from hospital. Nationally some of the voluntary organisations are driving some of the most innovative approaches to care and access, something which the CCG wants to enable and embed within its improvement interventions.

Carers: there are around 7 million Carers in the UK, saving the state approximately £119bn – this equates to one in ten of the population. Supporting Carers' wellbeing is in everyone's interests and can benefit the people being cared for, reduce overall spending in the NHS and help commissioners meet required outcomes. It is therefore important for the CCG to continue to recognise and support Carer's through actively engaging with them and by ensuring health professionals know how to identify a Carer and signpost them to appropriate services. Consideration of the role of carers and embedding a carer strategy will be considered by every improvement intervention.

Planning and transforming services in collaboration with our practices

Almost every Strategic Initiative and improvement intervention we are working on has an impact for primary care or requires our GPs and practices to refer or deliver care in a different way in the future. This will require practices to consider extending and expanding the scope of their general and enhanced services, and potentially partnering with a range of other stakeholder organisations in order to respond to new service tenders and opportunities such as Care Hub(s).

The CCG is working very closely with primary care to ensure practices understand and can contribute to all transformational initiatives, and is working to support any development needs which will help practices to use or deliver future services. Improvement and transformation support is being aligned to groups of practices through the establishment of Improvement Hubs which will support practices with understanding activity and data, highlight any variation in practice and allow practices to test and implement new pathways of care.

The development of providers and potential future partners to ensure there is sufficient capacity for market readiness is a significant enabler for delivering our integration programme. Ownership of new service models by our community of general practices is critical to the success of our transformation.

Our ambitions for the next five years

NHS Outcomes

We are committed to delivering the NHS Outcomes Framework, which sets out five areas of focus for all NHS commissioners:

- Preventing premature death (mortality) [Potential Years of Life Lost or PYLL];
- Improving quality of life for people with long term conditions;
- Supporting quick recovery from ill health;
- Ensuring a great experience of care;
- Ensuring safe care.

Over the past year we have worked closely with our partners to in the three Health and Wellbeing Boards on which we sit to address the key health issues we face. We have utilised the abundance of information in the Joint Strategic Needs Assessment documents to help prioritise potential programmes of work and will continue to do so. Understanding the determinants of ill health and monitoring the relevant indicators which measure our population's health and well-being are now captured in all our programmes of work and monitoring and reporting frameworks.

Reducing health Inequalities

Preventing ill health and targeting health inequalities is a priority for the Vale of York. We know that across the Vale of York there are significant differences in life expectancy for men (and women to a lesser extent) depending on where they live, and that for certain groups, access to

services can be more challenging¹. As a result outcomes are lower than the comparators in some areas, for example children's emergency admissions for lower respiratory tract infections and tooth decay in the under 3's.

We also work closely with the Health and Wellbeing Boards to address the wider determinants of health and target interventions for greatest impact on health inequalities. These include promoting mental health, economic well-being and housing reforms to reduce the health impact of poor quality housing.

Some examples of our current improvement interventions which are addressing key local health inequalities include reducing emergency admissions (urgent care – Emergency Care Practitioners, liaison psychiatry), frail elderly (integration/ Care Hubs) and neurology (Planned Care).

Our Care Hub model is a key enabler to reduce health inequalities, bringing together health and social care colleagues to assess and support an individual's needs holistically and provide a consistent single point of access for care.

¹ The CCG is also responding to the recommendation from the JSNA to work with local service providers to ensure that they record information on protected characteristics about their staff and clients / patients such as age, disability, gender re-assignment, marriage and civil partnership, pregnancy / maternity, race, religion and belief, gender and sexual orientation, in order to inform service provision to reduce health inequalities. Link: [http://www.healthyork.org/the-population-of-york/specific-population-profiles/lesbian,-gay,-bisexual-and-transgender-\(lgbt\)-population.aspx](http://www.healthyork.org/the-population-of-york/specific-population-profiles/lesbian,-gay,-bisexual-and-transgender-(lgbt)-population.aspx)

Each of our improvement interventions outlined in the next section clearly indicate which local ambition or priority they are driving.

Parity of Esteem

A mental health problem increases the risk of physical ill health -currently, men with a severe mental illness die on average 20 years earlier than other people; women 15 years earlier. Patients with a mental illness have higher rates of cancer, heart disease, respiratory disease and diabetes. Additionally, they have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is by people with mental health problems. The outcome indicator for parity of esteem is reduction in premature mortality.

The development of mental health services and addressing local inequalities is a significant priority for the CCG. As such, consideration of all opportunities to develop the access and quality of mental health services provision, as well as improving the physical health of patients with mental health conditions when developing other care pathways is embedded within the operational plans and improvement interventions of the CCG.

Commissioning for Prevention

Led by colleagues in Public Health, both within Public Health England and in our three local authorities, the CCG supports a range of screening and vaccination programmes and targeted work to tackle the particular health

issues for our population, these include programmes to support weight management, promote breastfeeding, reduce teenage pregnancy and smoking cessation, for example through the 'Stop before your Op' campaign and delivering the new local Alcohol Strategy.

We will also support national and local campaigns to improve health awareness, and through the Care Hub approach seek to provide and embed increased access to advice and support within communities on health promotion.

During 2014-15 the CCG will work with local partners through the Health and Well-Being partnership groups and Children's Trusts to implement targeted programmes in key areas:

- reduce smoking prevalence;
- excessive alcohol consumption (including binge drinking);
- reduce obesity levels (with a particular focus in Selby), and
- a review asthma prevalence using the five steps recommended in the national 'Call to Action Commissioning for Prevention' report².

-
- I. Analyse key health problems
 - II. Prioritise and set common goals
 - III. Identify high impact programmes
 - IV. Plan resource
 - V. Measure and experiment

Work with the Yorkshire Police, Lord Majors Office and in conjunction with business partners across York has seen the CCG join the 2014 Challenge Campaign to provide children across York with the knowledge to manage their health through promoting weight management, mental health and exercise. This will commence in the Summer 2014 and we will work with the Police and the children involved.

Cancer prevention, diagnosis and treatment is also a focus for this CCG with a dedicated work programme currently being established that can respond to some of the key requirements and improvement recommendations from the York Cancer Network. Cancer prevention will be supported through the promotion of smoking cessation and healthy eating, and during the initial plan period we will undertake a review of our cancer pathways, in conjunction with primary care and specialist commissioning to ensure we have timely and effective routes to support diagnosis and treatment.

This will be supported by the following key screening campaigns commissioned by Public Health England which will have local implications for the CCG and local authority, including significantly:

- Bowel screening Sigmoidoscopy at 5five years;
- Additional new-born screening;
- The transfer of Health Visitors commissioning responsibilities to Local Authority;
- Maximising the immunisations programmes delivered by school nursing;

Delivering for the Vale of York – setting trajectories for improvement

We want to ensure that the current services are not only sustainable, but are enhanced and have a positive impact on people's lives.

In order to drive these improvements and know that we are making a difference the CCG has there set challenging local targets for improvement against key health and quality outcomes and address health inequalities. These **Trajectories (or Ambitions)** are mapped out through to 2018-19 and we are working hard to drive these improvements through all our programmes of work.

These trajectories include:

- Reducing the potential years of life lost (PYLL) from causes amenable to healthcare by 15%;
- Improving the health-related quality of life for people with long-term conditions by 1.9% per annum;
- Reducing avoidable emergency admissions by 14%;
- Increasing the proportion of people having a positive experience of hospital care;
- Increase the proportion of people having a positive experience of care outside of hospital, in general practice and the community.

Each Ambition is outlined below with a clear indication of which strategic initiatives are driving potential improvements.

The **Quality Premium** (a national CCG incentive scheme which includes a composite of indicators) includes the falls metric as a local priority, as well as PYLL and reducing avoidable emergency admissions.

The national **Better Care Fund metrics** (a programme established to drive integration initiatives that would reduce hospital admissions and release funding to be targeted at joint health and social care services in 2014-15 and 2015-16) have also meant the CCG is reporting on the following metrics:

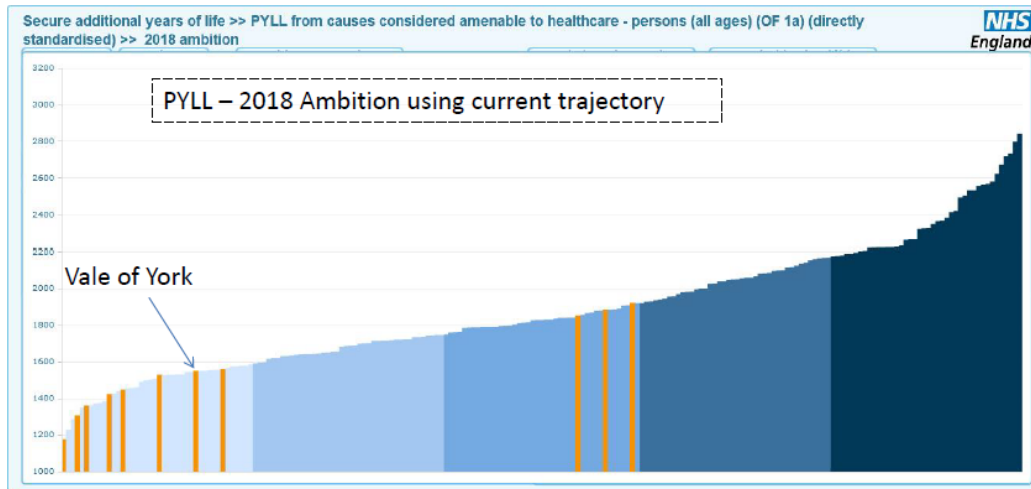
- Reducing avoidable emergency admissions;
- Reducing inappropriate admissions of older people (65+) in to residential care;
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services;
- Delayed transfers of care from hospital per 100,000 population;
- Improving patient experience;
- Injuries due to falls in people aged 65 and over.



AMBITION 1:

Reduce the potential years of life lost (PYLL) from causes considered amenable to healthcare by 15%.

An annual improvement of 3.2% would move the CCG into the top quintile and be 10th out of its comparator group of CCGs. This would also meet the requirements of the Quality Premium.

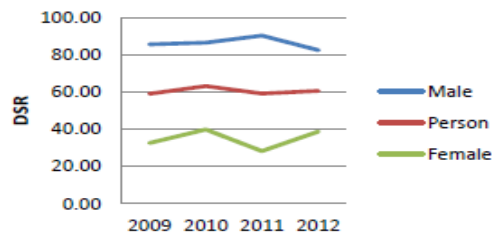


PYLL All	At 3.2% reduction (straight line)
Baseline	1951
2014-15	1888
2015-16	1828
2016-17	1769
2017-18	1713
2018-19	1658
Overall change	15%

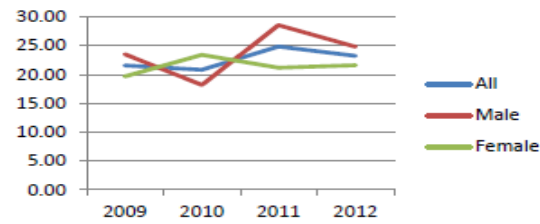
Main supporting indicators:

Respiratory disease shows the gap between male and female coming together. For Cancer the gap between men and women is getting wider. There is still a significant gap between men and women in CVD though this gap is closing. Premature deaths in under 75s due to serious mental health issues are above England figure but appears to have short term convergence. Position to be monitored. Therefore, possible opportunities exist in actions to improve outcomes in male CVD and Cancer.

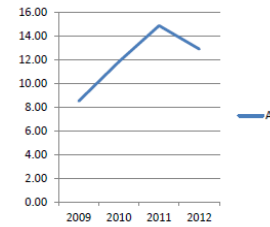
Cardiovascular Disease



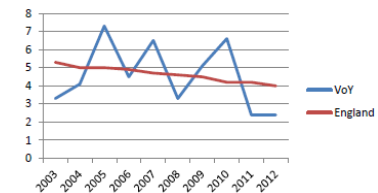
Respiratory Disease



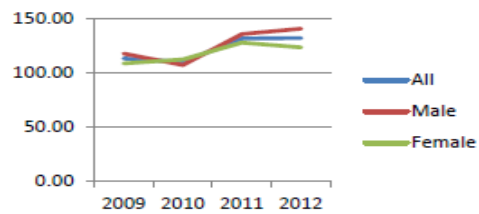
Liver disease



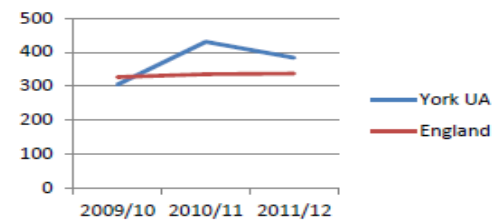
Infant mortality rates



Cancer



Serious mental health illness



CCG Strategic Initiatives driving trajectory:

- ✓ Planned Care:; diabetes; neurology; asthma pathway improvements; CVD hypertension and prevention initiatives;
- ✓ Mental health services review and re-procurement; psychiatric liaison;
- ✓ Primary care: GP care planning; risk stratification; neurology GP training;
- ✓ Prevention: binge drinking;
- ✓ Cancer;
- ✓ Children: Challenge Campaign and health promotion / self-care.

Metrics used for indicators:

PYLL from causes considered amenable to healthcare – persons (all ages) (OF1a) directly standardised.

Units: years lost per 100,000 population

Numerator: total years of life lost from amenable causes

Denominator: total registered patients (CCG-level) or ONS population estimates (LA-level)

Standardisation: directly age standardised to England population (CCG-level) or European Standard Population (LA-level)

Source: HSCIC Indicator Portal

Indicators used to measure improvement:

CCGOIS 1.2: Under 75 mortality rates from CVD

CCGOIS 1.6: Under 75 mortality rates from Respiratory Disease

CCGOIS 1.9: Under 75 mortality rates from cancer

CCGOIS 1.5: Reducing premature deaths in adults with serious mental health illness.

NHSOF1.3: Under 75 mortality rates from liver disease

NHSOF1.6i: Infant mortality rates

Dataset:

Levels of Ambition Atlas (CCG)

Time series from Levels of Ambition for England and City of York Council (2001-2012).

The baseline year for ambitions is 2012.

Baseline year with Comparator Group is 2012.

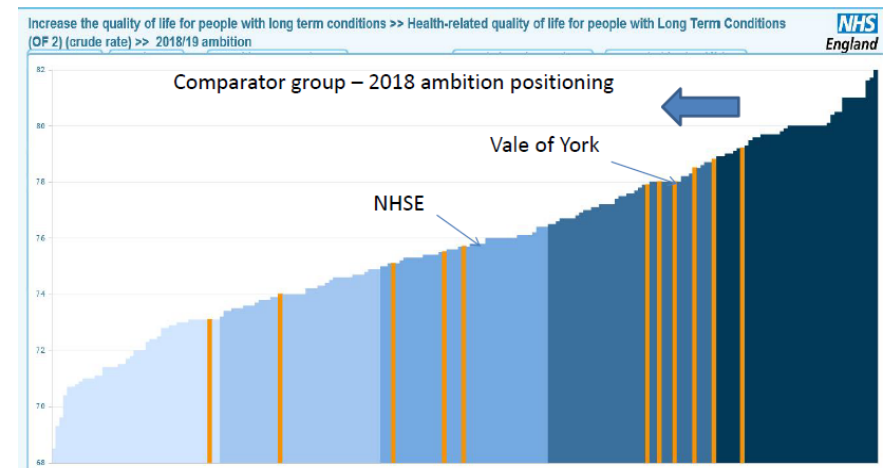
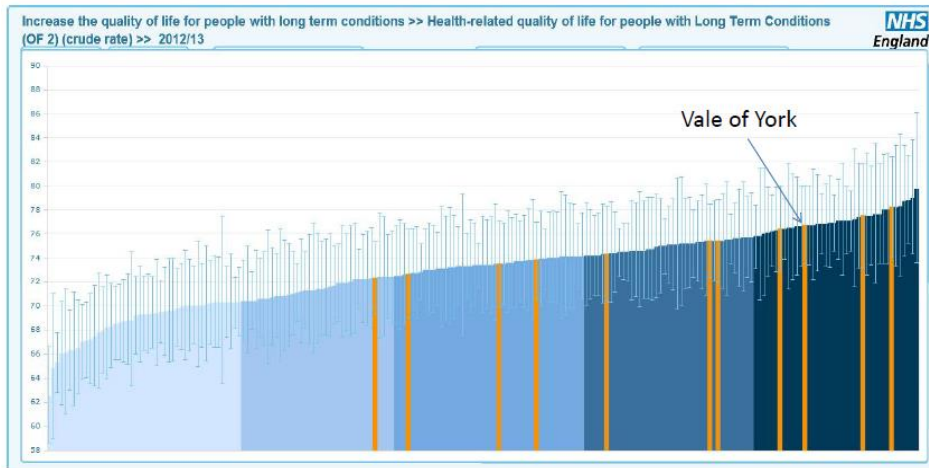
Ambition year with Comparator Group is 2018.

Conditions amenable to healthcare:

- Tuberculosis Conditions Amenable to Healthcare
- Selected invasive bacterial and protozoal infections
- Hepatitis C
- HIV/AIDS
- Malignant neoplasm of colon and rectum
- Malignant melanoma of skin
- Malignant neoplasm of breast
- Malignant neoplasm of cervix uteri
- Malignant neoplasm of bladder
- Malignant neoplasm of thyroid gland
- Hodgkin's disease
- Leukaemia
- Benign neoplasms
- Diabetes mellitus
- Epilepsy and status epilepticus
- Rheumatic and other valvular heart disease
- Hypertensive diseases
- Ischaemic heart disease
- Cerebrovascular diseases
- Influenza (including swine flu)
- Pneumonia
- Asthma
- Gastric and duodenal ulcer
- Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia
- Nephritis and nephrosis
- Obstructive uropathy and prostatic hyperplasia
- Complications of perinatal period
- Congenital malformations, deformations and chromosomal anomalies
- Misadventures to patients during surgical and medical care

AMBITION 2:

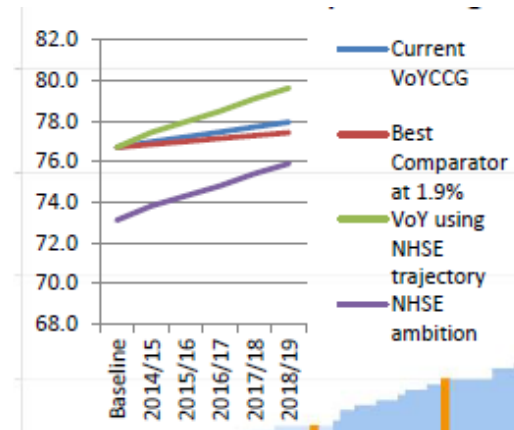
Ambition for improving the health-related quality of life for people with long-term conditions by 1.9% per annum



The CCG is towards the high end of performance (3rd best in its comparator group and comfortably in the top quintile) and there is limited headroom for improvement to the best levels currently measured nationally.

General improvement is required but no specific national target. Aiming for the current best comparator is a 1.9% increase per annum.

	Current NHS Vale of York CCG	Best Comparator at 1.9%
Baseline	76.7	76.7
2014/15	77.0	76.8
2015/16	77.2	77.0
2016/17	77.5	77.1
2017/18	77.7	77.3
2018/19	78.0	77.4



Strategic Initiatives driving trajectory:

- ✓ Integrated care: integration pilots (Care Hub approach) for LTCs and End of Life care
- ✓ Urgent care: ECPs and crisis management reducing admissions avoidance; out of hours procurement;
- ✓ Planned care: Neurology carers strategy
- ✓ Primary Care: Referral Support Service; Risk stratification;
- ✓ Prevention: self-care; assistive technology

Indicators used to measure improvement:

NHSOF2.1: People feeling supported to manage their condition

NHSOF1.4: Health-related quality of life for carers, aged 18 and above

Dataset:

Levels of Ambition Atlas (CCG)

Metrics used for indicators:

Units: total EQ-5D per 100 people with LTCs

Numerator: sum of the weighted EQ-5D values for all responses from people identified as having a long term condition

Denominator: The weighted count of all responses from people identified as having a long term condition

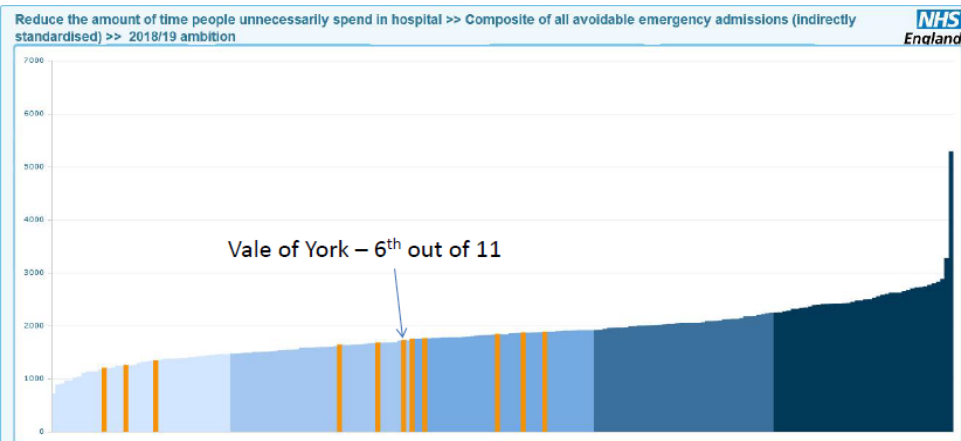
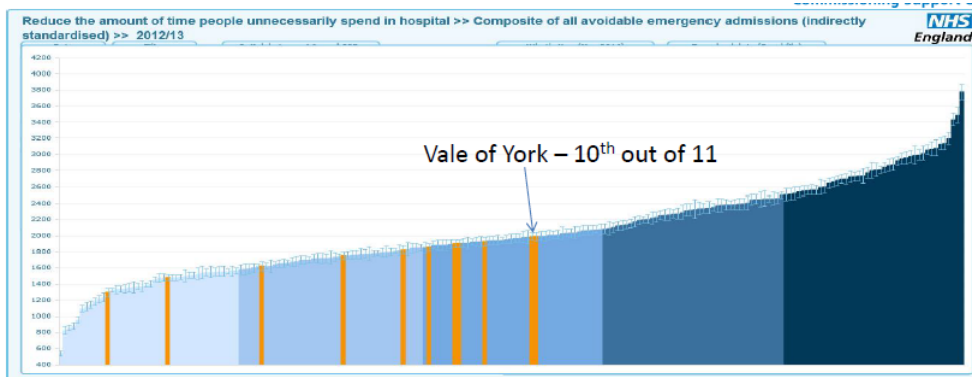
Standardisation: none

Source: GPPS HSCIC Indicator Portal

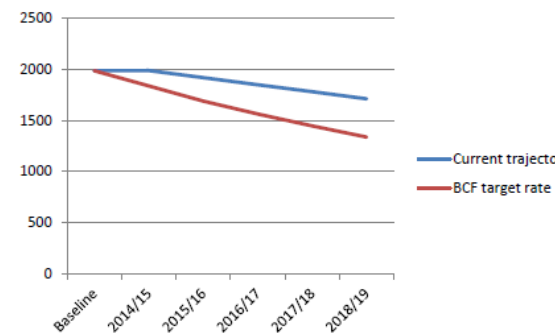
AMBITION 3: [This indicator is used to measure both the Quality Premium and the Better Care Fund metrics]
Ambition for reducing avoidable emergency admissions by 14%

Emergency admissions for any of the conditions considered avoidable per 100,000 population, based on composite of following 4 areas:

- Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions;
- Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s);
- Emergency admissions for acute conditions that should not usually require hospital admission;
- Emergency admissions for children with lower respiratory tract infections (LRTIs);



Reducing avoidable emergency admissions (composite measure)



	Current trajectory	BCF target rate
Baseline	1989	1989
2014/15	1990	1839.8
2015/16	1920.7	1690.7
2016/17	1851.4	1563.9
2017/18	1782.2	1446.6
2018/19	1712.9	1338.1

The current level for the CCG is in the middle quintile, but worse than most of its comparators (10th of 11, middle quintile).

Trajectory would improve comparator positioning to 6th out of 11 and second quintile. The trajectory to end 2015-16 is in line with the plans in BCF for the same indicator.

After 2015/16 there are no “target” levels to achieve, but the CCG should look to move closer to the comparator group, and the current end point achieves this.

Strategic Initiatives driving this trajectory:

- ✓ Urgent care: ECPs and 'see and treat' (impact on falls); Out of Hours Procurement with KPIs for the management of emergency demand; psychiatric liaison; street triage
- ✓ Integrated care: hospice at home; Cellulitis, Bronchiectasis and Community IV
- ✓ Planned Care: Diabetes: October 2014 onwards 10% reduction in admissions where Diabetes is secondary diagnosis and a primary diagnosis of: (i.) UTI with LOS 2+ days; (ii.) Syncope and Collapse; (iii.) Patients 70 years+ with a Mental Health primary diagnosis
- ✓ Planned Care: Neurology - new Integrated Care Pathways developed for Parkinson's Disease /Epilepsy/ Multiple Sclerosis / Motor Neurone Disease
- ✓ Planned Care: asthma
- ✓ Children: lower respiratory tract infections

Metrics used for indicators:

Units: admissions per 100,000 population
 Numerator: total emergency admission for the any of the conditions considered avoidable

Denominator: total registered patients
 Standardisation: indirectly age-sex standardised to the England rates
 HSCIC Indicator Portal

Source: HES
 Data for 2012/13 has been updated and is now based on HES rather than SUS data.

Indicators used to measure improvement:

NHSOF2.3i: Unplanned hospitalisation for chronic ambulatory care sensitive conditions
 NHSOF2.3ii: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
 NHSOF3a: Emergency admissions for acute conditions that should not usually require hospital admission
 NHSOF3b: Emergency admissions for children with lower respiratory tract infections

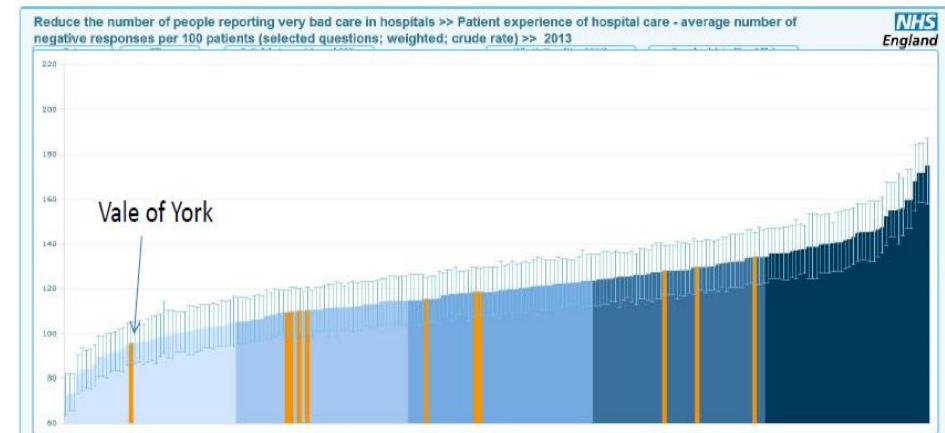
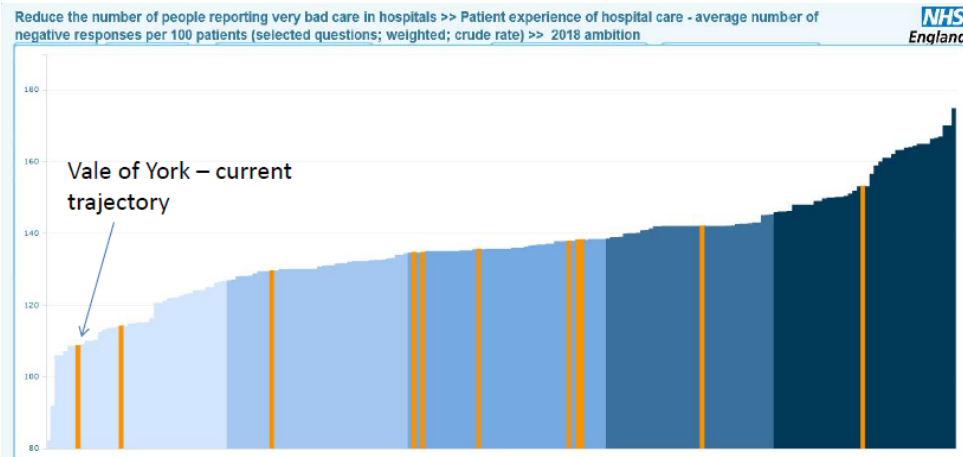
Dataset:

Levels of Ambition Atlas (CCG)
 Baseline year with Comparator Group
 2018 Ambition year with Comparator Group.

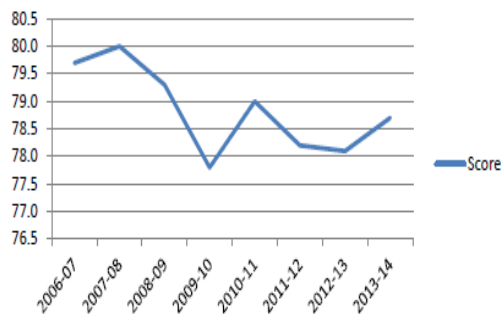
AMBITION 5:
Ambition for increasing the proportion of people having a positive experience of hospital care

The proportion of people reporting ‘poor’ experience of inpatient care in the 2012 Inpatient Survey.

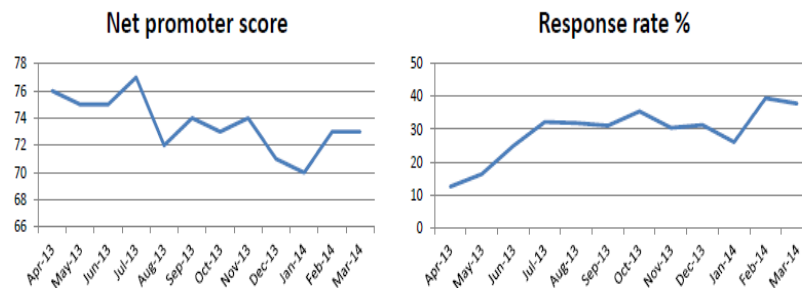
An *improvement* in the indicator is required, but no specific target set. The CCG performs very well on this indicator (1st in comparator group). There is little headroom for improvement against the current national best scores however the CCG will work hard to ensure that this high level of performance is maintained.



Patient experience of hospital care

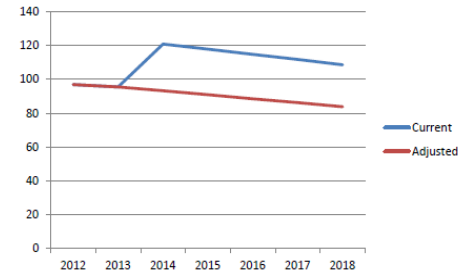


Friends and Family Test - Inpatient



	Current	Revised
2012	96.9	96.9
2013	95.5	95.5
2014	120.8	93.2
2015	117.8	90.9
2016	114.7	88.5
2017	111.7	86.2
2018	108.6	83.8

The proportion of people reporting poor patient experience of inpatient care – proposed revised trajectory



Strategic Initiatives driving trajectory:

- ✓ Planned care: Diabetes; Neurology
- ✓ Primary Care: Referral Support Service
- ✓ Quality improvement programmes – Patient Experience lead and soft intelligence analysis

Metrics used for indicators:

Units: negative responses per 100 patients
 Numerator: Total number of 'poor' responses
 Denominator: total number of respondents to the survey questions
 Standardisation: none
 Source: inpatient survey
 NHSE Statistics
 HSCIC Indicator Portal

Indicators used to measure improvement:

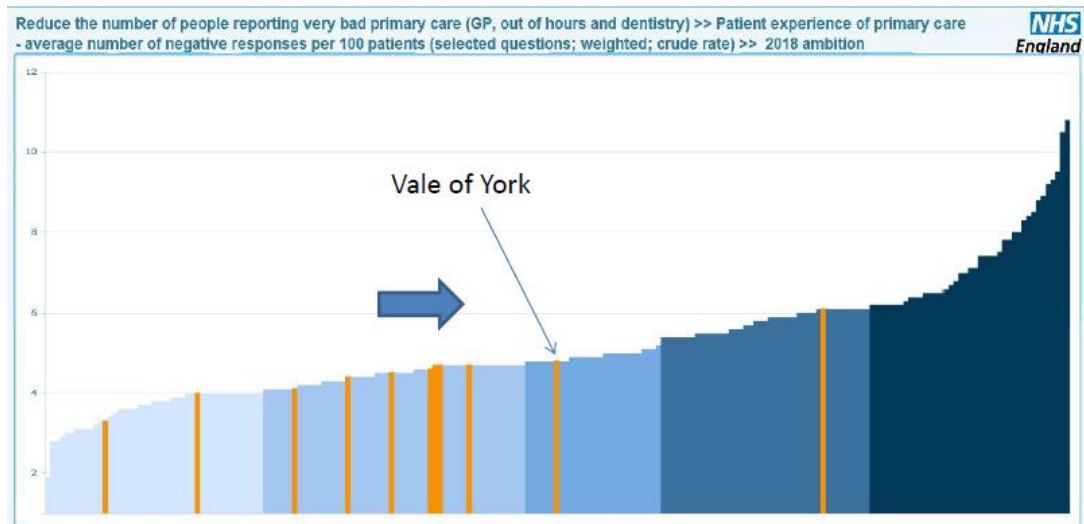
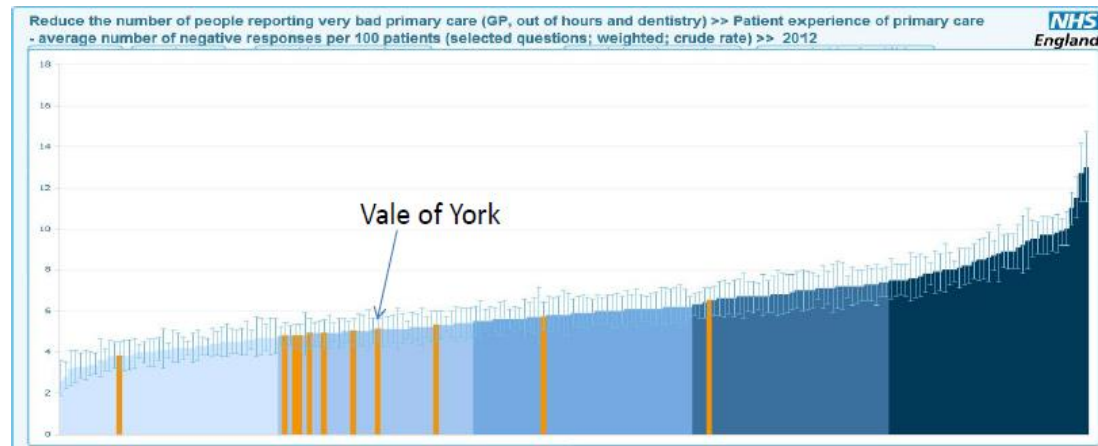
NHSOF4b: Patient experience of hospital care
 Friends and Family Test -inpatient
 Net Promoter Score and Response Rate

Dataset:

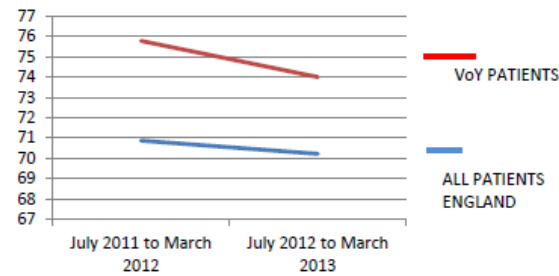
Levels of Ambition Atlas (CCG)
 Baseline year with Comparator Group
 2018 Ambition year with Comparator Group.

AMBITION 6:
Ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community

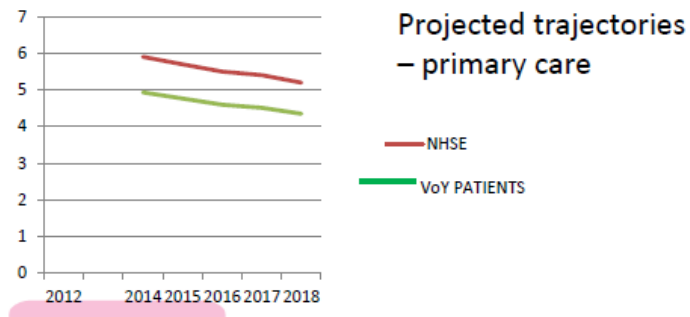
This indicator measures the average number of responses of a ‘fairly poor’ or ‘very poor’ experience across General Practice (GP), Out-of-hours services and Dentistry per 100 patients. The CCG is 8th out of 11 in its comparator group and falls in the middle of the second quintile. The recommended trajectory is to follow the NHS England trajectory giving a revised trajectory score of 4.3 in 2018 – upper part (good) of second quintile.



Current performance- OOH Services



	July 2011 to March 2012	July 2012 to March 2013
ALL PATIENTS ENGLAND	70.86	70.21
NHS VALE OF YORK CCG	75.78	74



	NHSE	VoY
2012	6.1	5.1
2014	5.9	4.9
2015	5.7	4.8
2016	5.5	4.6
2017	5.4	4.5
2018	5.2	4.3

Strategic Initiatives driving trajectory:

- ✓ Urgent care: out of hours re-procurement
- ✓ Integrated Care: Community IVs
- ✓ Planned Care: diabetes; neurology
- ✓ Primary Care: Referral Support Service; primary care web tool; GP care planning; GP education and training
- ✓ Quality improvement programmes – Patient Experience lead and soft intelligence analysis

Metrics used for indicators:

Units: negative responses per 100 patients
 Numerator: Total number of 'poor' responses
 Denominator: total number of respondents to the survey questions
 Standardisation: none
 Source: GPPS

Indicators used to measure improvement:

CCGOIS 4.1 Patient experience of GP out of hours services
 Projection of ambitions

Dataset:

Levels of Ambition Atlas (CCG)
 Baseline year with Comparator Group
 2018 Ambition year with Comparator Group.

2014-15 QUALITY PREMIUM MEASURES

Domain of NHS Outcomes Framework	Quality Premium Measure	Strategic Initiatives driving these indicators
National Measures 1. Preventing people from dying prematurely	<ul style="list-style-type: none"> ▪ Potential years of life lost from causes amenable to health care (all ages) 	<ul style="list-style-type: none"> ✓ Planned Care: CVD hypertension and prevention initiatives; diabetes; neurology; asthma ✓ Mental health services review and re-procurement; psychiatric liaison ✓ Primary care: GP care planning; risk stratification; neurology GP training
2. Enhancing quality of life for people with long term conditions	<ul style="list-style-type: none"> ▪ Improving access to psychological therapies (IAPT) 	<ul style="list-style-type: none"> ✓ Mental health review and increasing IAPT capacity to meet 15% target by 2015/16
3. Enhancing quality of life for people with long term conditions; helping people to recover from episodes of ill health or following injury	<ul style="list-style-type: none"> ▪ Reducing avoidable emergency admissions (composite measure) ▪ Unplanned hospitalisation for chronic ambulatory care sensitive conditions ▪ Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s ▪ Emergency admissions for acute conditions that should not usually require hospital admission ▪ Emergency admissions for children lower respiratory tract infections 	<ul style="list-style-type: none"> ✓ Urgent care: Out of Hours Procurement with KPIs for the management of emergency demand; psychiatric liaison; street triage ✓ Integrated care: hospice at home; Cellulitis, Bronchiectasis and Community IV ✓ Planned Care: Diabetes; Neurology; Asthma ✓ New Integrated Care Pathways developed for Parkinson's Disease / Epilepsy / Multiple Sclerosis / Motor Neurone Disease
4. Ensuring that people have a positive experience of care	<ul style="list-style-type: none"> ▪ Addressing issues identified in 2013/14 Friends and Family Test ▪ Supporting rollout of FFT in local health economy in 2014/15 ▪ Addressing Friends and Family Test roll out in out of hours 	<ul style="list-style-type: none"> ✓ Urgent care: out of hours re-procurement ✓ Integrated Care: Community IVs ✓ Planned Care: diabetes; neurology ✓ Primary Care: Referral Support Service; primary care web tool; GP care planning; GP education and training
5. Treating and caring for people in a safe environment and protecting them from avoidable harm	<ul style="list-style-type: none"> ▪ Improved reporting of medication-related safety incidents 	<ul style="list-style-type: none"> ✓ Quality improvement programmes
Local Measure 1. Local measure agreed by CCG with the local Health and Wellbeing Board	<ul style="list-style-type: none"> ▪ A reduction in the number of fall related injuries for residents over the age of 65 	<ul style="list-style-type: none"> ✓ Urgent care: ECPs and 'see and treat'

Our five year Strategic Initiatives

The CCG has 8 main strategic initiatives which will transform services and deliver the five year strategic vision ‘**My Life, My Health, My Way**’ and its associated ambitions for improving the health and well-being of the Vale of York Community.

At the core of our five year strategic vision is the **Care Hub Approach** which involves whole system change in order to get the right model of care for the future.

A new approach – Care Hub Implementation

Following discussions with our community, local clinicians and partners, a number of themes emerged around patient centered care, more community based services, continuity of care (including seven day working) and improvement in the provision of mental health services. There was also a desire to see the GP practice find a role at the centre of the health system of the future.

To respond to the outcomes the public have asked for, we have been actively researching various models of care provision across both this country, and internationally, including polysystem models in Redbridge through to fully integrated community models in Canterbury, New Zealand and ‘Extensivist’ models in the USA. We have, and will continue to facilitate the local clinical community to look at options for local delivery to implement a model of care that we are describing as the “Care Hub Model”.

Care Hubs’ responsibility will be to assess, diagnose and deliver care to enable individuals to remain at home, or return there at the earliest opportunity following a period of ill-health or crisis. The initial focus will be on the frail elderly and those individuals with long term conditions, with a view to expanding this across a range of health needs and population groups.

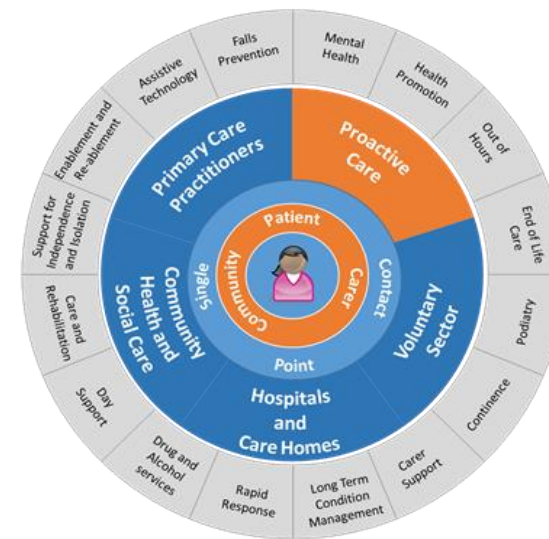
The hubs will be staffed by a multi-disciplinary, multi-agency team who will act as care co-ordinators to ensure care and support packages are put in place as quickly as possible and in the best interests of the individual and their carers. New funding models to incentivise providers to deliver this approach will be explored to ensure that providers truly deliver transformed models of care as alternatives to admissions to hospital or care homes.

People tell us they “only want to tell their story once”. We fully support this and see this as fundamental to delivery of joined up care. Integrated information systems and sharing of data to support patient care also provides us with one of the greatest challenges we face. We need to join up our different information systems so we can work with partners and the wider business community to look at how we can do this. It will mean new ways managing data and working across organisations, to share relevant information and we will use the NHS number across both health and social care as the single way in which we identify those we are supporting and providing services to.

Through Care Hubs, patients will have one care record, and move to having their care co-ordinated through a single contact point. This could be a GP, a care manager, a district nurse, a community matron, an OT or specialist MH worker or any other health and social care practitioner with whom the person has regular contact. This person will retain accountability for their patient and will act as the facilitator to all other services and interventions. When an individual is admitted to a hospital setting, clinical responsibility will transfer to the relevant hospital clinician but the single contact point will still have an accountable role for in-reach and discharge planning and co-ordinating the overall pathway of care.

The journey to develop a fully integrated care hub will take time and so the initial focus is on establishing a small number of integrated care pilots involving primary, secondary care, the voluntary sector and social care. These pilots are currently testing different models of delivery to inform best practice for the evolving care hub approach.

Care Hub Model



In order to ensure we gain maximum learning and innovation from this approach, we do not intend to be too prescriptive on how Care Hubs and Proactive Care should be delivered. The integrated care pilots will help us to learn which model delivers the best outcomes for patients and their families.

“Every system is perfectly designed to get the results it gets.”

Professor Paul Batalden
Dartmouth University.

We want to move away from traditional definitions of primary, secondary, community and social care to a model of 'care'. This exciting new opportunity requires new organisational structures to deliver it, drawing on the strengths of the different sectors.

We have set the outcomes we want to achieve and the impact we expect their respective models to have. Specifically we expect to see rapid and measurable evidence that the following ambitions and impacts have been delivered:

- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**
- **Increase the proportion of older people living independently at home following discharge from hospital from a baseline of 76.7**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers**
- A reduction in the proportion of residents being admitted to care homes from both acute and community settings
- A decrease in the proportion of delayed transfers of care and excess bed days from acute settings for those patients medically fit for discharge
- A reduction in the requirement for emergency placements
- A reduction in length of stay for individuals where emergency placements are necessary

- A reduction in the proportion of attendances at emergency departments for individuals presenting with mental health problems
- A reduction in the number of patients known to the Community Mental Health Team attending emergency departments
- A reduction in the number of falls related injuries for residents over the age of 65
- A shared care record for each individual accessing the Care Hub
- A named single contact point for each individual accessing the Care Hub
- A move towards 24 hours / seven day working

We will support the development of improvement initiatives this through evidence based improvement programmes, for example 'Virginia Mason Total Production System' (VMPS). The Care Hub approach will be continuously evaluated to ensure it delivers the required impact and outcomes.

We are aligning improvement support to groups of practices to ensure that the integration pilots (Care Hubs approach) use every opportunity to address and improve access to and delivery of mental health interventions as well as improve the physical health of patients with mental health illnesses. These approaches will be embedded within the final Care Hub model.

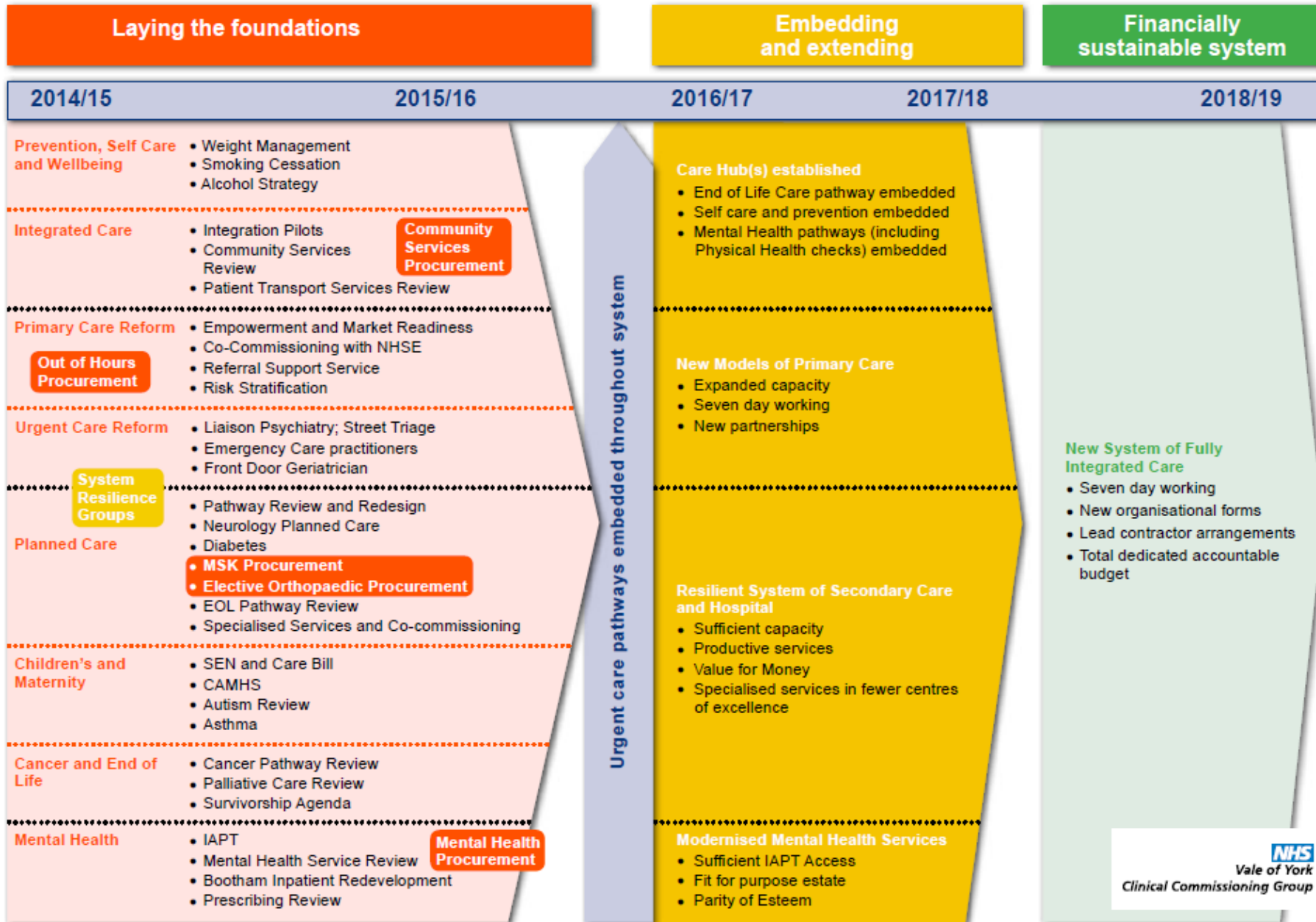
The five year roadmap to creating a financially sustainable local health and wellbeing system

Each of our eight strategic initiatives is being delivered through a set of **Improvement Interventions** which reflect the six characteristics of a modern and sustainable health care system as defined by the NHS 'Call To Action' and are embodied within the overarching strategic plan "My Life, My Health, My Way" and underpinned by the whole system move to the 'Care Hub' approach. The strategic initiatives and improvement interventions are outlined in detail in this section.

'**My Life, My Health, My Way**' will be officially launched on 3 August 2014 when the Vale of York CCG and its partners will run the ASDA Foundation York 10k (Jane Tomlinson Run For All). This will be an opportunity to highlight the overarching strategic plan for achieving the highest quality, sustainable service delivery by 2018-19 and to celebrate the significant work to date in establishing the integration pilots which will enable the delivery of transformed out of hospital services.

This will also focus on the person-centred care programme of work and what this means for local people in terms of well-being, self-care and prevention. The Roadmap to 2018-19 encompassed within '**My Life, My Health, My Way**' is summarised in the following Plan on a Page.





My Life, My Health, My Way: High quality care, in the most appropriate setting, to meet the needs of our population.
 Our work will deliver a sustainable and high quality health service available to all to improve health and wellbeing across the Vale of York. Targeting Health inequalities, increasing parity of esteem between physical and mental health and providing local access to care. The CCG will provide system leadership.



You said, we did	Our strategic initiatives	Enabling work	Our improvement interventions	Outcomes																		
<p>Help people to stay healthy</p> <p>Provide people with the opportunity to influence and change healthcare</p> <p>Ensure access to good, safe, high quality services closer to home</p> <p>Support people with long term conditions to improve quality of life</p> <p>Improve health-related quality of life and end of life care</p> <p>Implement local 'Care Hubs' across the Vale of York</p> <p>High quality mental health services for the Vale of York, with increased awareness of mental health conditions</p> <p>Ensure local healthcare services are sustainable</p> <p>Ensure people have access to world-class complex and specialist care</p> <p>Support health research in the local area</p>	<p>Prevention, Self Care and Wellbeing: help people stay healthy through informed lifestyle choices, support people to self-manage long term conditions where possible</p> <p>Integrated Care: coordinate health and social care services around the needs of patients to create a fully integrated out of hospital system of care</p> <p>Primary Care Reform: improve the continuity of care and delivering services seven days a week through GP practices working together to support larger populations; enabling the Care Hub Model</p> <p>Urgent Care Reform: improve and coordinate of all aspects of urgent care provision that ensure that patients are treated at home wherever possible</p> <p>Planned Care: enhance the referral support service to ensure the right care is delivered for patients first time. Improve productivity of elective care</p> <p>Transformed Mental Health: improve the management of people with mental health needs and improve their physical health through all new models of care across system</p> <p>Children's and Maternity: give children the best start in life possible, promote healthy lifestyles and supporting self-management of their conditions</p> <p>Cancer and End of Life: prevention, diagnosis and treatment; carers pathway</p>	<p>Co-commissioning of primary care with NHSE</p> <p>Primary care improvement hubs</p> <p>Workforce planning</p> <p>IT connectivity across the system</p> <p>Shared care record and individual care plans</p> <p>Sophisticated Commissioning and Contracting</p> <p>Procurement choice and market readiness</p> <p>Estates and infrastructure</p> <p>Clinical data review and analysis</p> <p>Assistive technology (referral support; community equipment)</p> <p>Research and innovation</p> <p>Prescribing</p> <p>Carers and voluntary sector</p>	<ul style="list-style-type: none"> Drinking interventions and joint delivery of Alcohol Strategy and Wellbeing Business Plan with local authorities Weight Management (Selby) Smoking Cessation <ul style="list-style-type: none"> Piloting of four Care Hub Models Community services review and procurement Embedding urgent care, self-care and End of Life pathways in Care Hub Model Patient transport services <ul style="list-style-type: none"> Referral support service and care plans for frail old people and complex needs Out of Hours review and procurement Doctor First; Risk stratification Extended role of community pharmacy Dentistry in residential homes <ul style="list-style-type: none"> Street triage and emergency care practitioners Psychiatric liaison in A&E Paediatric zero length of stay Front door geriatrician <ul style="list-style-type: none"> Systematic service review and pathway redesign – ophthalmology, critical care review New pathways of care in diabetes and neurology; System resilience: planning capacity MSK and elective orthopaedic procurements <ul style="list-style-type: none"> Mental health service review and procurement Autism review; dementia service development; IAPT expansion; prescribing Bootham inpatient redevelopment <ul style="list-style-type: none"> Children and Families Act: Special educational needs Regional work programme 2014-16 Asthma, CAMHS and health reviews for looked after young people <ul style="list-style-type: none"> Palliative Care Review Cancer Pathway Review and Survivorship 	<p>Quality outcomes:</p> <ul style="list-style-type: none"> Delivering on the NHS Constitution Enhanced quality and safety of care Improved patient experience of care outside of hospital (12%) Increase in number of people having positive experience of hospital care <p>Health outcomes:</p> <ul style="list-style-type: none"> Reduce the potential years of life lost (15%) Reduced emergency hospital admissions (by 14%) Increase in proportion of older people living independently at home following discharge Improve the health-related quality of life of people with LTCs Improving physical health of those with mental illness (parity of esteem) Reducing Falls Improve dementia diagnosis <p>Impact on activity 2014/15:</p> <table border="1"> <thead> <tr> <th>Elective</th> <th>-£</th> <th>27,757</th> </tr> </thead> <tbody> <tr> <td>First appointments</td> <td>-£</td> <td>335,863</td> </tr> <tr> <td>Follow-up appointments</td> <td>-£</td> <td>816,443</td> </tr> <tr> <td>A&E</td> <td>-£</td> <td>782,357</td> </tr> <tr> <td>Non-elective</td> <td>-£</td> <td>1,489,179</td> </tr> <tr> <td>Total</td> <td>-£</td> <td>3,451,600</td> </tr> </tbody> </table> <p>Impact on finances:</p> <ul style="list-style-type: none"> Delivering on the NHS Constitution Financial sustainability of the Vale of York health economy. Increase productivity of secondary elective care (target 20% by 2018/19) Ensuring Value for Money for every £ spent. Contribution of QIPP schemes of £5m to financial gap of £9.4m 	Elective	-£	27,757	First appointments	-£	335,863	Follow-up appointments	-£	816,443	A&E	-£	782,357	Non-elective	-£	1,489,179	Total	-£	3,451,600
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<p>Our values will underpin everything we do: Quality • Governance • Engagement and co-design • Prioritisation • Equality • Sustainability • Empathy; Integrity • Respect • Courage</p>																						
<p>2014/15 - 2015/16 Laying the foundations</p>		<p>2016/17 - 2017/18 Embedding and extending</p>		<p>2018/19 Financially sustainable system</p>																		

2014-15 and 2015-16 (Years 1 and 2)

The improvement interventions currently being delivered are mostly aligned to the Better Care Fund (the national programme for driving integration across health and social care) and delivering the national Urgent Care programme and associated Out of Hours procurement. They represent a robust and comprehensive programme of improvements addressing the fundamental transformation required in the local health and social care system. They focus on increasing productivity wherever possible and where there is an opportunity to release savings they are being accelerated in 2014-15 in order to support the CCG managing the existing financial gap. Together they form a strong foundation for developing our other Strategic Initiatives and the basis for whole system change.

Moving forward these improvement schemes will be delivered alongside a dedicated programme for transforming primary care that will be enabled through the CCG co-commissioning primary care services with NHS England. This will support the provision of sufficient capacity in primary care, community and social care to deliver the activity changes and transfers anticipated from acute hospital settings into community through the Better Care Fund in 2016-17.

Two large whole service reviews are currently underway for community services and mental health services, culminating with the anticipated procurements for each with contracts awarded for mental health provision in October 2015, and community services in April 2016.

Alongside the transformational programmes there will be a systematic review of key services and care pathway commencing with our acute providers (involving baseline assessment, service mapping and benchmarking) and running throughout the next 2 year period to 2016-17. This will enable us to ensure we are continuously driving up efficiency and identify areas where we should target for transformation jointly with our providers in the following ways:

- ✓ Services are being delivered in the right place for our patients and have considered models of delivery which represent best practice, lean, innovative and technology-enabled ways of working which avoid unnecessary attendances and admissions;
- ✓ Services are productive, cost effective and represent VFM for every pound we spend in order ensure the sustainable use of our finite resources;
- ✓ Services are improved and performance managed against a range of increasingly sophisticated contractual targets, incentives and outcomes-based commissioning mechanisms which encourage transformation and integration;
- ✓ The CCG is assured it is commissioning the right amount of capacity to deliver the NHS Constitution targets for Referral to Treatment (RTT) in every specialty and in A&E;
- ✓ Services are paid for under the most appropriate tariff and price;
- ✓ Referrals into services are always appropriate and at the right point of access.

The additional resource generated by this process will be used to fund:

- new investment requirements for new treatments and service developments we are agreeing with our providers
- pump priming of new models of care or invest to save schemes (e.g. integration pilots)
- programme management and development costs of large transformation programmes of work,
- enabling work programmes
- the parallel running of services as models and pathways transform and procurement and re-commissioning is rolled out, and ensure there is no destabilisation of current providers who are committed to working with us to transform pathways of care
- and to ensure that the CCG continues to commission services within the resources available

We have established some key principles for our programmes and investments from 2014-15 as follows:

- ✓ Our aim is to invest a proportion of productivity gains back into services to support the delivery of the transformed services our population require and thus to enable providers to securely plan for a healthy and financially sustainable future delivering the services we require locally
- ✓ Transfers of activity and associated funding across the health and care system will be undertaken in a planned and collaborative way based on joint delivery of our transformational work – we will avoid

destabilisation of any current provider and support future providers in readiness for all tendering of new or re-commissioned services

- ✓ Investment in schemes which enable transformation and result in savings in the longer-term will be prioritised
- ✓ Given the significant financial challenge facing the CCG a prioritisation framework has also been developed against which to consider any new initiatives/ developments as well as the review existing services for continued funding to ensure that the services we currently commission represent VFM

The current financial efficiency target for the CCG remains high and challenging, and the CCG is working hard to identify all opportunities available at this point to develop QIPP schemes which can contribute towards meeting our target:

- Current programmes of redesign are being accelerated wherever appropriate
- Review and revisit all outlier areas in terms of benefits gained for investment made (Commissioning For Value indications) and unwarranted variations which can be addressed
- Reflection on other CCG's improvement and productivity plans showing evidence of productivity gains
- Utilising national tools such as the portfolio of NHS England Call to Action reports identifying opportunities for transformation

Systematic pathway review will also support the continued drive to deliver productivity savings (QIPP) each year and ensure that we address QIPP in a systematic, rigorous and coherent manner which aligns with our providers CIP programmes and supports our transformation.

During 2014-15 the full impact of the specialised services commissioning plan for the area will also be considered and addressed collaboratively with our providers, NHS England and our fellow area commissioners on our wider Unit of Planning footprint.

It is anticipated that newly restructured funding and reimbursement models will emerge for 2015-16 that enable us to focus on commissioning for outcomes and explore the potential for using population-based virtual commissioning budgets and to work closely with local authorities on effective ways of targeting joint budgets.

Key in 2014-15 will also be the establishment of **System Resilience Groups** which CCGs will co-ordinate across the unit of planning to ensure that sufficient capacity is commissioned throughout the year in both urgent care and planned care to meet the access and performance required in the NHS Constitution. All the CCGs transformational and productivity work with its providers and social care will support planning and delivering this resilience, and this group will be a significant enabler for unit of planning-wide collaboration and co-ordination.

2016-17 to 2018-19 (Years 3 to 5)

The main focus of transformation in Years 3 to 5 will be the continued evolution, embedding and extension of the future Care Hub approach based on the outcomes of the 4 integration pilots. The hubs will incorporate the emerging pathway changes in out of hospital care from other care areas such as self-care and prevention, and mental health.

Our other Strategic Initiatives will all be delivered with the Care Hub approach as the central framework for delivery. Opportunities for improving the physical health of patients with mental illness will be also be considered in every improvement intervention.

Further development of primary care and out of hours community services will be enabled by the CCG co-commissioning primary care with NHS England. Our systematic review of all care processes which will ensure all in-hospital care is highly productive and cost-efficient, being delivered in the right setting and with a service specification and contract that is fit for purpose.

Further development of our modelling will allow us to understand the scale of the changes in practice and behaviour required from our GPs, providers and public to deliver significant transfers of activity from different settings.

We envisage there will be a potential need for estate review and development in line with the future model of out of hospital care, and most critically a more flexible and mobile workforce with new roles and responsibilities working across hospital and community settings.

Additionally the CCG recognises its responsibilities to make ready the market and our potential future providers so they are empowered and fully functional to bid for new contracts and tenders alongside new partners and in a complex business environment.

These transformations will require significant capacity and capability in terms of programme management, modelling, engagement and investment. Our existing programme plans for each strategic initiative are already developing workstreams to capture these requirements and enable delivery of the whole system change through to 2018-19.

The CCG has submitted several bids for the Regional Innovation Fund and every improvement manager is actively seeking through individual and collaborative efforts with providers to access the best innovative new ideas and developments related to their work programmes.

However, dedicating sufficient capacity and energy now will lay the foundation for a transformed and sustainable healthcare system in 2018-19 where there is truly potential to deliver:

- Integrated health and social care services delivered from Care Hub (s) in the community, seven days a week by multi-specialty provider groups, with lead contractor arrangements and dedicated joint multi-year budgets from primary and secondary care;
- Strong, healthy secondary care services providing the planned diagnostic, treatment and care and specialised services required in hospital settings seven days a week;
- Enhanced and extended primary care services and GP networks with responsibility for co-ordinating the care of the elderly and most vulnerable through care hub(s) and local hospitals and delivering out of hours services consistently seven days a week;
- Transformed mental health and learning disability services which ensure that all patients have access to the right services in the best environment seven days a week in order to optimise both their mental and physical health;
- An urgent care model that meets unplanned care needs across primary care, secondary care, community services and mental health and is embedded appropriately within Care Hub(s) and the future hospitals.

Strategic Initiative 1: Integration of Care

Objectives

- **When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible;**
- **Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life;**
- **A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services;**
- **Integrated care co-ordinated through a strong community system of Care Hubs with seven day working, full out of hours services in place and accountable GPs caring for our frail elderly and patients with moderate LTCs in the community;**
- **When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.**

The integration of care will be led through the implementation of the Care Hub approach. During 2014/15 and 2015/16 this is supported by the 'Better Care Fund' programme which plans and co-ordinates the transfers of activity from emergency admissions to hospital into community and the associated transfers of funding to a pooled budget to fund joint health and social care projects. The integration pilots are initially focusing on frail elderly individuals and those with Long Term Conditions, and then will expand to incorporate a wide range of care needs, including community mental health and end of life.

This strategic initiative is complex but critical to delivering the foundation for whole system change required for the five year vision.

A detailed planning model has now been developed which enables the CCG to clearly describe and cost our vision of future in-hospital care versus out-of-hospital care, and to understand implications of our programmes of work on both our GPs/ practices and providers in terms of impact on activity delivered to patients in hospitals and the associated number of beds required.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Implementation and Evaluation of Care Hubs has commenced with 3 **Integration Pilots** established and 1 further pilot in development
- **Mental Health Street Triage**, creating a team of skilled mental health professionals to be deployed by the police to provide initial assessment and advice for individuals with mental health needs to help avoid unnecessary detentions
- **Hospice at Home** to focus on clients who are approaching the end of their life and wish to die at home or their usual place of care
- A dedicated **Acute Liaison Psychiatry Service** to the Emergency Department at York Teaching Hospital 24 hours a day, seven days a week to support patients with mental health issues.
- **Single point of contact** to enable patients to have one care record and a single point to contact health services. There will be a named care coordinator who will retain accountability for the individual and act as facilitator to access other services and interventions
- **Enhanced rapid assessment team and domiciliary support service** to provide clinical management of patients who have urgent care needs as close to home as possible
- **Full Community Services review** to ensure our services are commissioned in line with the new approach and deliver high quality local services
- **Community equipment review** to ensure that people have timely access to high quality and safe equipment to support independence and care at home
- Implementation of new community pathways of care in **diabetes**

and neurology

- **Community IV:** Delivery of intravenous therapy at home and in the community as an alternative to hospital stays

Enabling work:

- **Co-commissioning of primary care** between the CCG and NHS England (community pharmacy, ophthalmic services, community dentistry, self-care opportunities are all currently being considered)
- **Training:** implementing a consistent approach to lean improvement methodology (Virginia Mason Production System methodology) including some of our partners are now also adopting this approach – City of York Council are to train their team in same methodology to support partnership working and system change.
- Development of **Improvement Hubs** focussed round groups of GP practices to support development and innovation in readiness for market development
- Recruitment of GP ST4 posts to provide backfill capacity to practices to free up clinicians to develop hubs and pathways of care
- **Risk stratification tool** is now commissioned to target patients who would benefit from early interventions
- **Supporting IT infrastructure**
- Development of a **Carer strategy**
- The CCG has also submitted a bid to **NHS Accelerate** to have the Care Hub supported as one of 5 national pilot sites

Future interventions which are currently being explored include:

- Revised pathways for the management of asthma in children
- Extended roles for community pharmacy
- Community dentistry into residential homes
- Direct access diagnostic services for primary care

IMPACT:

On our Ambitions and Trajectories:

- Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital ;
- Increase the proportion of older people living independently at home following discharge from hospital from a baseline of 76.7;
- Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers;
- A reduction in the number of falls related injuries for residents over the age of 65;
- Reduce avoidable hospital admissions;
- Increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community.

On addressing health inequalities:

- Focus on frail elderly
- Focus on parity of esteem for people with mental illness and improving both their mental and physical health

Expected Outcomes:

- ✓ Increase in the proportion of older people living independently at home following discharge from hospital
- ✓ Reduction in the number of people admitted to hospital who can be supported in other settings (community or home)
- ✓ Improve the health related quality of life for people with long term conditions to equal the best among our peers
- ✓ Reduced bed occupancy
- ✓ Reduced length of stay
- ✓ Reduction in delayed transfers of care
- ✓ Single point of access for clinicians
- ✓ End of life care plans

On meeting what patients need and want:

More co-ordinated care, with a single point of contact for managing and supporting the whole care pathway regardless of number of agencies involved.

‘it would be better if regular services could be provided in the community’

‘carers need to be considered and included’

On our providers:

- York Hospitals NHS Foundation Trust: Community services review
- Leeds and York Partnership Foundation Trust: mental health services review
- Voluntary sector

Milestones:

Future re-procurement of community services following evaluation of integration pilots

- Tender July 2015
- Award contract October 2015
- Start delivery April 2016

Savings/ Productivity:

QIPP savings have been identified from a number of these interventions based on reductions in A&E attendances, reduction in emergency admissions and reductions in length of stay.

CCG Clinical Lead:

Dr Mark Hayes

CCG Improvement Managers:

Ryan Irwin
Paul Howatson
Shaun Macey

Local Authority Leads:

- Dr Paul Edmondson-Jones, City of York Council (CYC)
- Richard Tassell, Group Manager, Adults Social Care/ACE - CYC
- Richard Webb, Corporate Director of Health and Adult Services, North Yorkshire County Council (NYCC)
- Rosy Pope - Head of Adult Services, East Riding County Council (ERCC)

Provider Leads:

- Mike Proctor, Deputy Chief Executive, York Teaching Hospitals NHS Foundation Trust

Other Partners:

GPs, emerging Federations and practice collaborations

Reports to:

Health and Well-Being Boards for

- City of York Council,
- North Yorkshire County Council and
- East Riding County Council

Supporting Working Groups:

- Integrated Commissioning Board (NYCC)
- Collaborative Transformation Board (CYC)
- Healthcare and Wellbeing Action Board (ERoYCC)
- Joint Delivery Group (all 3 Boards)

Strategic Initiative 2: Person Centred Care

Objectives:

- **People will have more opportunities to influence and choose the healthcare they receive and shape future services.**
- **People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life**

Patients, carers and the public are at the heart of health services and we are committed to the philosophy of 'no decision about me - without me'. Delivering a sustainable and successful NHS in the local area is a collective challenge, and we will work with the public to put them at the centre of their care, help people stay healthy through informed lifestyle choices, support people to manage long term conditions and offer people choice through a range of providers. This also includes the move towards more personalised health care services and the roll-out of personal health budgets for people with complex needs and disabilities.

Our vision of the way services will look and feel like for patients

- ✓ Local people will be supported to achieve their optimal well-being and independence through early intervention and support to change in choices, lifestyle and behaviour.
- ✓ For those with long-term conditions will be fully empowered in their own care through the equipment, support, education, development of their personal resilience.

- ✓ Specific local social challenges such as alcohol abuse, binge drinking and weight management will be addressed through targeted interventions
- ✓ Improving peoples' knowledge and understanding of access points, services available and signposting.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Implementation of the local Public Health Strategies in collaboration with providers, public health and Public Health England (see below);
- Encourage GPs and other health care workers to promote healthy lifestyle and provide access to support to stop smoking, increase physical activity levels and eat a balanced diet;
- Implementation of personal health budgets for people with complex health needs to extend their choice and influence over the care that they receive;
- Explore options of a health 'service directory' to increase public knowledge of services and promote choice;
- Healthy eating and weight management (focus on Selby population);
- Brief drinking interventions for over drinking and binge drinking;
- Review of asthma prevalence.

Enabling work:

- Refresh and implement our **Communication, Engagement and Involvement Strategy** to ensure that all stakeholders and members of the public can influence the shape of local health services.
- **Carers Support Strategy.** As we support people to manage their conditions and live at home for longer, we recognise this can place different demands on the people who care for them.
- **Technology:** we recognise the positive impact advances in technology can have in health care, both in improving efficiency and outcomes in planned care and to support self-management of conditions. The opportunity to make greater use of technology is considered in our approach to service improvement, with investments in:
 - Referral Support Service
 - The expansion of Choose and Book
 - Exploring opportunities for advanced technology through Care Hubs (exploration of e-consultations, integrated care records and risk profiling systems)
 - The introduction of Doctor first project to improve triage of calls and appointments, prioritise patient visits and use technology to support a reduction in unneeded contacts – freeing up clinician time for patient care

Public Health Commissioning Plans

The local authority Public health team currently commission sexual health services, stop smoking, school nurses and alcohol treatment.

There are a number of key recommendations identified from the JSNA 2014 which the CCG will be working with the Public Health Directorate to address key actions from their Well-Being Business Plan 2014-16, including:

- Review the effectiveness of smoking cessation services for specific population groups; particularly stop smoking support offers for pregnant women, and for manual workers.
- Development of a holistic strategy to address childhood obesity which includes consideration of; Breastfeeding Support Programmes; UNICEF accreditation initiative; targeted sport and active leisure programmes; access to active sport and leisure options; dietary advice and support.
- Development of an in-depth multi-agency local needs assessment and alcohol strategy to include consideration of; licensing; harm prevention; interventions and brief advice; crime and disorder; hospital based and specialist treatment services; parental alcohol misuse; risky behaviours in young people; older people and alcohol.
- To develop a more detailed understanding of the local needs and service provision around Stroke, Transient Ischemic Attacks (TIA) and vascular diseases which can contribute to Stroke. To include within this a review of Stroke pathways, opportunities for prevention and how local Health Checks can contribute to identification of risk factors for Stroke.
- To explore options for early supported discharge and re-ablement.
- To maximise the effectiveness of any health checks that are locally commissioned or provided by working with practices to analyse the take up of health checks by factors such as gender and deprivation. To use this information to target the offer of health checks to those groups less likely to attend and to increase the number of health checks that are completed, specifically for people with learning disabilities.

IMPACT:

On our Ambitions and Trajectories:

- Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19.
- Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers.
- Reduce avoidable hospital admissions.
- Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.
- Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%.

Expected Outcomes:

- Reduction in smoking prevalence;
- Take up of vaccination and immunisation and screening programmes;
- Increased take up of the friends and family test;
- Increased opportunities for engagement across the Vale of York;
- Increased access to personal health budgets;
- Use of technology in healthcare to deliver improved services for patients which are more flexible and convenient – increasing time for clinicians to spend with patients who require their support.

On meeting what Patients need and want:

- Seeing the right person, at the right time, as quickly as possible;
- Telling their story once;
- 'We need to be provided with reliable, relevant information to allow us to make informed decisions, particularly about our medications'.

On our providers:

Acute provider - York Teaching Hospital Foundation Trust.

Procurement:

None immediately but self-care and prevention will form part of any community services procurement in relation to delivering the Care Hub approach.

Savings/ Productivity:

Services which support people to stay well, and to remain well after recovery from illness. Reduction in number of people requiring clinical support for preventable conditions.

CCG Clinical Lead:

Tim Maycock/Emma Broughton.

CCG Improvement Manager:

Shaun Macey.

Local Authority Lead:

Paul Edmondson-Jones, Director of Public Health, City of York Council
Julie Hotchkiss, Consultant in Public Health, City of York Council.

Other Partners:

Healthwatch, Public Health England.

Reports to:

Health and Wellbeing Boards.

Supporting Working Groups:

Collaborative Transformation Board, CYC
Joint Delivery Group (all three local authorities).

Strategic Initiative 3: Primary Care Reform

Objective:

When people become ill, they are treated in a timely manner with consistent access to expert medical support as locally as possible seven days a week

National Context as of June 2014

The national Primary Care Strategy proposes significant reforms to Primary Care, taking account of national proposals for the Accountable GP, the 14/15 GP Enhanced Service around 'admission avoidance and proactive case management', seven day working and transforming GP practice.

Reasons for supporting changes in general practice:

- ✓ more proactive, coordinated care will be of real benefit for frail older people and other people with complex needs;
- ✓ more person-centred care for people with long term health conditions and people with mental health problems;
- ✓ responsive care for the general population, including same-day access to services for people with urgent care needs; but also different ways of accessing services may benefit other groups such as young people;
- ✓ preventative care, advice and interventions that will support communities and individuals to better manage their own health to avoid becoming ill, and prevent unnecessary interventions.

- **Ambition one:** proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.
- **Ambition two:** holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.
- **Ambition three:** fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.
- **Ambition four:** health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.
- **Ambition five:** consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

Our vision of how services will look and feel like for patients

General Practices will be working together, through the Care Hub approach, across populations of at least 100,000 to provide an enhanced and integrated care service. We want to move away from traditional definitions of primary, secondary, community and social care to a model of community based integrated 'care'. This requires working closely with pharmacy, dental services and community based services, and workforce reform to enable a seven day service within the community.

Patient Experience Now	Patient Experience in five years
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Primary Care	
GP managed Personalised Care Plans starting to be developed for 2% of patients through Enhanced Service.	Care Plans in place for all patients with a LTC by end April 2015 (NHS Constitution).
Patients don't routinely have access to their Personalised Care Plans.	Patients will be able to access and contribute to their own Care Plans online.
Patient Care can be fragmented with patients telling their story/details many times.	Community based care will be co-ordinated by General Practice - the delivery of care for patients will be integrated across supporting Community Nursing, Mental Health and Social Care teams.
Provision of care can be reactive for patients.	Through Risk Profiling and access to real-time admissions/discharge information, patients will be identified for proactive case management and post-discharge support.
Patients may have avoidable admissions and avoidable long stays in Hospital.	General Practice co-ordinated care teams will help to prevent emergency admissions and work with Hospitals on proactive discharge planning.

Patient Experience Now	Patient Experience in five years
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GP Out of Hours Services	
Three potential OOH providers for different areas within Vale of York CCG; variable quality/type of service available.	Single provider giving integrated, high quality service, supporting all Care Hubs.
Clear distinction between in-hours and out of hours services with disconnect in communication.	Integration between in-hours and out of hours services as Care Hubs progress and GP hours change in line with national policy. Communication systems with GP's that automatically flag patient changes in OOH period.
Limited and variable support for EOL patients.	Integrated support with Hospice, Pharmacies and acute Trust involvement.
Call process via NHS111 still requires improvement.	Additional staffing expertise around specialist services available.
Limited access to Mental Health Services OOH.	Psychiatric Liaison Services will be improved in 2014-15 and part of on-going Mental Health contracting from 2015-16 to provide much more robust access to services.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- Integration of Care
- Engagement strategy with practices through regular GP Forums and education and learning events to ensure that GP's are up to date with the latest clinical developments and aware of best practice and opportunities for improvement that have been tested elsewhere.
- Procurement and provision of risk profiling tools to assist in the systematic identification of 'high risk' patients who would benefit from proactive case management.
- Investigate the use of electronic consultations to improve access to GP appointments
- Implement Doctor First appointment triage
- Community Pharmacy
- **Community Dentistry in Residential Homes:** the CCG will commission a dedicated dental service for care and nursing home residents that builds on international evidence with local support from the Local Dental Network. This initiative is in response to the currently unmet need of this group of patients. The evidence suggests that poor oral hygiene leads to malnutrition which in turn leads to weight loss and decline in physical wellbeing. This can push an already compromised elderly person into an irreversible decline. The proactive management of oral health can ensure that patients maintain their optimum level of health. There are sufficient numbers of patients in these homes within the CCG to make the provision of a mobile dental unit a viable proposition. This development also forms part of the portfolio of schemes within our "Co-commissioning Primary care" submission.

Enabling work:

Co-commissioning of Primary Care

The CCG is currently exploring opportunities for the co-commissioning of Primary Care services in partnership with NHS England in order to support the shift of hospital activity into a more community based setting, through the development and collaboration of GP Practices enhanced services with community pharmacy, dental and optometry services. The CCG will pilot different models of general practice and extended primary care alongside the integration pilots, including consideration of how all current enhanced funding can be best utilised in order to tackle local priorities across the whole system change requirements. Potential opportunities identified include:

- ✓ **Community pharmacy;**
- ✓ **Ophthalmic services;**
- ✓ **Community dentistry;**
- ✓ **Self-care, prevention;**
- ✓ **Primary care variation in disease management;**
- ✓ **Estates strategy;**
- ✓ **Whole system funding and budgets.**

The Improvement Hubs

These will support General Practice in developing common approaches to both clinical and operational issues - addresses workforce planning, identification and proactive management of high intensity users, workplace efficiencies and the development of standards and operating procedures

Risk Stratification

In order to promote a more standardised approach to the proactive identification and management of patients who are at risk of unplanned admission across Practices, the CCG is making a Risk Profiling system (RAIDR) available to Practices to support the Enhanced Service on Admissions Avoidance.

One of our main strategic aims for this year is to support Primary Care in starting to do more to help reduce unplanned hospital admissions, and to develop services that help patients to better manage their conditions closer to home.

A key enabler for this work is the 2014-15 GP Enhanced Service on “Avoiding unplanned admissions: proactive case review and care planning for vulnerable people”, which the CCG is actively supporting through the provision of the NECS RAIDR Primary Care Dashboard to its Practices.

The NECS RAIDR Primary Care Dashboard is a web based system (accessible from all Practices) that links both GP and Hospital data (using the Combined Predictive Model algorithm) to give Practices monthly data sets that allow them to easily and systematically identify their patients who are at most risk of an unplanned hospital admission. Through the Enhanced Service (which we understand 31 of our 32 of our Practices have signed up to) we are keen for Vale of York Practices to develop Personalised Care Plans for patients who are identified as ‘at risk’ through Risk Profiling – in order to proactively manage their care and prevent hospital admissions.

This proactive approach to Care Planning, co-ordinated from within General Practice, but with support from a range of ‘wraparound’ community based services firmly underpins the CCG’s plans and aspirations around Care Hub Models (initially through Integration Pilots), and puts the patient at the centre of an integrated health, mental health, voluntary sector and social care system. As Personalised Care Plans for the most at risk patients become more established, our aspiration is that Practices should then also be able to adopt a more preventative approach to managing long term and complex conditions for a wider cohort of their patients.

The NECS RAIDR system also provides Practices with risk algorithms to predict AF/stroke, fracture, and COPD – we already have our first data extract from GP systems, and the planned go-live date for RAIDR is 24th June 2014. We believe that 31 of our 32 Practices will use RAIDR to support their work for the Enhanced Service.

Closely linked to this, and another enabler for Practices to work more proactively with elderly/complex patients is the ‘£5 per head’ funding for General Practice that was referenced in ‘Everyone Counts’ - to support GP’s in improving the quality of care for elderly patients. The CCG is committed to making this funding available to Practices to help them to quickly get up to speed with the development of Personalised Care Plans for the 2% of patients required through the Enhanced Service.

The GP Education and Engagement Programme involves subsidising GP attendance at the RCGP accredited ‘GP Update’ programme which is delivered by HYMS and updates clinicians on best practice and recent clinical developments. It is hoped that over a 2 year cycle, all Vale of York GP’s will attend this update course in order to promote best practice.

Understanding and managing unwarranted variation in primary care

Using tools such as the Primary Care Web Tool the CCG is supporting practices to understand and work through the variations in referrals and non-elective and A&E attendances for Practices when adjusted for Age and Population.

The CCG will provide support to address unwarranted variation including utilising the further roll-out and expansion of the Referrals Support Service (RSS) which was launched last year.

Use of technology

Optimising the use of technology at various stages of the pathway can have a significant impact on releasing time to care for patients. The CCG will scope and implement services which use technology to increase the value added time for patient care and reduce unnecessary steps and waiting. Schemes to be explored include Doctor First, telemedicine solutions and the use of electronic consultations where appropriate.

IT Strategy

Strategically, the interoperability agenda is a key enabler to deliver 'whole system' efficiencies and cost-savings through more effective communication and sharing of information - and to support the CCG's aspirations to further develop GP co-ordinated care planning across multidisciplinary teams. This will require collective engagement and agreement to delivering a preferred IT option for delivering across all sectors of health and social care. A critical component of this is engagement and cooperation from individual providers in making their data available to systems that support the wider sharing of information.

The CCG has commissioned a recent review to start understanding the aspirations and requirements of all relevant stakeholders and this will form the foundation of a dedicated programme of work around IT systems which will need to be co-ordinated with NHS England, all our providers, local authorities and other CCGs in the wider unit of planning.

The CCG is currently talking to two major integration suppliers: Cerner, who would like to bring their Population Health Management system from the US to the UK; and Orion, who have already integrated Health and Social Care records in Northern Ireland.

The overall recommendation is that we proceed with a number of small projects across the area to test integration/interoperability engines that sit over existing health and social care information systems (i.e. no rip and replace) and enable relevant information to be surfaced from those systems via a portal for sharing (with patient consent) across care professionals. The interoperability layer should also enable the development of electronic shared care plans that are accessible by multidisciplinary teams of care professionals, and patients and their carers.

IMPACT:**On our Ambitions and Trajectories:**

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19.**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers.**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%.**
- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**

On addressing health inequalities:

- Identifying those patients who will most benefit from early interventions and care planning.

On Parity of Esteem:

- Taking into account the mental health needs of vulnerable patients and those of high risk of disease at the same time as supporting physical health needs.

Expected Outcomes:

- Better identification of at risk patients to enable proactive care
- Seven day working patterns across the Vale of York;
- Delivery of out of hours service (new procurement);
- More patients being cared for and supported to live independently at home by community based services;
- Targeted care for elderly, end of life and complex patients (using Risk Profiling tools to assist with case finding of appropriate patients) – with shared care plans for these patients and named care leads;
- More complex services accessible in a Primary/Community care setting;
- More flexible access to Primary Care services;
- Closer working between Primary Care and Acute elderly/LTC specialties.

On meeting what patients need and want:

Co-ordinated care planning which take account of all the physical and mental health needs of an individual, with the patient at the centre of care planning regardless of the range of providers and services involved.



“We need more open access GP appointments.”

On our providers:

Primary care teams
Voluntary sector

Procurement:

Out of hours procurement could have impact
Future community service procurement

Milestones:

OOH Contract start April 2015

CCG Clinical Leads:

Dr Tim Maycock, Dr Emma
Broughton, Dr Andrew Phillips

Reports to:

Primary Care Strategy Group,
Quality and Finance Committee

CCG Improvement Manager:

Shaun Macey and Becky Case

Local Authority Lead:

Dr Paul Edmondson Jones

Other Partners:

Social Care teams, Primary Care and
GP practices

Strategic Initiative 4: Urgent Care Reform

Objectives:

- **When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible.**
- **Only the highest acuity patients are seen in A&E and alternative models of urgent care delivery will be developed in home, ambulatory care and within the community (via Care hubs and extended primary care).**

We will implement revised delivery models and pathways to reduce avoidable attendances and admissions. This will be supported by the Integration of Care transformation detailed above, as well as specific funding from winter pressures support which allows testing of new services and pathway change. This programme of work is led through the Urgent Care Working Group.

Our vision of how services will look and feel like for patients

Patient Experience Now	Patient Experience in five years
Emergency Care Practitioner Expansion	
<p>Limited ECP service available; only 4 for Vale of York area.</p> <p>Level of training and hence competencies can vary depending on where ECP trained.</p> <p>Not all appropriate calls are picked up by ECPs so patients can be conveyed to hospital unnecessarily.</p>	<p>Expanded service with predicted 9 ECP's plus admin support to filter calls.</p> <p>Standardised job role and description for all ECP's.</p> <p>Admin support and increased public face of team will increase usage.</p>
Psychiatric Liaison Provision	
<p>Patients presenting to ED have a hugely variable wait time depending on the time of day they present, available staffing and day of the week.</p> <p>A subsequent wait for assessment means that patients are further delayed in getting the help that they need.</p> <p>Currently the MHALT team can provide some assistance to 65 and overs but not working age adults.</p> <p>Social care teams are not currently involved in patient care and decision making.</p> <p>Other vulnerable patients and children, and potentially those with alcohol issues may have to wait in ED alongside people with mental health problems.</p>	<p>Patients will get a consistent service whatever day or time they present, and will not breach 4 hour waiting times.</p> <p>Assessment capacity will be better matched against demand and assessments will not be seriously delayed.</p> <p>Service will have capacity for all adults and provide different pathways for different life circumstances and presentations.</p> <p>Social care teams will be part of the MDT and available for support/advice.</p> <p>Separate and appropriate waiting areas will be provided and wait times cut so there will be a reduction in mixing between patient groups.</p>

Our Improvement Interventions which will support delivery of this strategic initiative include:

- Demand and Capacity planning for system – wide resilience planning;
- Increased Emergency Care Practitioners across the area. These will help to respond quickly to crisis and urgent need, seeing and treating at the scene to reduce transfer to Emergency Departments, working with our Yorkshire Ambulance Service;
- Under 5's admissions review, to reduce the numbers of children experiencing a 'zero length of stay' in hospital and ensuring children have swift access to high quality diagnosis in emergency departments;
- Patient Transport Services review to improve access to healthcare services;
- Out of hours services review, to enhance out of hours services aligned to the Care Hub approach and supporting the transition to 24hr/ seven day working across the health system;
- Provision of a geriatrician at the front door of ED to ensure the frail elderly have swift access to high quality diagnosis in emergency departments;
- A revised Deep Vein Thrombosis Pathway to ensure people have timely access to diagnosis and treatment.

Enabling work:

- NHS 111 as part of care co-ordination;
- In hours GP service and primary care reform initiatives.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19;**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers;**
- **Reduce avoidable hospital admissions;**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%.**

Expected Outcomes:

- Reduce unplanned emergency hospital admissions by 14%;
- Compliance with NHS Constitution targets for urgent care services;
- A more flexible and integrated service between OOH and GP provision;
- Better provision for paediatric urgent care in the community as well as through hospital;
- Better integrated support for frail elderly/care home urgent care;
- 24 hour, seven day working patterns across the Vale of York.

On meeting what Patients need and want:

Timely and responsive care in the right setting.

On our providers:

Yorkshire Ambulance Service NHS Trust
York Teaching Hospitals Foundation Trust
NHS 111

Procurement:

Out of hours (OOH) procurement
Re-procurement of mental health services will also impact

Milestones:

Tender OOH procurement July 2014
Contract award OOH procurement October 2014
OOH Contract start April 2015

Savings/ Productivity:

From reductions in emergency admissions

CCG Clinical Lead:

Dr Andrew Phillips

Reports to:

Urgent Care Working Group

CCG Improvement Manager:

Becky Case

Local Authority Lead:

Richard Tassell - CYC
Richard Webb – NYCC
Rosie Pope - East Riding CC

Provider Leads:

David Whiting, Yorkshire Ambulance
Services Trust
Liz Booth, York Teaching Hospitals
NHS Foundation Trust
Mathew Walker, OOH lead Harrogate
and District Hospital

Other Partners:

Primary Care

Strategic Initiative 5: Planned Care

Objectives:

- A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York.
- Highly productive elective care delivery based on a jointly transformed acute pathway.

Our vision of how services will look and feel like for patients

We propose to deliver efficiencies in Planned Care through reducing variations and enhancing outcomes and productivity of elective care. We support developing the hospital as a centre for elective excellence and will review of clinical pathways targeted at areas of lower performance or inefficiency and prescribing approaches. There will be a streamlining of all processes for referral.

Theme	Patient Experience Now	Patient Experience in five years
Diabetes	<p>Access to provision only available via a hospital centric service.</p> <p>Lack of information and therefore confidence in patients to self-manage.</p>	<p>Service provision to be shared between primary, community and acute services, allowing patients to be seen at the right place and at the right time.</p> <p>Extend current education programmes i.e. Good2Go second stage/advance education to include insulin courses, as well have developed stronger links to eating well and correct dietary advice for people with diabetes. Easy access to advice, via website, should improve confidence to self-manage.</p>
Neurology	<p><i>"I was given no information at diagnosis about my condition or what to expect in the future. When I got home I did my own research on the internet."</i> (Person with Parkinson's)</p> <p><i>"Some years ago there was a specialist neurology ward which worked very well and understood patients' needs. It was abruptly closed in the interests of efficiency. Result: disaster. Other wards</i></p>	<p>Referral guidelines to ensure admission of neurology patients is appropriate.</p> <p>An alert system when a neurology patient is admitted to a non-neurology ward.</p> <p>Introduce 'medication on time' initiatives into hospitals for Parkinson's patient.</p> <p>Address out-of-hours support for neurology.</p> <p>A general practice monitoring system for people with epilepsy who are not collecting prescriptions due to the higher risk of seizure.</p>

	<p><i>are having to deal with those cases and can't.</i>" (Person with Motor Neurone Disease)</p>	<p>Training GP staff to handle neurological queries Develop a one-stop-shop advice line for managing acute problems.</p>	<p>Referral Support Service</p>	<p><i>"Good, really quick definitely seems more efficient, easy and quick extremely impressed, less than 24 hours from seeing doctor to hospital booking."</i> (Patient Feedback)</p> <p><i>"How simple it is to get an appointment when and where you need it, all sorted with just one phone call amazing service."</i> (Patient Feedback)</p>	<p>Look to maintain standards and to improve where possible through acting on feedback that is continually sought.</p>
<p>Elective Care Procurement</p>	<p>Current contracts for Elective Orthopaedics and MSK are due for renewal – procurements to ensure that current high level of service provision based within the community is maintained.</p>	<p>Develop innovative, creative, workable and robust evidence based clinical pathways placing the patient at the centre of the process and further developing working relationships with both primary and secondary care providers.</p> <p>Have embedded a continuing development programme of further clinical pathways which not only meet 18 week target but also relieve the pressure on the wider district health economy and meet the local needs of the populations.</p> <p>Provide patients with a seamless pathway of care from outpatients through to diagnostics/ procedures and on to discharge.</p> <p>Develop care pathways reflecting local needs and demands in partnership with patient users and clinical referrers.</p> <p>Maintain a high quality of health care that will be reflected in patients' continuous reporting of high satisfaction and further patient selection of the service through choose and book.</p>	<p>Cellulitis, Bronchiectasis and Community IV</p>	<p>Patients requiring IV antibiotics for Cellulitis or similar problems are required to attend a ward and stay as an in-patient for days or weeks on occasion to receive treatment. Patients defer treatment because they know they'll be in hospital for some time and hence may deteriorate. Beds can be difficult to access at busy times and again elective admissions for treatment may be delayed.</p>	<p>Patients will be able to have a homecare company provide the necessary equipment, drugs and monitoring to be able to receive treatment at home. This would be supported by YTHFT community staff.</p> <p>Same as above.</p>

	<p>Other patients requiring IV antibiotics may attend as an outpatient but may need to attend a local hospital once or twice daily; limiting their quality of life.</p>	
<p>Prescribing</p>	<p>Branded medicines prescribed in large numbers.</p> <p>Some practices prescribing non-commissioned drugs; which may have been taken off formulary for clinical or financial reasons.</p> <p>Patients prescribed dressings in large volumes that are difficult to store and may be wasted if not used.</p> <p>Gluten free products are not prescribed equitably across the region.</p> <p>Stoma care products are not prescribed equitably across the</p>	<p>Generic medicines prescribed more where appropriate, freeing up spend for other specialist drugs to be commissioned.</p> <p>All patients only prescribed commissioned drugs; safety improved and freeing up spend for other specialist drugs to be commissioned.</p> <p>Dressings all prescribed from dedicated software, enabling split packs to be issued and hence a reduction in storage, more appropriate dressings used, and less waste across system.</p> <p>There will be a standard testing and diagnosis regimen which will ensure equity and management of gluten free products for patients requiring them.</p> <p>Stoma care products will be prescribed as required, with less wastage and appropriate products</p>

	<p>region and patients may be prescribed products in large volumes that are difficult to store and may be wasted if not used.</p> <p>Sip feeds are often prescribed to patients inappropriately or in unsuitable volumes creating storage difficulties and wastage for patients.</p>	<p>for patient complaints.</p> <p>Patients will be prescribed products appropriately and they will be issued to reduce wastage and improve adherence to feeding regimens.</p>
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IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19**
- **Improve the health related quality of life of people with one or more long-term condition, including mental health conditions to equal the best amongst our peers**
- **Reduce avoidable hospital admissions**
- **Increase the number of people having a positive experience of hospital care by 12%**

Expected Outcomes:

- Improved patient access to care with a reduction in referral to treatment time for key conditions
- Roll out of the Referral Support Service across targeted disciplines
- Reduction in procedures of limited clinical value
- Reduction in zero length of stays
- Effective care as specified by NICE guidelines – building on the success of the diabetes model
- Improved sharing of information across service providers
- More electronic referrals, less paper in the system
- review delivery of all planned admissions for less complex treatments and maximisation of day case activity
- Pathway and VFM review (benchmarking and new prioritisation framework)
- Reductions in LOS (QIPP)
- Improvement of new: follow-up ratios (productivity)

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

The following areas will be reviewed to ensure that the pathway from diagnosis to treatment and long term management, where appropriate, is timely and as efficient as possible and delivers high quality and safe care.

- Clinically appropriate management of outpatient follow-ups
- Diabetes pathway review
- Neurology pathway review
- Dressings Management
- Ophthalmology service review
- Cellulitis, Bronchiectasis and Community IV

On meeting what Patients need and want:

Telling my story only once

Co-ordinated care across providers and settings

‘We want more time with Consultants’

‘We want to wait less time for our hospital treatment’

On our providers:

York Teaching Hospitals Foundation Trust, Leeds Teaching Hospitals NHS Trust, Hull and East Yorkshire Hospitals NHS Trust

Procurement:

Elective orthopaedics procurement, Musculoskeletal service procurement

CCG Clinical Lead:

Dr Shaun O’Connell

Reports to:

Collaborative Improvement Board

CCG Improvement Manager:

Andrew Bucklee

Provider Lead:

Mike Proctor, YTHFT

Strategic Initiative 6: Transforming mental health and learning disability services

Objectives:

- **Reduction in premature mortality**
- **High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area.**
- **Services delivered from modernised and fit-for-purpose infrastructure**
- **Delivering the required system capacity to target local need, address inequalities and meet our challenging access and diagnosis targets**

Development of mental health and learning disabilities (LD) services and addressing the current inequalities in access and outcomes is a key priority for the CCG.

Our IAPT psychological therapies services currently have long waiting times and the inpatient estate at Bootham Park Hospital requires redevelopment.

We plan to transform our mental health and LD services in the local area to enable a greater parity of esteem between mental and physical health and ensure that timely, safe and quality care is equally as accessible as care for physical illness or injury.

This will be an area for investment for the CCG in the next five years, with a complete review of the model of provision and the supporting estate to ensure that it is fit for purpose.

This will include a focus on dementia, access to psychological therapies (IAPT) and the physical health of people with mental health issues. The challenge of meeting IAPT and dementia targets will require innovative approaches to developing capacity and pathways and we are working with Leeds & York Partnership Foundation Trust (LYPFT), the voluntary sector providers locally and NHS England to plan further capacity development.

Our vision of what services will look and feel like for patients

A new model of mental health provision for the local area, which will:

- Increase dementia diagnosis rates;
- Reduce out of contract placements;
- Improved access to psychological therapies;
- Support people with dementia who move from acute to community care to live independently;
- Improve the standards of physical health care within mental health in-patient facilities to support earlier diagnosis and treatment of common illnesses. This is vital to our on-going goal of reducing premature mortality;
- Encourage people with mental health problems to access existing health and dental checks, and to understand the effects of medication and the need for screening and immunisation;
- Reduce waiting times across mental health provision;
- A clear and appropriate autism strategy and pathway;
- Estate that is fit for purpose;
- Reduce delayed transfers of care.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- **Full review of Mental Health services** including all provision, quality performance and contract monitoring – this will be in support of tendering the current contract in November 2014 and service commencement October 2015;
- Review and development of an **estate development plan** to ensure all estate is fit for purpose; currently there is work on-going to provide an interim facility while the Bootham Park Hospital estate is redeveloped;
- Commission a comprehensive **liaison psychiatry service** that is responsive to those within A&E and complex cases on wards for those with mental ill health (Leeds and York Partnership Trust working in partnership with York Teaching Hospitals NHS Foundation Trust). This should also support an increase in the diagnosis rates of those with dementia;
- Active review of placements to **reduce out of contract placements**
- Investment in the psychological therapies service (**IAPT**) to provide a range of therapies from low level interventions to high intensity treatments within primary and community settings with an expected achievement of 8% by the end of 2014/15;

- Dementia pathway review including:

- Work in partnership to develop **Dementia Friendly Communities** to reduce stigma and improve early diagnosis and provide support to people to live independently for as long as possible
- Dementia work with primary care to increase the knowledge and skills of practice staff, increase efficiency of screening, coding and links to memory clinics
- **Dementia Care Navigator** tender currently being developed with NYCC in order to (i.) reduce stigma and encourage people to seek support, (ii.) maintain and develop social networks and support mechanisms to live well with dementia, and (iii.) maintain independence for as long as it is safe to do so

Enabling work:

- The **DISCOVER! engagement programme** to inform the service specification for the future mental health tender;
- Hospital staff training programme for Dementia for clinical staff and all staff with general public contact;
- Implementation of the Lester Tool by clinicians to support the assessment and diagnosis of physical health needs in patients with mental illness (cardiac and metabolic health);
- Work with Primary Care to increase the knowledge and skills of practice staff, increase efficiency of screening, coding and links to memory clinics and care navigator.

Parity of Esteem

Transforming mental health services also provides an opportunity for the CCG and its providers to focus on tackling wider health inequalities. We recognise that reforming mental health services are integral to the transformation of the whole health and care system to meet the needs of our population.

Access to primary and community care for physical and mental health issues should be comparable. Therefore, our vision of Care Hub Models will be to integrate the mental and physical health services helping improve the recognition and diagnosis of mental health conditions, including dementia. We will also work in partnership with health promotion and local authorities to help remove the stigma surrounding mental health conditions.

The CCG will consider all opportunities to:

- develop the access and quality of mental health services provision
- consider how to improve the physical health of patients with mental health conditions developing other care pathways

The mental health and learning disability services review and procurement will focus on identifying all opportunities for improving health promotion work (smoking cessation, weight management, routine health checks; screening; oral health and screening/ immunizations) and early diagnosis of physical health issues in all mental health service settings.

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19;**
- **Improve the health related quality of life of the people with one or more long-term condition, including mental health conditions to equal the best amongst our peers;**
- **Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%;**
- **Quality Premium;**
- **Improving access to psychological therapies (IAPT).**

Expected Outcomes:

- 'a new model of mental health services' (see above)

On meeting what patients need and want:

Patients will:

- Be able to make sense of their change of behaviour;
- Get an earlier diagnosis;
- Be able to make informed choices about their future – how they want to live and how they want to die;
- Be able to learn coping mechanisms – for the person with dementia and their family and friends;
- Be able to arrange for support to help them maintain their independence for as long as possible;
- Receive parity of care which takes account of mental health and physical health needs – focussing on the whole individual and not just disease pathways;
- Have an improved quality of life.

On our providers:

Leeds and York Partnership Foundation Trust

Milestones:

Mental health procurement – tendering the current contract in November 2014 and commencement of new service October 2015

CCG Clinical Lead:

Dr Louise Barker

Reports to:

Mental Health Partnership group
Health and Well Being Board

CCG Improvement Manager:

Paul Howatson

Supporting Working Groups:

Procurement Project Group

Partnership Commissioning Unit:

John Clare

Bootham Park Hospital
Programme Board

Local Authority Leads:

Paul Edmondson Jones, CYC
Richard Webb, NYCC
Rosy Pope East Riding CC

Other Partners:

East Riding CCG

Strategic Initiative 7: Children and Maternity

Objective:

- **People will be supported to stay healthy through promoting healthy lifestyles, improving access to early help and helping children have a healthy start to life**

Our vision of what services will look and feel like for patients

We want to enable the best start in life through supporting children and families to achieve improved health outcomes. This incorporates safe and effective maternity services for the local area, and support to vulnerable children throughout their childhood and transition to adult life.

The major focus of transformation is the move to more personalised packages of care for children with special educational needs and disabilities, the review of child and adolescent mental health services, aligned to the Mental Health Transformation, and the reduction of health inequalities for children and families.

NHS England Public Health key priorities

We will work with NHS England and contribute to deliver the following key public health priorities, through co-commissioning:

- Additional elements to screening programme e.g. new born / antenatal x four additional test as part of Blood spot screening, plus additional new immunisation programmes;
- Health visitor trajectories;
- Childhood flu as 2014/15 plus increase in primary schools and secondary schools;
- Childhood flu as 2013/14 Age 0-4 Years plus School Years 7-8 years;
- Re-procurement of school nursing immunisation service in North Yorkshire with North Yorkshire Council;
- Maximise immunisation programme Coverage (16 immunisation programmes) screening coverage (cancer, non-cancer, new-born and antenatal);
- Adolescent vaccinations in schools

Yorkshire and Humber Children's and Maternity Work Programme 2014-16

A number of our improvement initiatives contribute to the wider regional improvement programme, for example:

- Developing systems to reduce the level of unplanned admissions to hospital for Long Term Conditions
- Developing systems to support the review of CAMHS provision and the transition between CAMHS and adult services

Children and Families Act

We are working with our partners, particularly local authorities to implement a number of changes required under the Children and Families Act, including: Special Educational Need reforms, Education, Health and Care plans and Personal Health Budgets.

We are also contributing to the three Health and Wellbeing Strategies across our area, for example York's Health and Wellbeing Strategy's priority 'Enabling all children and young people to have the best start in life'.

A number of our improvement projects link to other work programmes our partners are undertaking, for example:

- Improvements to Health Visiting before the transition from NHS to local authorities in October 2015
- Healthy Start Programme and Breastfeeding programmes
- Weight Management initiatives
- Food for Life Partnership, engaging with communities to promote healthy eating
- Reducing smoking during pregnancy and supporting young parents.

Our **Improvement Interventions** which will support delivery of this strategic initiative include:

- To revise the Maternity Commissioning Strategy working collaboratively with North Yorkshires CCGs to provide sustainable and safe maternity services;
- Develop a maternity dashboard to ensure we have the appropriate information to affectively monitor the quality and performance of the maternity services we commission;
- Enhance health reviews and health promotion service for Looked After Children (LAC). This includes ensuring that all LAC receive health assessments and developing health passports for care leavers;
- Review the emergency admissions for children with lower respiratory tract infections (part of our wider objective to reduce unplanned admissions and promote quality of life);
- Access to Personal Health Budgets for those with Continuing Health Care and Long Term Conditions;
- Access to person centred Education, Health and Care Plans, ensuring we meet the new duties under the Children and Families Act to give children and parents more flexibility in their health and care support;
- Establish a clear pathway to tiers 1 to 4 Children and Adolescent Mental Health Services (CAMHS) based on the review of CAMHS Strategy, working with local authorities to ensure we have a comprehensive services across the levels of need, delivered in a timely way;
- Autism pathway to improve diagnosis assessment timescales and support to children and families across the Vale of York;
- Weight management (particular focus on Selby population);
- Supporting the local 2014 Challenge Campaign to support children in managing their own health through weight management, mental health and exercise promotion and awareness
- Review of asthma prevalence

IMPACT:

On our Ambitions and Trajectories:

- **Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19;**
- **Reduce avoidable hospital admissions.**

Expected Outcomes:

- Improved performance on the maternity dashboard
- Increased breastfeeding rates
- Timely health reviews for all Looked After Children
- Access to personal health budgets and education and Health and Care plans
- A clear pathway across tiers 1-4 for CAMHS
- Decrease waiting times for Autism diagnosis
- Ensure comprehensive and timely services across the varying levels of need

On meeting what Patients need and want:

- Safe and sustainable maternity services that promote increased choice.
- Timely health reviews for all Looked After Children
- Improved performance framework for maternity services leading to more effective commissioning aligned with population need.
- Increased collaborative working to ensure delivery of the Healthy Child Programme.
- Looked After Children will be more engaged in decisions about their own health and wellbeing with improved access to health services.
- Care in the right place at the right time and by the appropriate health professional.
- Personal Health Budgets will allow increased choice and control for children and families, supporting personalisation.
- Person centred, rather than service led, care and support for children and families integrating education, health and social care.

- Decrease waiting times for Autism, achieving higher quality diagnosis assessments and support in accordance with NICE guidance.
- Clearer pathways for tiers 1-4 mental health services.

On our providers:

York Teaching Hospitals Foundation Trust
 Leeds and York Partnership Foundation Trust
 Leeds Teaching Hospitals NHS Trust
 Hull and East Yorkshire Hospitals NHS Trust

CCG Clinical Lead:

Lucy Botting (Chief Nurse and Safeguarding Lead)
 Dr Emma Broughton – Maternity Clinical Lead for Children to be appointed July 2014

Reports to:

YorOK (and report to Health and Well Being Board CYC)

CCG Improvement Manager:

Polly Masson

Partnership Commissioning Unit:

Jayne Hill

Local Authority Lead:

Directors of Children’s Services for each of our Local Authorities

Provider Lead:

York Teaching Hospitals Foundation Trust

Strategic Initiative 8: Cancer, Palliative and End of Life Care

Objectives:

- **When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care.**
- **Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.**

Cancer prevention, diagnosis and treatment are a key focus for this CCG. This will be supported through promotion of smoking cessation and healthy eating initiatives. This will also be supported by the screening campaigns from Public Health England and the Well-Being plan which includes an alcohol strategy.

During the initial planning period we will undertake a review of our cancer pathways, in conjunction with primary care and specialist commissioning to ensure we have timely and effective routes to support diagnosis and treatment.

Concurrently, the CCG will also start a review of the local Palliative Care and End of Life care services and pathways. It is envisaged that future End of Life services will be embedded within the Care Hub (s).

Our vision of what services will look and feel like for patients

Patient Experience Now	Patient Experience in five years
<p>Care and support for carers and palliative care patients and those facing the end of life is variable and disjointed.</p> <p>Currently, the only consistent providers of quality care are Marie Curie Overnight Nursing Service and the services provided by St Leonard's Hospice.</p> <p>It has been acknowledged that some health professionals across a variety of settings struggle to identify when someone may be facing the end of their life and lack the confidence to discuss this. Workforce planning.</p>	<p>Patients and carers will have their needs assessed and navigated to the right service, first time.</p> <p>Patients and carers will experience joined up care between provider organisations.</p> <p>VOICES surveys of patients/their carers will show a stepped change and more positive responses to questions raised.</p>

Improvement Interventions that will deliver this strategy:

- Cancer pathway review and redesign working with Survivorship programme
- Palliative care review

Enabling work:

- Carers strategy
- Well-being plan implementation
- Work with GPs to deliver primary care Hospice at Home

IMPACT:

On our Ambitions & Trajectories:

- Reduce the Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare by 14% by 2018-19
- Increase the number of people with mental and physical health conditions having a positive experience of hospital care by and care outside hospital in general practice and the community by 12%
- Reduce the amount of time people spend avoidably in hospital by 14% through better and more integrated care in the community, outside of hospital.

Expected Outcomes:

- Improve screening uptake;
- More patients being cared for and supported to live/die at home by responsive community based services;
- Carers needs are assessed and addressed appropriately;
- Targeted care for elderly, end of life and complex patients (using Risk Profiling tools to assist with case finding of appropriate patients) – with shared care plans for these patients and named care leads;
- More complex services accessible in a Primary/Community care setting;
- More flexible access to Primary Care services;
- Individuals and carers' will be more engaged in decisions about their own health and wellbeing with improved access to health services;
- Work towards an accountable lead provider in future procurements, specifically for palliative/end of life care.

On meeting what patients need and want:

- Care in the right place at the right time and by the appropriate health professional.

On our providers:

- Increased collaborative working to ensure seamless care delivery

Procurement:

Development of the Palliative and end of life care specification for future procurements.

Savings/ Productivity:

Opportunity within future commissioning of community services to further improve quality and efficiency.

CCG Clinical Leads:

Dr Joan Meakins – Cancer
 Dr Andrew Phillips – Palliative & End of Life care

CCG Improvement Manager:

Paul Howatson

Local Authority Leads:

Richard Tassell – CYC
 Chris Jones- King – NYCC

Provider Leads:

YTHFT, LYPFT, HEYHT

Other Partners:

Marie Curie, Macmillan, St. Leonard's Hospice, Independent Care Group, St. Catherine's Hospice

Reports to:

Vale of York and Scarborough and Ryedale Palliative and End of Life Care Programme Board.

Supporting Working Groups:

Vale of York Palliative and End of Life Care Locality Group.

Quality Assurance and Improvement

Objectives:

- **Population Wide Quality Outcome Improvement**
- **Parity of access to safe, high quality healthcare services**
- **Improved quality outcomes for people with physical and mental health conditions**
- **Increase the number of people with physical and mental health conditions having a positive experience of health care**
- **Increase harm free, effective quality care across all areas of health and social care**
- **Increase the practice of continual quality improvement through learning from our past mistakes**

Achievements in 2013/14 - Laying the Foundations:

1. Development of robust quality governance arrangements internal and external to the CCG to support a focus on quality surveillance, assurance and a relentless focus on continuous quality improvement;
2. Development of close collaborative partnership working with providers to support continuous quality improvement. This included work during winter 2013 /14 to relieve the pressure on urgent care and work to support a reduction in health care acquired infections;

3. Collaborative working with providers to deliver the 2013/14 CQUIN schemes and put in place appropriate CQUIN measures for 2014-15;
4. Successful renegotiation of the 2014-15 quality schedules within our main provider contracts to include updated critical outcomes and reporting from lessons learnt from the Francis and Berwick Report(s), Winterbourne View, Munroe Report and Hard Truths;
5. Development of triangulated information systems (quality, performance, patient experience) to enable a proactive focus on quality surveillance and its improvement.

Achievements going forward in 2014-15:

6. Building a proactive collaborative quality surveillance, assurance and improvement system;
7. Continued development of robust quality governance arrangements extending to our members within primary care i.e. the development of a clinical commissioning network for health professionals in line with compassion in practice;
8. In line with HEE and the demographics around an aging workforce a relentless focus on workforce development for all professionals in line with the strategic plan;
9. Continued development of triangulated surveillance and intelligent systems extending to our members within primary care to include quality improvement support;
10. Soft Intelligence development – clinical and patient soft intelligence development to enhance the quality and richness of information

received to enable “you said, we listened, we did “in line with the Francis Report;

11. Development of a CCG Quality Strategy and Quality Assurance Framework in line with the CCG five year Strategic Plan;
12. Collaborative working with our providers to further reduce harm and promote a ‘lessons learnt’ approach to quality and safety improvement. This will include a further reduction in health care acquired infections and improvement in areas such as pressure ulcer care, falls and performance (RTT/Diagnostics/ Cancer Waits);
13. A focus on proactive safeguarding for children, young people and adults deemed as vulnerable.

Quality

Quality means different things to different people, however improving people’s lives (quality outcomes) and improving their experience of care is at the heart of what matters and helps drive the change we want to see to improve quality care within the Vale of York CCG.

As an overarching principle ‘quality care’ can be defined as:

- The improvement of patients’ lives (quality outcomes- life expectancy, health outcome)
- Patient experience of care
- The safety of the care and treatment provided.
- The clinical effectiveness of the care and treatment provided
- Parity of esteem.

To achieve this vision the CCG have put in place robust systems and processes to enable quality to become co-centric and embedded within the five year strategic plan. This includes a focus on:

- **Quality Outcomes** – the development of meaningful quality outcome measures that enable us to monitor the health of our population and focus resource on areas deemed critical to health improvement
- **Quality Governance** – the structure, process, values and behaviours internal and external to the CCG that enable us to provide the assurance and the control that care is safe and of high quality.
- **Quality Surveillance and Assurance** –the proactive monitoring, management and evaluation of services that we commission to ensure high quality, harm free care.
- **Quality Improvement** –continuously challenging quality assumptions, learning from past mistakes and adapting our approach to health care in order to achieve a better focus on improved quality outcomes.

Quality Outcomes

In line with the Quality Outcomes Framework and in conjunction with our demographic health profile the CCG has prioritised population need and developed meaningful commissioning intentions in line with the Strategic Plan for years 1-5 which aim to improve the quality of life for all our population (health outcomes and life expectancy): this includes those with a mental health illness, those vulnerable and frail elderly and children and young people starting out in life. Meaningful quality outcome measures will enable us to gauge how well we have achieved our ambition and enable us to refocus our intentions in the future on those with the greatest need.

Quality Governance

In line with Monitor's Quality Governance Framework the Vale of York CCG firmly believes that robust quality governance is essential to achieve our desired outcomes for success. We have ensured this through:

- Leadership for Quality at Executive and Governing Body levels (GP and Nurse Clinical leadership)
- A review of our quality governance processes (internal and external to the CCG) to include a clinical effectiveness group as a sub-committee of the Quality and Finance Committee to assure that health care planning is bound by best practice guidance. This includes research governance.
- A review of current intelligence systems, processes and reporting which has included a refresh of our quality and performance dashboard to ensure that intelligence is up to date, triangulated and includes patient experience. This provides richness and a more robust degree of accuracy to the information we source to enable intelligent commissioning in line with recommendations from the Francis Report.
- A Commissioning for Quality Network across the CCG to ensure all professionals, nurses and allied health professionals have a voice in the commissioning of healthcare
- The CCG Quality Strategy refreshed to form a strategic alignment with the five year plan
- Quality embedded in everything we do, everything we plan and in all our processes and systems

Quality Surveillance and Assurance

It is important when an organisation appears to be failing that we take immediate and effective notice of 'early warning triggers'. The CCG will work in partnership with providers, partners and stakeholders to collaborate and share soft and hard intelligence to ensure that triggers to failure are highlighted with immediate effect and the recipient organisation is supported in order to minimise risk and harm.

Lessons learnt from the recommendations from the Francis and Berwick Report(s), Winterbourne View and the Munroe Review have been applied to enhance and further develop quality within our organisation (the tools, systems and processes we use to plan, monitor, assure and evaluate quality) and within our commissioned services. These recommendations are routinely applied to the renegotiation of contracts and the setting of quality schedules and form part of the Key Performance Indicators that the provider will report on i.e. Hard Truths (workforce), Duty of Candour. These recommendations also form part of our Quality Assurance Checklist for existing or new services.

To provide a further degree of scrutiny and rigour to the surveillance and assurance of quality the CCG:

1. Monitor the performance and quality of commissioned services using the triangulation of quality, performance and patient experience. These indicators analyse baseline thresholds as well as performance trends and local and national benchmarked averages. This is reported to the Quality and Finance Committee on a monthly basis with escalation to the Governing Body. An escalation contingency plan enables the ad hoc escalation of risk should risk rise about a threshold.

2. Higher level quality scrutiny occurs with partner organisations such as our neighbouring CCGs, NHS England, regulators i.e. CQC, TDA and Monitor and others such as Health Watch and the Local Safeguarding Children and Adults Boards. The CCG work with partnership with these organisations to communicate, monitor and assess the risks in relation to quality. Where harm is identified and / or care deemed unsafe the necessary processes, levers and enforcements are put in place to support and resolve mitigation. This includes the work of the Quality Surveillance Group whose remit it is to share quality concerns across Yorkshire and Humber.
3. Oversight of a provider's quality and performance targets are undertaken by each CCG, these may include serious incidents, complaints, and failures in performance. The lead and associate commissioners meet with the provider on a monthly basis at the respective quality and performance committee, a sub group of the contract management board to discuss any decreasing trends or quality concerns to challenge and improve practice. Where escalation is required these concerns are taken to the contract management board.
4. Formal Contract Management Boards take place each month with the respective providers to manage, challenge and resolve quality and performance concerns. This takes the format of informal to formal challenge, which may include holding the provider to account through improvement actions assuring each CCG that failures in quality are actioned and improved.
5. Where care has been deemed unsafe and at a degree of escalated concern that it puts patient safety at risk, with no immediate actions to resolve, the commissioner in conjunction with NHS England and / or the regulator may have no other option but to suspend the service. Full consideration of resolution will be considered in the first instance.
6. Quality Accounts. All providers are required to produce an annual quality account, which sets out the provider's standards and achievements in relation to the quality of care and patient experience provided in the previous year and ambitions going forward. It is our duty as commissioners in accordance with the Health and Social Care Act 2012 to ensure that these accounts are a true and accurate representation. These accounts are published on the provider's website.
7. In line with providers cost improvement plans it is the expectation that they will also produce quality impact assessments (QIAs). These assessments are undertaken to assess risk in relation to the quality and safety of care provided. As commissioners it is our duty to assess and assure these plans to ensure that no detriment to quality occurs. These plans are monitored and reviewed regularly at the quality and performance committees.
8. Other surveillance and assurance activities include walking the walk with patients and providers and other forms of soft intelligence such as networking events, forums and patient engagement events.

Quality Improvement

In accordance with the recommendations from the Frances and Berwick Reports and the government's response to these reports (Hard truths) quality improvement is the basis for which we continuously challenge assumptions on quality, striving to improve areas of quality and safety in line with clinical effectiveness.

We have ensured that quality improvement is embedded within everything we do and within the five year strategic plan. Actions related to this include:

1. **Quality Governance:** The clinical effectiveness group monitor commissioning plans in relation to area of quality effectiveness change in relation to National guidance and policy. This includes NICE Guidance i.e. changes to treatments such as IVF, Varicose Vein procedures. Recommendations are presented to the Governing Body.
2. **Clinical Quality and Improvement Scheme (CQUIN).** The CCG work with providers to agree local CQUINs. These are schemes and associated payment to improve the quality of care, based on areas of provider weakness or changes to national or local policies which indicate a higher degree of quality in a given area. Indicators are set at national and local levels. These are monitored throughout the year.
3. **Quality Premium.** Set at national level the quality premium is a retrospective payment made to the CCG to improve areas of quality, based on national quality and performance indicators of concern. Whilst most of the indicators are national i.e. Accident and Emergency 4 hour waits, ambulance response rates, there is also the opportunity for CCGs to set local indicators to oversee quality improvement. In 2014-15 the CCG have chosen falls and the family and friends test (Out of Hours) as markers of quality improvement. These indicators are managed by work streams within the CCG and reported to the Quality and Finance Committee.

Safeguarding

The failures at Mid Staffordshire NHS Foundation Trust and at the independent care home, Winterbourne View as well as child protection (Baby P), provide stark reminders that when the NHS falls short of their responsibilities in respect of quality, the consequences for patients, service users and their families can be catastrophic.

The Vale of York CCG have made safeguarding a priority and as such are increasing the capacity within both the children's and adults safeguarding teams to ensure there is the capacity to deliver a robust model of proactive assurance across the Vale of York.

Equally the CCG as the accountable health organisation for safeguarding must have:

- An Executive lead on the Governing Body for safeguarding
- A GP lead on the Governing Body for safeguarding adults and children
- Are permanent members of the Local Safeguarding Children and Adult Board

Safeguarding is also embedded within all the work of the CCG, staff training and a full list of relevant policies are in place.

The following table summarises some of the initiatives that we will reinforce over the next year to promote and enable service quality.

Quality: Our Priorities for 2014-15

Patient Experience	Increase the use of Friends and Family Test across all care delivery sectors. This includes providing support to Primary Care
	Promote real time data capture of patient/ carer and clinical experience to inform quality delivery.
	Monitor staff survey results and ensure that action is taken to resolve any significant concerns.
	Actively work with providers to ensure their duties in relation to the duty of candour are appropriately discharged.
	Work with the Looked after Children's team to ensure that Children have parity of access to health and have are happy, fulfilled and their wellbeing prioritised
	Promote the use of digital technology to reach professionals and the public.
Patient Safety	Work with YHFT to reduce hospital mortality rates.
	Work with all providers to reduce the incidence of Never Events and to ensure organisational learning from Serious Incidents
	Reduce Hospital Acquired Infections in line with or preferably below national thresholds
	Ensure robust arrangements are in place for safeguarding adults and children
Commissioning Clinically Effective Care	Work with YHFT to develop a service recovery plan where required to support improved compliance with nationally identified staffing ratios
	Commission services based on NICE clinical quality standards and ensure all providers are performance managed against the relevant standards
	Work with providers to meet the standards in service specific outcome strategies for mental health services, cancer, COPD, asthma and LTC associated with premature mortality.
	Continue to support clinical strategies aimed at reducing early mortality from CVD, Stroke, kidney disease, diabetes and for patients with mental illness.
	Promote the CCG approach to commissioning for outcomes ensuring a robust approach to using evidence to support commissioning decisions and the development of performance monitoring metrics to measure outcomes
Winterbourne	Work with the continuing healthcare team in line with the concordat for Winterbourne View to ensure vulnerable adults are placed appropriately including MCA/DOLs capacity assurance.

National CQUIN Indicators 2014-15

National CQUIN Scheme	Acute Services (York Hospital)	Community Services (York Hospital)	Ambulance Services (Yorkshire Ambulance Service)	Mental Health Services (Leeds and York Partnership Foundation Trust)
Friends and Family Test	√	√	√	√
NHS Safety Thermometer	√	√	N/A	√
Dementia and Delirium	√	N/A	N/A	N/A
Improving physical healthcare to reduce premature mortality in people with severe mental illness	N/A	N/A	N/A	√

Local CQUIN Indicators 2014-15 NHS Providers

Organisation	Local CQUIN Indicators
York Teaching Hospital NHS Foundation Trust	<ul style="list-style-type: none"> • Sepsis Care Bundle • Care of the Deteriorating Patient – 12 Hour Assessment by Consultants • Pressure Ulcers • Stroke – Early Supported Discharge • Medicines Management – prescribing and missed critical medicines
Leeds and York Partnership NHS Foundation Trust	<ul style="list-style-type: none"> • Care Planning – training to improve quality of care plans and audit to ensure CPA standards • Establish a culture of engagement and involvement with service users and carers – set up service user forums • Incident reporting – rollout Datix web system to York Services, train staff and encourage a culture of open and transparent reporting.
Yorkshire Ambulance Service Emergency Services	<ul style="list-style-type: none"> • Care Homes: Right Care, Right Place • Improving Red 1 and Red 2 performance in underperforming CCGs (including NHS Vale of York CCG) • Improving Patient Safety and Reducing Harm (reporting incidents on falls/medicine errors and harm whilst in YAS care)
Yorkshire Ambulance Service Patient Transport Services	<ul style="list-style-type: none"> • Improving the experience of patients with complex needs • Improving patient experience related to transfer times for patients attending outpatient clinics
Nuffield, York	<ul style="list-style-type: none"> • VTE • Electronic Discharge Letters • Falls Risk Assessment and Care Plan
Ramsay – Clifton Park Hospital	<ul style="list-style-type: none"> • VTE • Electronic Discharge Letters • Nutrition and Hydration Audit

Quality outlier : areas for further improvement (YHFT)	Specific Area of Improvement	Mitigation
Falls	Increase in the number of fractured neck of femur	Action plan in place.
Refer to Treatment Times	Capacity issues identified with:- <ul style="list-style-type: none"> • Cardiology • Dermatology • ENT • Gastroenterology • General Surgery • Gynaecology • Neurology • Rheumatology • Thoracic medicine • Urology 	RTT external report outstanding. Discussions with YHFT: system and process issue including capacity. Not a growth demand assumption. Monitor and NHSE aware.
Diagnostics	Cystoscopy, Gastroscopy, Audiology Assessments and Non-obstetric Ultrasound	Systems, process and capacity issue. Awaiting RTT report.
Cancer Waits	Particular areas include Breast Screening.	Included within RTT external report. Possible systems, process and capacity issue. Report outstanding.
HCAI	C.Diff – 7 cases against plan of 59 (May 2014)	Operational Lead In place for Vale of YorkCCG. Action plan in place.
Safe Staffing (Hard Truths)	Report to be submitted to Trust Board in June 2014	Report outstanding. CCG monitoring in relation to areas of quality/ performance concern.
Audiology Assessments for Children	Scarborough	Managed and action plan In place by PCU
IAPT	Modelling and capacity issues	Business case submitted for 8% growth threshold. Modelling to drive – 15% by end of 2014-15.

Financial Sustainability

Financial Strategy 2014-15 to 2018-19

Introduction and 2013-14 Successes

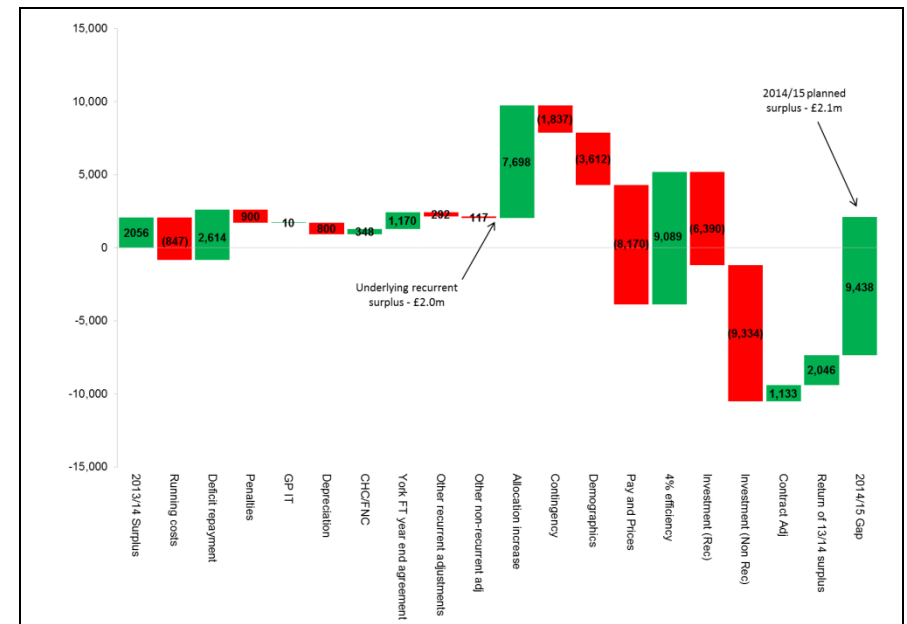
The financial strategy for the CCG provides a framework for supporting and driving the delivery of the five year Strategic Plan. It is aligned with the overarching timeline of the strategic plan of ensuring foundations are laid to enable a move to long term financial sustainability. It supports the integration programme, improvement interventions and delivery of better quality care for the Vale of York population.

2013/14 was the first year of operation for the CCG and financially, a challenging one. In the early part of the year, the legacy of the PCT was evident with a historic deficit to repay, a reduced finance and contracting team and gaps in financial governance processes. However, the CCG achieved some significant financial successes:

- Planned surplus of £2.05m delivered;
- Annual Accounts prepared and submitted with an excellent, unqualified audit report;
- Increased finance and contracting team resource recruited including Chief Finance Officer;
- Significantly improved accuracy of contracting data and influence in contract negotiations;
- Built good relationships with local providers and partners which led to 2013/14 agreement on financial positions and agreement of 2014-15 contract baselines.

2013-14 Outturn and Underlying Position

The outturn for 2013/14 was £2.05m surplus (0.57%). The impact of the changes to allocations, business rules and key financial assumptions on the CCG's underlying position that will be carried forward in to 2014-15 is shown below. This has also been communicated and discussed in detail with senior management in the CCG and the Governing Body.



This shows that after the return of the £2.9m transfer from running costs, the one-off £3.5m repayment of the historic deficit and a series of other in-year adjustments, including the application of penalties on the YFT contract (£0.9m) and GP IT depreciation (£0.8m), the CCG will carry forward a recurrent surplus of £2.0m. It also highlights that the basis for the plans for

2014-15 creates a gap of £9.4m that will be bridged in order to generate the required surplus through a combination of QIPP, BCF and contract management and negotiation.

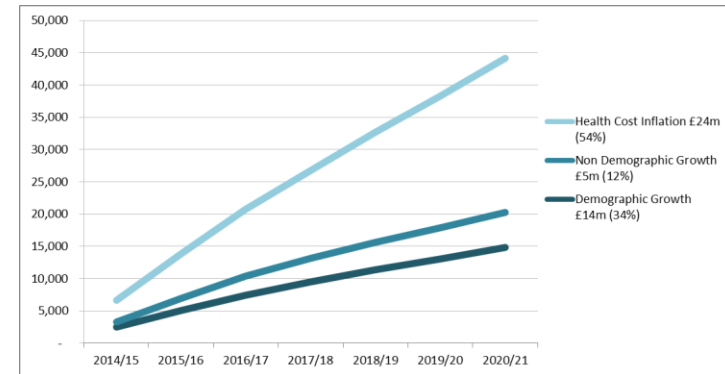
Financial Sustainability – A Call to Action and the Funding Gap

Spending on the NHS in the UK as a share of national income has more than doubled since its introduction in 1948, rising by an average of 4.8% in real terms. This period of rapid growth has now come to a halt but funding pressures on the NHS continue to rise. The NHS in England has been targeting efficiency savings of £20bn by 2014-15 to meet this challenge. Looking further ahead, in July 2013 NHS England published the ‘Call to Action’, which projected that the NHS may have to make a further £30bn of efficiency savings by 2020/21:

- Health Cost Inflation (pay and prices) – 50%
- Non-Demographic Growth (over and above demographic growth) - 27%
- Demographic Growth (change in population by age band) - 23%

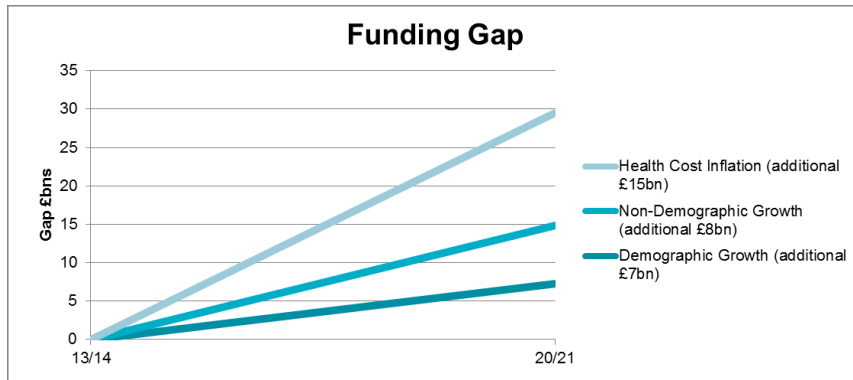
Locally, for the Vale of York CCG, this translates to a funding gap of potentially £44m:

Funding Gap – NHS Vale of York CCG



National

Funding Gap



The proportions that relate to inflation and growth are noticeably different locally than the national picture for demographic and non-demographic growth showing that the impact of projected population growth in Vale of York is considerably more than the average nationally.

Ensuring financial sustainability is about finding ways to raise the quality of care for all in the Vale of York communities to the best possible standards, while closing the funding gap at the same time. Fundamentally, this requires a significant shift in activity and resource from the acute hospital sector to the community.

Key **enablers** to deliver financial sustainability are:

- **Integration with social care**

The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, particularly by reducing emergency admissions. Investment in and reconfiguration of existing community services will provide a robust alternative to hospital admission, reducing the volatility of non-elective acute activity and subsequent financial impact.

- **Improving productivity**

There is a planning expectation for acute providers to aim to deliver a 20% productivity improvement in elective care within five years. Productivity is about having the opportunity and ability to treat more patients with better outcomes at the same or lower cost.

- **Increasing efficiency**

This relates to delivering the same service for less cost, time or resource and is a key driver for financial sustainability. It is essential that all parts of the system are innovative, ambitious and transformational in their plans for delivering care in order to help ensure long term financial sustainability.

- **Effective funding mechanisms**

NHS England and Monitor have joint responsibility for the payment system for NHS services and they have indicated their intention to review funding mechanisms to ensure they truly support improving outcomes. They will focus on twin themes of operational

improvement and creating new patterns of care. The funding and payment system is critical to ensuring financial sustainability for the whole health system.

- **Excellence in performance**

Commissioners are not in a position to be able to pay for quality and performance that does not deliver the best possible care for patients. Creating an environment and culture where all health, social care and third sector stakeholders can work together to deliver this is critical to helping ensure long term financial sustainability.

- **Co-commissioning and effective partnerships**

Close alignment with primary care and specialist commissioners through co-commissioning and alliances with other partners such as public health and local authorities to ensure congruence of plans and services.

- **System Resilience Groups**

Evolution of Urgent Care Working Groups into SRGs and the inclusion of planned care will align disparate systems of care and enable system wide discussion and whole pathway change.

- **Commissioning for Quality and Innovation (CQUIN)**

Incentivising improvement in quality standards has had a significant effect since the introduction of CQUIN and effective use of targets in commissioning will see this key enabler continuing its critical role.

Financial sustainability will be achieved through a number of *mechanisms*:

- **Financial governance**

Excellence in financial governance and rigorous financial management in the CCG is key to ensuring financial systems and processes are robust. This will ensure that financial planning, reporting and management are well controlled and directed and that investments, disinvestments and QIPP schemes are subject to appropriate challenge and approval. Internal audit have an important role to play in this and the plan developed in conjunction with internal audit for the next 3 years reflects the CCG priorities and Governing Body views on gaps in assurance.

- **Procurement**

Effective procurement of identified services drives significant improvement in the quality of services, innovation, efficiency and value for money. In particular, innovative procurement mechanisms focussed on outcomes and incentives will drive service and quality improvements that would not otherwise be realised through traditional contract extensions. The CCG has a number of complex and large scale procurements planned over the five year planning which will drive improvement in the quality of services provided on an unprecedented scale.

- **Contract management**

Rigorous approach to contract management to ensure defined outcomes are achieved, activity paid for is coded and counted correctly, performance objectives are met and demand is managed

to ensure value for money. Contracting levers and incentives must also be utilised effectively to ensure the best outcomes. The CCG has taken the approach of ensuring baselines agreed for 2014-15 are realistic and accurate, reflecting current and predicted future demand and agreed with providers. This provides a robust baseline position from which to make future decisions and allows modelling of improvement interventions to be done accurately.

- **Business intelligence and modelling**

Real time and outcome focussed business intelligence and predictive modelling is critical to ensure the CCG has the tools it needs to respond quickly to emerging issues and flex contracts and resources accordingly.

- **Benchmarking**

Considered use of key benchmarking data and participation in exercises to identify where the CCG is an outlier or performing well and where costs are currently incurred to enable informed decisions to be made about QIPP and investments.

- **Innovative commissioning and informed decommissioning**

The CCG will use an outcomes based approach to commissioning to cultivate innovation and a consistent, fair, prioritisation framework to ensure services decommissioned are those that do not deliver the desired outcomes. The CCG will also conduct a full baseline assessment of services that are currently provided to ensure equity in consideration of where resources should be focussed.

▪ **Working with, and sustainability of, partners**

Sustainability of provider organisations, particularly York Teaching Hospital NHS Foundation Trust, is critical to ensuring a sustainable local health economy for the Vale of York. Effective working with all partners and working in partnership, including co-commissioning and shared resources, is an important focus for the CCG as a whole pathway approach to the provision of healthcare in the area is critical. Local partners in delivery include providers, primary care and GPs, specialised commissioners, NHS England and Area Teams, the three local authorities, the Partnership Commissioning Unit (PCU), the Commissioning Support Unit (CSU) and the diverse voluntary sector.

NHS Vale of York CCG Strategy for Financial Sustainability

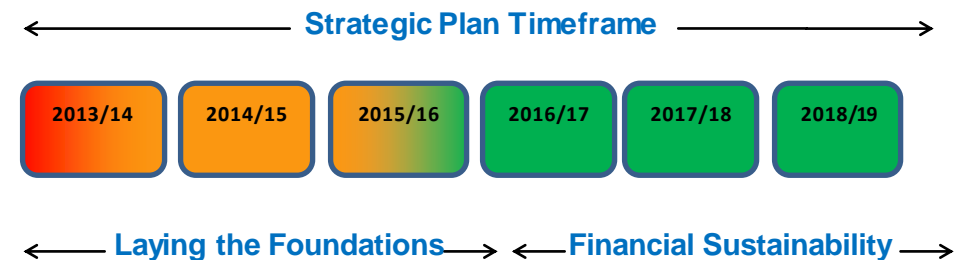
The CCG delivered a surplus of £2m (0.57%) in 2013/14 which, although not meeting the 1% recurrent surplus requirement, was a significant achievement given the debt inherited from the former PCT. Long term sustainability can be achieved and the CCG believes, through rigorous planning and consideration of risks, that a realistic timeframe for this is 3 years. 2014-15 is the second year of this important which lays the foundations for future financial sustainability.

The CCG has made the decision to plan for a surplus in 2014-15 in line with that achieved in 2013/14. This gives the CCG a planned surplus of £2.1m (0.57%) in 2014-15 and a move to the level required in the business rules of 1% from 2015-16 and thereafter.

The CCG has agreed a baseline contract for 2014-15 with York Teaching Hospital NHS FT at a level which both organisations believe is realistic and delivers the RTT constitutional targets. There has also been considerable work done across the North Yorkshire and Humber patch during 2013/14 and early 2014-15 to agree further baseline allocation adjustments for specialised commissioning.

These issues have created considerable additional pressure for the CCG in the early part of 2014-15 and, whilst a positive step for the organisation in recognising realistic activity levels and commissioning appropriately, are consistent with a phased approach to achieving longer term financial sustainability.

This is also consistent with the staged that the CCG has already taken to reinstating investments in the CCG's financial plan which have not previously been available. These include investment of readmissions and marginal rate rule funding and carer's breaks and reablement funding. Furthermore, the CCG's integration and care hub plans and implementation of the Better Care Fund in 2015-16 align with this move towards financial sustainability from 2016-17 onwards.



Financial Plan 2014-15 – 2018-19

Allocations

The NHS Vale of York CCG allocation for programme activity is £367,439,000 and £8,312,000 for running costs in 2014-15.

Following an extensive review and consultation, NHS England agreed a new funding formula for local health commissioning based on more accurate, detailed data and including a deprivation measure specifically aimed at tackling health inequalities. The new methodology has regard for population on a per capita basis and takes into account both inequalities and the impact of an ageing population on demand for healthcare.

The new 'fair shares' allocation formula sets the Vale of York CCG budget over the five years of the strategic plan as follows:

Year	Growth %	Allocation per Head £	Programme Allocation £'000	Running Cost Allocation £'000
2014-15	2.14%	1,062	367,439	8,312
2015-16	1.70%	1,072	373,685	7,476
2016-17	1.80%	1,100	380,411	7,471
2017-18	1.70%	1,111	386,878	7,465
2018-19	1.70%	1,122	393,455	7,460

Programme allocations have been published for 2014-15 and 2015-16 and indicative allocations published for 2016-17 – 2018-19 and the CCG's plans are based on these. An additional recurrent allocation of £5.94m will also be received in 2015-16 relating to the Better Care Fund (BCF) and corresponds to existing funding currently transferring from Health to Social Care.

Running cost allocations have been published for 2014-15 and indicative allocations published for 2015-16 – 2018-19 and the CCG's plans are based on these. The 10% reduction in running costs planned nationally for 2015-16 is also reflected.

Non-recurrently, the CCG is assuming return of the 2013/14 outturn surplus of £2.05m in 2014-15 and the 2014-15 planned surplus of £2.1m in 2015-16. From 2015-16 the planned surplus is the recurrent requirement of 1% and return of this in 2016-17 and thereafter is assumed in the CCG's plans.

Business rules

The business rules published in the planning guidance are included in the plan for 2014-15 and 2015-16 as follows:

Requirement 2014-15	Target 2014-15	Actual 2014-15	Target 2015-16	Actual 2015-16
Surplus	1.0% = £3.7m	0.57% = £2.1m	1.0% = £3.8m	1% = £3.8m
Contingency	0.5% = £1.8m	0.5% = £1.8m	0.5% = £1.9m	0.5% = £1.9m
NEL Threshold	£1.2m	£1.2m	£1.2m	£1.2m
Readmissions	£1.0m	£1.0m	£1.0m	£1.0m
Non-Recurrent	2.5% = £9.2m	1.9% = £6.9m	1% = £3.8m	1% = £8.3m
Better Care Fund			£19.4m	£19.4m

The 2.5% non-recurrent requirement in 2014-15 also includes the following requirements in the planning guidance:

Reablement and Carer's Breaks Funding	£2.3m	£0.7m
Primary Care Elderly Care Funding	£5/head = £1.7m	£1.2m

Both of these are provided non-recurrently in 2014-15 with the expectation that all plans will form part of the recurrent Better Care Fund from 2015-16 onwards.

The PCT historically and the CCG in 2013/14 were not able to create and fund the NEL threshold and readmissions funds due to underlying financial pressures. The CCG has committed to ensuring a transparent financial planning process by re-creating all required lines of expenditure and making active planning decisions. £0.5m has been identified for work to reduce readmissions and emergency admissions and will be governed by the multi-stakeholder Urgent Care Working Group. The CCG has been clear that a staged approach is required to attaining levels of investment in a number of areas and that these will not be funded in full in 2014-15. This will demonstrate planned partial funding through 2014-15 with full impact in 2015-16 for all areas, particularly those related to the Better Care Fund.

The CCG is also required to include £1.4m non-recurrently for payments relating to retrospective continuing care claims made during the period up to 2012/13. This is included in baseline allocations and will be transferred to a national central risk pool where payments will be made from. Initially, CCGs will be required to make these payments to ensure no cases are delayed while this process is established but this will not impact on the CCG's baseline allocation.

The business rules for 2015-16 and beyond are also included, notably the reduction in the non-recurrent requirement to 1% in 2015-16. The CCG is planning to deliver all of these in full by 2015-16 and, assuming there are no changes to the requirements, on an on-going basis for 2016-17 to 2018-19.

Running costs

Running costs are planned and anticipated to be within the allocations for each of the five years of the strategic plan. Pay and non-pay inflation have been factored into the planning assumptions and increased resource in Governing Body representation, quality, performance, medicines management, procurement and organisational development have been included. The 10% reduction in allocation in 2015-16 is included from 2014-15 in that recurrent expenditure is being kept below 90% with the remaining 10% being available for flexible use relating to project work and development.

Planning Assumptions

Published alongside the planning guidance is the Call to Action technical paper. This sets out the key financial and activity assumptions that underpin the £30bn challenge that was published in July 2013. This guidance, together with additional local work, has been reviewed to develop these assumptions further for the CCG's financial plan.

The core financial planning assumptions over the next five years are therefore as follows:

Area of Plan	Assumption	2014-15	2015-16	2016-17	2017-18	2018-19
Acute	Demographics	1.5%	1.5%	1.4%	1.4%	1.4%
	Pay and Prices	2.5%	2.9%	4.4%	3.4%	3.3%
	Efficiency	(4.0%)	(4.5%)	(4.0%)	(4.0%)	(4.0%)
Community	Demographics	1.5%	1.5%	1.4%	1.4%	1.4%
	Pay and Prices	2.5%	2.5%	2.5%	2.5%	2.5%
	Efficiency	(4.0%)	(4.0%)	(4.0%)	(4.0%)	(4.0%)
Community – YFT**	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	0%	0%	0%	0%	0%
	Efficiency	0%	0%	0%	0%	0%
Mental Health**	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	0%	0%	0%	0%	0%
	Efficiency	0%	0%	0%	0%	0%
Other Services*	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	2.5%	2.5%	2.5%	2.5%	2.5%
	Efficiency	0%	0%	0%	0%	0%
Prescribing	Demographics	0%	0%	0%	0%	0%
	Pay and Prices	4%	4%	4%	4%	4%
	Efficiency	0%	0%	0%	0%	0%

*Includes Continuing Healthcare and Funded Nursing Care

**The community and mental health position is based on agreement for 2014-15 and 2015-16 to maintain these block contracts at the 2013/14 level while the significant redesign and integration work is undertaken across these sectors.

In 2014-15, an additional 0.3% pressure in the acute tariff relating to CNST in specific HRGs results in a net tariff adjustment of 1.2% for core acute services. Also included in planning assumptions is an assumed 0.7% pensions pressure for 2015-16 arising from the revaluation of public sector pension contributions and a further 1.4% pension pressure for 2016-17 arising from reforms to the state pension. These are predominately cost pressures for providers and assumed to be funded through tariff. The 1.4% in 2016-17 is however currently an estimate and in practice NHS England and Monitor will need to discuss with central government closer to the time the exact amount of funding pressure that will need to be met by the NHS and any funding arrangements to meet this pressure.

Areas such as prescribing and continuing healthcare, that are not subject to a percentage efficiency requirement, do have specific and targeted QIPP schemes applied in order to continue to deliver efficiency in these areas.

Financial Plan Summary – Programme Costs 2014-15 to 2018-19

The income and expenditure impact has been modelled on an individual provider basis, in line with the monthly financial dashboard headings presented to the Quality and Finance Committee and Governing Body. This is provided at summary programme line level in the table below for 2014-15 to 2018-19. The QIPP gap is shown here in total for transparency but in reality is profiled across the relevant programme lines and embedded in contracts.

	13/14	14/15	15/16	16/17	17/18	18/19
Acute	214,366	219,418	217,178	219,420	221,175	222,723
Mental Health	37,325	37,974	38,966	38,967	39,968	39,969
Community	28,905	30,729	30,660	29,772	29,763	29,753
Continuing Care	23,458	24,174	24,885	25,607	26,344	27,093
Primary Care	49,147	51,053	53,015	55,037	57,122	59,275
Other Programme	6,046	11,643	33,505	45,322	51,248	58,234
Contingency		1,838	1,868	1,932	1,964	1,997
Gap (QIPP / BCF / Other measures)		(9,438)	(22,156)	(29,775)	(34,833)	(39,717)
Total Programme Costs	359,247	367,391	377,921	386,282	392,751	399,327
In-year Gap (Non Cumulative)		(9,438)	(12,718)	(7,619)	(5,058)	(4,884)

	14/15	15/16	16/17	17/18	18/19
Allocation	367,439	373,685	380,411	386,878	393,455
BCF	-	5,938	5,938	5,938	5,938
Prior Year surplus	2,046	2,094	3,796	3,863	3,928
Total Resources	369,485	381,717	390,145	396,679	403,321
Total Expenditure	367,391	377,921	386,282	392,751	399,327
Surplus	2,094	3,796	3,863	3,928	3,994

QIPP

The QIPP gap/targets for each year of the strategic plan are shown in the table above. Of the £9.4m target in 2014-15, £5.0 has been identified and agreed with providers recurrently and there is an unidentified gap of £4.4m. However, there is a clear plan of additional opportunities to explore, scope and develop to provide additional contribution to the remaining financial gap. Until these plans are agreed and contracted, the CCG is being clear in identifying these separately to ensure an accurate picture of the QIPP and financial risk is presented.

There is also a future pipeline of potential improvement interventions which could drive further cost efficiency and support delivery of a financially sustainable local health system from 2015-16 and these are being worked on now in 2014-15. These are a mixture of transactional programmes of work which are currently being mobilised now that the activity and contractual baselines have been agreed with our main providers; and transformational programmes driven by intelligence, benchmarking and analysis which is identifying areas of unjustified variation and areas of care pathways which show significant potential to improve both efficiency and quality.

The detailed BCF modelling that we have undertaken indicates that significantly greater impact is likely than that included as 'identified' QIPP at this stage and this will be a major contributor to the remaining QIPP target. However, as this is not yet embedded in provider contracts as agreed QIPP is based on provider modelling at an earlier stage in the integration pilot planning process.

All transactional and transformational opportunities mobilised into programmes of work will be assessed and aligned against the Integration programme and will also adjust in line with the evolving national direction in order to ensure all opportunities for maximising sustainability and efficiency are realised.

Remaining risk in the unidentified proportion of QIPP will be met through transactional measures, delay in investments and other non-recurrent actions during 2014-15.

Local position and alignment

Expenditure on health services in Vale of York CCG covers acute, mental health and community services, primary care, prescribing, continuing care, ambulance and urgent care services and a number of independent and voluntary sector contracts. Our footprint also covers three local authority areas. Citizens in the Vale of York area have a wide choice of possible providers, particularly for hospital care and, for many of these contracts, the CCG is an associate to a lead contract held by another CCG.

We have close working and robust contract management arrangements in place with all providers and this is particularly important in working with acute, mental health, community, social care and primary care partners in agreeing plans to deliver the required outcomes of QIPP schemes and the Better Care Fund. Considerable work has been undertaken to ensure congruence of strategic plans and that the CCG vision is a joint and shared one. Financially, contracts are agreed with all providers and longer term trajectories are agreed in principle and are in line with the CCG's vision, integration planning and implementation of care hubs which will deliver the reduction in unplanned admissions.

We have agreed and approved extensions to key contracts in community and mental health services to ensure that there is stability operationally and financially over the period where services are undergoing transformation and new pooled budget contracts are being agreed.

We also ensure close working with Scarborough and Ryedale CCG through considerable alignment with QIPP plans and investments as we share our main provider. This ensures consistency in approach to Better Care Fund, Quality, Innovation, Productivity and Prevention (QIPP) and that investment plans and joint quality and performance management arrangements in place.

Contracting

The NHS standard contract remains the form of contract which commissioners must use for all contracts for clinical services, other than primary care. Commissioners are expected to enforce the standard terms of the contract, including the application of penalties.

One of the CCG's critical mechanisms for delivering financial sustainability is rigorous contract management. This will ensure defined outcomes are achieved, activity paid for is coded and counted correctly, performance objectives are met and demand is managed proactively. Contract levers and incentives will also be utilised effectively to ensure the best outcomes. The CCG has taken the approach of ensuring baselines agreed for 2014-15 are realistic and accurate, reflecting current and predicted future

demand and agreed with providers. This provides a robust baseline position from which to make future decisions and allows modelling of improvement interventions to be done accurately.

We have fully assessed the impact of existing QIPP programmes on financial and activity baselines and these are embedded in provider contracts through detailed Service Development and Improvement Plans (SDIP). A Heads of Terms is also agreed with YTHFT which defines risk share arrangements, non-recurrent and recurrent investment, demand management and cap arrangements and areas of joint working and review through 2014-15 for impact in 2015-16 and beyond. It also clarifies agreement on areas of contract negotiation and the outcomes.

Identified QIPP schemes and Better Care Fund modelling has been done to specialty and POD level and included in contract level baselines.

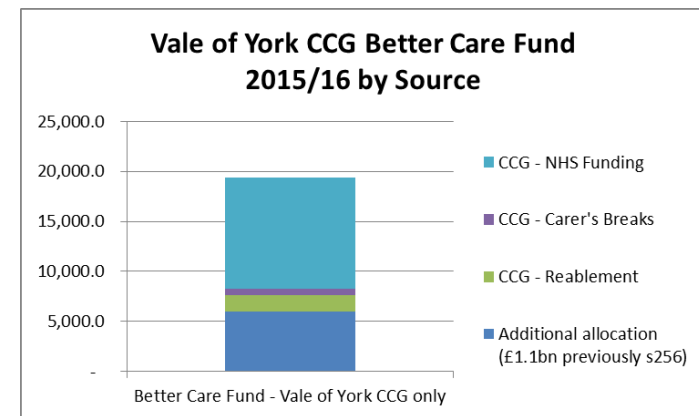
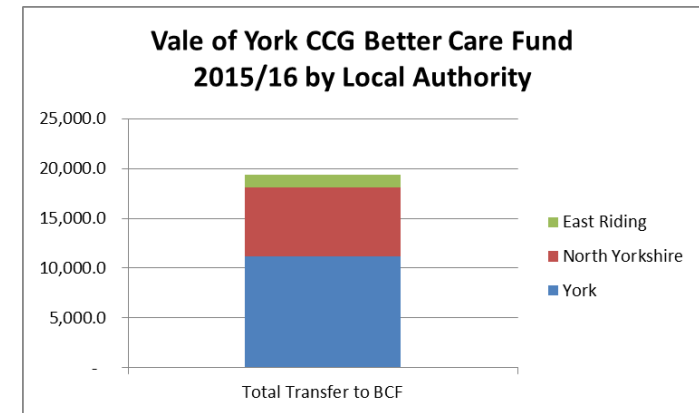
We have invested significantly in additional contracting team resource and will ensure detailed analysis of contract positions throughout the year in addition to conducting audits and reviews of a range of activity areas to ensure counting and coding rules are applied correctly. The CCG is also developing an enhanced Business Intelligence (BI) specification with the Commissioning Support Unit to ensure contracting support is fit for purpose and focussed on the CCG's vision and strategy. The CCG also has an embedded member of staff from the BI team who is critical to bringing together the QIPP modelling and BI contract work.

This is a considerably more robust approach to contracting than the CCG has had previously and establishes a baseline of good practice moving forward into years 2-5 of the strategic plan.

Better Care Fund

The £3.8 billion national Better Care Fund that comes into operation in 2015-16 is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of the people that need it most and is a key driver for long term financial sustainability. We have included in our plans the actions we will take in 2014-15 to create the funding required to make the Better Care Fund affordable when it is introduced in 2015-16. For the Vale of York, this takes the form of 3 separate BCF plans aligned with the 3 local authorities in the CCG boundary and are submitted as distinct plans in their own right, led by the respective Health and Wellbeing Boards.

For the Vale of York, the Better Care Fund in 2015-16 is £19.4m and is analysed as follows:



The total CCG contribution in 2015-16 is £13.4m, the difference being made up by an additional allocation of £6.0m relating to the funds previously transferred directly to social care from the NHS under s256 arrangements. The £13.4m also includes re-ablement and carer's breaks funding not previously funded by the CCG or the PCT historically.

The Better Care Fund in the Vale of York will be managed through 3 distinct pooled budgets for each local authority and will be governed by the Health and Wellbeing Boards. Formal agreements will enable the creation of the pooled budgets and transfer of funds from social care to health to contract for agreed services.

A proportion of the fund will be performance related with payments linked to progress against national metrics, such as delayed transfers of care and avoidable emergency admissions. Hospital emergency activity is expected to fall by around 15% to generate the savings required to resource for the Better Care Fund so CCG plans are focussed on this area of activity as described in the strategic plan.

Statement of Financial Position (Balance Sheet)

The financial plan templates include a detailed statement of financial position, previously known as the balance sheet. This includes details of assets, liabilities and taxpayers' equity and reconciles to the cash plan. We hold non-current assets, previously known as fixed assets, relating to medical equipment at the independent treatment centre and GP IT.

Cash

We are expected to manage its cash within the resource allocation available and financial plan demonstrates this. The cash profile takes in to account the phasing of QIPP and improvement interventions impact and

specifically, a front-loaded cash profile has been agreed with YTHFT to ensure the CCG's main provider is not disadvantaged during the early part of the year.

Capital

We have submitted, and had approved, a capital planning return to NHS England Finance and Investment Committee, which approves the capital plan and indicative allocations for CCGs, subject to the approval of business plans. This includes investment in IT and community equipment.

In the medium term, the CCG is leading the development of a new, permanent mental health facility in York to re-provide the services currently delivered in Bootham Park Hospital. A high level feasibility study is being conducted initially to determine the best option and then a decision will be made in conjunction with stakeholders as to the proposed way forward.

Financial Risks

The CCG faces a number of specific financial challenges and risks through 2014-15, 2015-16 and in the latter years of the plan. The critical ones are described below:

Area of Plan	Risk	Mitigation
Acute Services	<p>Specialised commissioning</p> <p>Issues relating to the correct distribution of resource relating to specialised services have continued from 2013/14 in to 2014-15 and remain a material cost pressure for the CCG.</p>	<p>A complete re-base exercise has been undertaken for two principal local providers and provision has been made in the plan for the estimated impact of these. A further risk is also highlighted explicitly in the financial risk analysis until an agreement is made.</p>
Acute Services	<p>Activity Variation, Demand Management and Achievement of RTT Targets</p> <p>The CCG has made a number of growth and activity assumptions that it considers reasonable and have agreed</p>	<p>Monthly detailed analysis and contract reconciliations done by contracting team</p>

Area of Plan	Risk	Mitigation
	<p>these with providers, but there is a risk that activity exceeds this or issues arise in year that haven't been planned for and RTT targets cannot be met within contracted activity.</p>	<p>followed by monthly Contract Management Board meetings with relevant Trusts will ensure any issues are identified and mitigated early.</p>
QIPP	<p>Under-delivery of QIPP schemes</p> <p>QIPP schemes are at differing stages of development and while some are well advanced and the risk to delivery is low, others are still being developed and there remains an element of unidentified QIPP in the 2014-15 plan as schemes are transformational and delivery of activity impact starts during 2014-15 will full impact in to 2015-16 and beyond.</p>	<p>Further QIPP schemes are actively being developed alongside a number of contractual actions and levers to further reduce spend and drive efficiency.</p>

Area of Plan	Risk	Mitigation
Mental Health	Costs in 2015-16 and beyond The current contract with the main provider of mental health services has currently been extended to September 2015 so there remains a degree of uncertainty as to the costs of the service after that point depending on the procurement route undertaken.	The plan assumes a flat position currently with no savings or investment other than specific investments already agreed. Any procurement process will ensure services are contracted within available resources. Decisions on additional further investment in services will be taken through the CCG process for approval.

Area of Plan	Risk	Mitigation
Integration Programme (and Better Care Fund)	Savings and outcomes not delivered as planned The CCG will contribute to three funds across three local authority areas. The vision is clearly articulated and stakeholders are agreed but there remains significant risk that the savings and outcomes required are not realised and activity does not shift from the acute sector to community and primary care as planned. Investment will have been made in BCF schemes but activity continues to flow to current providers creating significant financial risk.	Governance arrangements are in place for all three local authorities and CCG plans are consistent across all three. Risk share arrangements are being discussed to ensure no one stakeholder holds all the financial risk.

Finance Development

The CCG is a member of the Healthcare Financial Management Association Commissioning Finance Faculty which aims to provide a network for finance staff within commissioning organisations, offering support, education and advice that will help them to tackle the challenges they face. The Faculty offers opportunities to share experience and expertise and to influence thought and policy in the commissioning finance arena. It will also provide a forum for learning, technical development and networking. The HFMA also gives the CCG access to finance training and networking opportunities for other Governing Body members, including lay members.

The CCG is also signed up to 'Future-Focussed Finance'. In January 2014, the six heads of the finance profession in the NHS came together to initiate Future-Focused Finance which offers a vision for NHS finance to aspire to over the next five years. The three strategic themes, incorporating 6 action areas, align extremely well with the five year strategic plan and financial strategy of the CCG:

1. **Securing Excellence**

- Best possible value
- Efficient systems and processes

2. **Knowing the Business**

- Close partnering
- Skills and strengths

3. **Fulfilling our Potential**

- Great place to work
- Foundations for sustained improvement

The CCG CFO will ensure these principles are embedded in the Finance and Contracting function and throughout the organisation in terms of financial values and governance.

Workforce

The Current Situation: The Health and Social Care workforce across North Yorkshire and Humber

Current workforce data suggests that the number of people working in the Health and Social Care sector across North Yorkshire and Humber region is upwards of 160,000. This number comprises of approximately 27,710 people working within secondary care [1], 4,200 in primary care [2], and 120,000+ people working in social care settings [3]. Note that the estimate for the number of people working in social care are judged to be on the conservative side, owing to the challenge with collecting data from independent providers.

Within secondary care 52% of staff work in a large acute; 28% in a teaching acute; 10% in mental health/learning environment and 9% within a community provider. Of these staff 31% are deemed to be nursing/midwifery; 20% admin/clerical; 19% additional clinical services; 10% medical and dental; and 6% allied health professionals. The secondary care workforce is 78% female, 22% male with around half the workforce (45%) in AfC bands 1-4 and 41% in AfC bands 5-6. As of October 2013 17% of staff were aged 55 or over. In ten years' time 49% of the current secondary care workforce will be 55+. Unless radical intervention occurs this will have a direct impact on our ability to deliver high quality care and the ensuing achievement of health outcomes aligned with the strategic plan.

There are approximately 245 General Practices in North Yorkshire and Humber serving 1,747,077 registered patients. [4]. These practices comprise of 1,023 GPs, 526 practice nurses and 2037 admin/clerical workers. In 2012 a quarter of GPs in North Yorkshire and Humber were 55+. In 10 years' time approximately 61% of the current GP workforce will be 55+. With an ageing workforce it is therefore critical in line with our strategic vision that we explore how we retain, attract and recruit nurses and doctors to positions in primary care or explore very different future solutions to providing proactive, high quality care within this setting.

There are approximately 3,600 social care establishments in Yorkshire and Humber employing 120,000+ people within residential homes (42%), domiciliary homes (38%), community care (15%) and day care (4%). Two thirds of the care homes in the region are independent (67%), 13% local authority and 5% NHS. Of the 120,000+ workforce, 73% are care workers, 7% managerial/supervisory and 7% community and professional roles. The average pay rate for a care worker is £6.50/hour with NHS trained nurses receiving £24,000.

There is a high turnover in the social care workforce (29%, approximately 14,500 posts per year) even though 87% are permanent staff. It is estimated 40% of the social care workforce have no qualifications, 24% a level 2 and 11% a level 3 diploma. The workforce is primarily female (84%), a quarter are aged 50-59 and 9% 60+. In ten years' time 60% of the current workforce will be 55+.

Workforce trends: North Yorkshire and Humber (August 2009 to Oct 2013)

There has been an overall increase of 1,405 FTE across the main providers in North Yorkshire and Humber with 14,820 at August 2009 and 16,225 at August 2013, however it is worth noting that the nursing workforce has seen a decline. In summary from August 2008 to August 2013:

- Nursing/midwifery numbers decreased by 400fte;
- Administrative and clerical increased from 2,605 to 3,305 in August 2010 followed by a decline to 2,870 at Aug 2013;
- Additional clinical services have increased by 370fte;
- Medical and dental increased by 275fte;
- Additional professional and scientific roles increased by 140fte.

Workforce current gaps, risks, issues

In 2013 Providers highlighted a number of risks and issues around:

- An aging medical and nursing workforce with difficulties in recruitment;
- Training/recruitment difficulties in Psychiatry, A&E, GP, Anaesthetics and General Medicine (Consultant level); advanced nurse practitioners;
- Reduction in training numbers (Surgery Anaesthetics and Core Medicine);
- Gaps in nursing and medical recruitment / rotas (Acute and Emergency Medicine and medical specialities), leading to high locum, bank and agency spend;
- Implications of the North Yorkshire and Humber health and social care workforce.

The health and social care workforce in North Yorkshire and Humber is an aging workforce. As of Oct 2013 approximately 20% of the workforce were aged 55+, and hence close or eligible to retire. In ten years' times approximately 55% of the current health and social care workforce will be aged 55 and over. This will have implications for leadership and hence the development and coaching of newly qualified staff. Equally there is the potential for the loss of skills across the area.

All Clinical Commissioning Groups have voiced concerns about the aging GP workforce in North Yorkshire and Humber. Workforce planning trends indicate that there should be enough medical trainees to meet this demand, if they consider GP registrar training. However, there are additional factors (geography in particular) which may affect the ability for North Yorkshire and Humber to recruit GPs and it may be the case that Clinical Commissioning Groups will need to look at Innovative approaches to recruitment. Equally there may be opportunities to develop more advanced level nursing roles to fill this void.

It is noted that there is a large gap in the skills, training and education of social care staff in comparison to health staff. Approximately 40% of social care staff have no qualifications. If social care staff are to support the reduction in unnecessary admissions to hospitals there will be a need to educate/up skill this staff group.

The move towards an integrated health and social care system may benefit from the experiences and learning of current multi-agency (or multi-disciplinary) approaches to team working especially within the children’s sector. In particular learning from the social pedagogical approaches, a team around the patient approach. A team led by a lead-professional (someone with advanced skills across a wide-range of disciplines). Such an approach would require a change of culture and language, new training and development approaches with rotational training programmes and the development of a common induction programme. This has already been seen with the development of virtual wards for those with complex long term conditions.

The move towards an approach to bring care closer to home, back into the community (which will also include specialist care) will have an impact on the professional staffing types trained and the staffing numbers required for 24/7 staffing and out of hours care. This may have an immediate adverse effect of increasing bank, agency and locum costs in order to meet safe/appropriate staffing levels. To mitigate this risk, innovative approaches may be needed i.e. joint, shared and rotational posts across community and secondary care settings.

The move towards a greater level of self-care, assisted by technology, will require staff to be appropriately trained to use, manage and support the technology. Such skills and abilities should be built into training and CPD programmes for new staff. Existing staff would need to undergo training as appropriate.

Staff Survey Results (2012) - North Yorkshire and Humber

N.B. The following data has been adapted from the Staff Survey Toolkit (2012).

Most Improved Key Findings since 2011

Since 2011 there has been:

- (A) A 6.8% increase in equality and diversity training.
- (B) A 6.4% increase in overall engagement score.
- (C) A 6.1% increase in feeling able to contribute towards improvements at work.

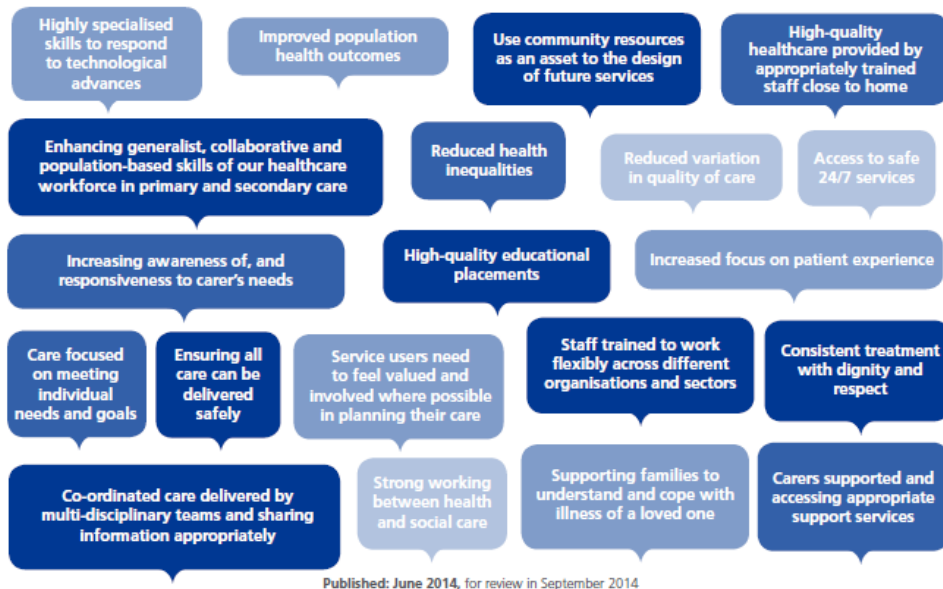
TOP 10 MOST IMPROVED KEY FINDINGS FROM 2011 TO 2012		
KEY FINDING	RELATIVE CHANGE FROM 2011	
KF26. % having equality and diversity training in last 12 mths	6.8%	Increase
Overall engagement score	6.4%	Increase
KF22. % able to contribute towards improvements at work	6.1%	Increase
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	3.3%	Increase
KF6. % receiving job-relevant training, learning or development in last 12 mths	3.0%	Increase
KF7. % appraised in last 12 mths	2.8%	Increase
KF23. Staff job satisfaction	1.9%	Increase
KF28. % experiencing discrimination at work in last 12 mths	1.7%	Decrease
KF24. Staff recommendation of the trust as a place to work or receive treatment	1.5%	Increase
KF8. % having well structured appraisals in last 12 mths	1.3%	Increase

Most Deteriorated Key Findings since 2011

- An increase in bullying / harassment from patients (1.4.8% increase) and staff (8.6% increase) across the region;
- An additional 8.1% have reported an increase in work-related stress;
- Health and safety training has decreased by 7% since 2011;
- A 7% increase in the experience of physical violence.

Workforce Development

Workforce development plays a significant role in the delivery of high quality healthcare. Stakeholder responses to the HEE workforce strategy development (2009-2014) highlighted some key areas of importance.



Equally futures modelling work by Health Education England highlighted that:

Area	Key messages/ future trend
Informal and formal care	There will be a need for a larger informal workforce; carers, volunteer's, families and even app-based self-care. This may take the form of formal support complemented by these informal networks etc. Alternative sources of health advice with less state dependence and more family dependency.
Co-production	Co-productive health models; Patient expertise; Users as assets; Shared power.
Whole person care	A generalist and adaptable workforce to complement specialist care; reduced specialists; greater flexibility of roles/careers; more flexibility and co-ordination around the individual.
Care Access	Increased consumerism, evidence and transparency will drive greater access to 24/7 care with a need for more access across settings. There will need to be an increase in more flexible working, with hours and patterns that respond to patient need (recognising work/life balance); Remote working with I.T support may also support this.
Knowledge, skills and compassion	Increased training in relation to technology; Information and intelligence as a currency; Healthcare workers as knowledge brokers.
Expectations	Patients will expect no waiting; Patients will expect seamless, high quality care, 24/7 in a range of settings; more "active consumers" than "grateful citizens"; value, care and compassion will be expected above all else; Staff want a better work/life balance; More part-time working; Staff want more "time to care".
Informed, engaged and active	More appetite for health information; Greater use of technology to inform decisions but some inequality in technology access and use; More engagement to self-care and be active; Greater disparity between those who can and those who can't.
Communities of health	Blurring of roles between patients and professionals; More co-productive care; "Community of health" will include more family, friends and fellow sufferers; Increased isolation for some groups; Less distinction between physical and mental wellbeing.

Key workforce issues for NHS Vale of York CCG:

Alongside the Strategic Plan our workforce will need to be:

- Responsive and flexible, meeting the holistic needs of patients 24 hours a day, seven days a week;
- Multi skilled and multi trained for instance, joint roles between health and social care health, practice and community staff, practice, community and hospital.

To enable this we need to ensure that we are clear about the:

- Capacity modelling plan for our workforce for the next 1-five years;
- Development of models for recruitment, retention and succession planning;
- Develop, market and support local initiatives around training and learning i.e. GP registrars, advanced nurse practitioners and post registration practice nurses;
- Work with Health Education England (HEE) and our local university providers and colleges to deliver and support educational requirements.

Equally:

- Our care should be driven by evidence and research and supported by the latest technology i.e. tough books, single system entry into all care records no matter what system;
- With a greater role for the informal support role i.e. carers, families and communities, in line with localism.
- With a greater role for preventative self-care and management i.e. public health champions, volunteer public health champions and digital technology i.e. self-care apps.

NHS Vale of York CCG - our starting point:

Through our strategic planning and vision and by undertaking detailed work on capacity modelling we will ensure that the future model of care supports the health care workforce and its capacity plan for the future, so that we have a flexible, response, 24/7, fit for purpose workforce: the right skills, at the right time, in the right location.

In order to align 7-day working across primary, community and secondary care there will be the requirement to develop multi-disciplinary, multi-agency teams embedded with the care hubs, led by the most appropriate clinician who are equipped with the right skills to support assessment, diagnosis and treatment along the patient pathways which will include urgent, emergency and routine care.

Education will need to accommodate the delivery of the skills and competencies required to deliver a 7-day service across the sectors. Modelling will also see a shift from increased numbers of staff working in an acute setting to the transfer of numbers and skill base into the community. This will have implications for education, training and development as well as culture and language change.

There is much work to be done to better understand and define the required roles, skills and knowledge required to deliver the integrated health and social care workforce for the future. There will also be opportunities to explore different ways of working i.e. opportunities for advanced nurse practitioners (assuming appropriate supply) to undertake tasks traditionally allocated to junior doctors and General Practitioners, hence enabling the reallocation of time/resources amongst junior doctors in secondary care and General Practitioners in Primary Care. The Vale of York CCG will need to work with HEE England to ensure the requisite vision and demand for staff for the future meets the supply. This in itself will also have implications for mentorship and coaching among the existing workforce.

In summary the Vale of York CCG's future workforce needs to be:

- Flexible (both in terms of roles/duties performed and location of service);
- Adaptable (to undertake new/alternative roles across different settings);
- Informed (to either make the right decisions or refer for appropriate advice);
- Multi Skilled (to undertake a variety of tasks and skills across different sectors);
- Resilient (to deal with both the change to working conditions but also culture).

And supported with appropriate education, training and governance structures that enable new ways of working across health and social care without compromising the quality of care and patient safety

The Vale of York will work closely with the HEE to look to model the workforce for the future. This includes:

- Workforce capacity and remodelling planning;
- Supporting the recruitment locally of workforce programmes;
- Influencing the commissioning of education and training for healthcare students.

What will success look like?

When a person turns to the NHS for help, their needs are met by professionals of the right numbers, skills, values and behaviours to provide high quality care:

- Patients able to self-care and treated in ways that recognise their needs
- Communities empowered to co-deliver care
- Better patient/provider relationships
- Reduced inequalities and greater high-quality care provision
- Improved technology and research whilst maintaining care and compassion

Building on the work of W. Edwards Demming, we are committed to the idea of the 'joy of work' and implementing this through our Care Hub model. This new approach will enhance the working environment and encourage key staff to defer retirement plans, increase retention and so bridge the potential staffing gap over the next few years.

Through workforce remodelling, working with the Local Education Training Board, universities and providers we will ensure that we have the right skill mix to deliver our ambitions.

Programmes such as the Advanced Training Practice in primary care and the new student nursing programme inclusive of internships in primary care at the University of York have helped pave the way and the CCG will continue to work with provider and CCG members to build a future workforce, fit for purpose in line with our vision for success.

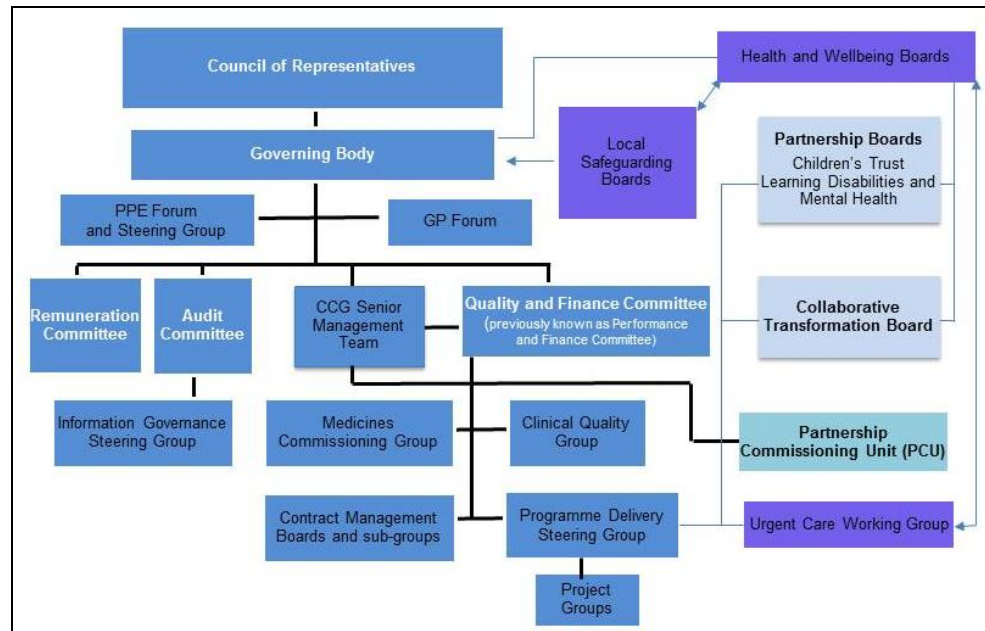
Governance

NHS Vale of York CCG works within a national framework for NHS bodies, and is governed through the Constitution, supporting policies and scheme of delegation. These are available on our website at the following links:

<http://www.valeofyorkccg.nhs.uk/data/uploads/constitution-version-2-15-08-13.pdf>

<http://www.valeofyorkccg.nhs.uk/publications/policies/>

<http://www.valeofyorkccg.nhs.uk/data/uploads/publications/policies/new/tailed-scheme-of-delegation.pdf>



The Health and Wellbeing Boards drive the implementation of the strategy across the whole health economy. The partnership structures underpinning the Health and Wellbeing Boards play a key role on monitoring the delivery of commitments within the plan.

Within the health infrastructure, the commitments will be translated into the contract management processes, and monitored monthly through contract management boards and quality and performance contract monitoring meetings. For areas of improvement across North Yorkshire or North Yorkshire and Humber CCGs, these are also monitored through the Strategic Collaborative Improvement Group and Collaborative Improvement Board.

The delivery of the Better Care Fund will be led through partnership groups, for example the Joint Delivery Group (City of York) and the Integrated Commissioning Board (North Yorkshire), which will report both to the CCG's Improvement and Innovation Steering Group and through to partners' boards as appropriate. This Board will lead on the transformation activity through the Better Care Fund and the development of Care Hubs.

Programme Delivery

The CCG has rigorous programme delivery framework in place in order to drive action and change in order to meet all the associated indicators, targets and priorities for improving the health and experience of our Vale of York population when accessing services they need.

Within the CCG, the Governing Body holds overall responsibility for the delivery of the strategic plan, with oversight of the plan through the Quality and Finance Committee.

The Programme Delivery Steering Group provides programme management of the improvement interventions and associated QIPP schemes within the operational plan, driven by all teams within the CCG. Each scheme of work within the Strategic and Operational Plans has associated impact measures and will have a named CCG lead that will hold accountability for the progress of the work, financial and quality impact. The Programme Delivery Steering Group reports directly to the Quality and Finance Committee.

The programmes of work set out in this plan, and the enabling projects will be overseen by the CCG Programme Office within the corporate team. Each scheme of work will follow a formal process including:

- An initial viability assessment;
- Business Case development and approval at the appropriate committee;
- Project plan and support project documentation, including a risk register, issues log and tolerances for timescales and resource;
- Monthly reporting on progress through the Innovation and Improvement Steering Group and monitored through the programme office;
- Highlight and exception reporting to Committee to monitor progress and manage changes to projects or programmes of work.

There are detailed plans for each programme of work which include the following:

Programme Delivery:	Supporting documentation:
<ul style="list-style-type: none"> ▪ Description of the specific improvement interventions and purpose 	Initial viability assessment Business Case Project plan
<ul style="list-style-type: none"> ▪ The activity impact – what changes to volumes of activity delivered, where that activity delivered, by which provider and with what performance targets for on-going efficiency 	QIPP Monitoring report Contract Monitoring report
<ul style="list-style-type: none"> ▪ The finance impact – any investment required, contribution to financial gap and productivity 	QIPP Monitoring template
Expected Outcomes: <ul style="list-style-type: none"> ▪ The impact on health outcomes – the trajectories (targets over five years) and indicators which give an indication or measure of improvement in health and social care outcomes ▪ The impact on specific health inequalities in the local population or within specific population groups ▪ The impact on patient experience of service ▪ The impact on quality and safety improvements ▪ The contribution towards delivering parity of esteem 	Reporting on the specific metrics and indicators within each programme of work which can demonstrate progress in each of these areas.

Programme Delivery:	Supporting documentation:
<ul style="list-style-type: none"> The impact on our local service providers and our contracts with them 	Service Development and Improvement Plan in contracts Service Specifications Contract Variations
<ul style="list-style-type: none"> The implications for procurement tendering for new, existing and re-commissioned services) 	Procurement plans
<ul style="list-style-type: none"> The timelines and phasing for each work-stream The significant milestones in that programme of change The enabling pieces of work which will drive and facilitate delivery and change by stakeholders (patients and providers) in order to transform 	Project plan Flash reports (monthly) Workforce plans Estates plans
<ul style="list-style-type: none"> The engagement and patient needs which drive each programme and which define what services need to look and feel like in the future 	Engagement plan and events Collaborative partnerships and working groups
<ul style="list-style-type: none"> Risks (barriers to success) 	Risk assessment and mitigation plans

We are combining process improvements in the way we identify, plan and deliver improvement projects with a programme of training to embed a culture of delivery and assurance across the CCG which will help us to deliver measureable quality improvements with our partners. We are doing this through:

- Training the Innovation and Improvement team and clinical leads in lean methodology to support delivery of improvement events, and enhance planning and service delivery skills
- Identifying a Programme Management structure for key work themes and improvement projects
- Standardising the project management approach to service improvement to ensure accurate planning, reporting and evaluation of improvement projects
- Delivering projects through a team approach which includes a dedicated finance and governance lead to support the transformation and efficiency agenda.

We are investing in tools to enable systematic modelling of activity, finance and workforce impact, and an integrated programme and risk management tool (Covalent) to ensure consistent and systematic project management and risk reporting. This is supported by the CCG's 'lean' service improvement methodology and programme approach.

All Improvement Interventions will be managed in line with this systematic approach, with dedicated governance support to ensure all work is compliant with relevant governance processes, including risk, equalities, information management and procurement assessments.

Financial Governance

We are committed to a robust process for financial governance. This is underpinned in the Financial Policies and Procedures. The financial plan is an integral element of the strategic plan, and all planning assumptions are worked collectively between finance and innovation teams. All Improvement plans will have a direct finance support to ensure effective impact modelling and monitoring of spend. The Senior Management Team monitors the financial plan on a weekly basis to manage and mitigate operational risks.

The Quality and Finance Committee maintains oversight of the financial plan; receives and acts upon monthly reports on the financial positions and issues arising from the Contract Management Boards. The Audit Committee meets quarterly and scrutinises the financial plan assumptions and decisions. The Quality and Finance Committee and the Audit Committee report into the Governing Body and escalate key risks. The Chief Financial Officer provides a standing financial report to the Governing Body to provide update and assurance.

These processes embed the focus on good financial governance across the organisation. Assurance on these processes and their effectiveness is provided through our internal and external audit functions.

Annual Plan Reporting

The strategic and associated operational plan will be monitored monthly to assess the delivery against committed actions, performance and financial position to ensure that any emerging risks are addressed in a timely manner and to avoid slippage. This process will be led by the Quality and Finance Committee and reported to the Governing Body.

The Plan will be formally reviewed annually using both the financial and performance perspective, but also the 'you said, we did' framework and the results published to increase transparency for the public.

Procurement

Our five year strategy involves significant transformation including service review and potential procurement or re-procurement. We are already planning five major procurements from 2014-15, including the Out of hours services; mental health services and community services in order to establish the Care Hub Approach for fully integrated care in 2016-17.

Choice and competition

As a CCG we need to make a decision on where choice and competition for services is in the best interest of the patients and to do so the following factors would need to be considered:

- Needs assessment and the priorities of patients and communities
- The quality of existing services
- Feedback from service users
- Scope for quality and/or efficiency improvement
- Sustainability of existing service configurations
- The levels of clinical risk
- The need to maintain continuity of service
- The potential benefits of integration
- The availability and capacity of providers
- The scope for patient choice and control

The future aim is to enable health care services to be provided in an integrated way and the provision of health care services to be integrated with the provision of health-related or social care services where it considers this would:

- Improve the quality of services and outcomes
- Reduce inequalities between persons with respect to their ability to access services
- Reduce inequalities between persons with respect to outcomes achieved for them

Although the vast majority of procurements will fall within Part B of Schedule 3 of Part 10 of the Public Contract Regulations 2006 (the "Regulations") (and therefore not subject to the full scope of the Regulations), it is recommended, throughout the whole of any procurement process, to apply best procurement practice.

Healthcare Services are not subject to all competition law but must comply with competition obligations in S75 regulations and not engage in anti-competitive behaviour unless to do so is in the interests of people who use healthcare services

The NHS recognises that Procurement provides a transparent mechanism for securing new contracts for services which reflect patient and population needs. Done well, procurement can be a powerful tool for stimulating innovation and enabling improvements in quality and value. Procurement can stimulate or enable providers to develop new service models and/or

redesign care pathways to improve quality of care to patients (e.g. greater personalisation) and make better use of the available healthcare resources in responding to the diverse needs of patients and communities.

It is important to ensure that an appropriate procurement approach is followed to allow compliance and reduce the risk of legal challenge and has a system to facilitate efficient and effective communication with the provider market.

Innovation and Research

Supported by our member practices and partners, we are leading a range of system wide transformational programmes to improve health and social care outcomes for our population.

- Working in partnership with key stakeholders to identify and implement system change which benefits our communities across the health and social care system;
- Identifying examples of good practice nationally, undertaking benchmarking and other comparative data and utilising patient feedback information to identify areas for improvement;
- Working in partnership with organisations such as the University of York to establish robust evaluation mechanisms for key areas of work such as Community Hubs;
- Exploring opportunities to bid for any funding which will support testing new approaches to care delivery, and innovation across the health and social care system.

We are combining process improvements in the way we identify, plan and deliver improvement projects with a programme of training to embed a culture of delivery and assurance across the CCG which will help us to deliver measureable quality improvements with our partners.

We are doing this through:

- Training the Innovation and Improvement team and clinical leads in lean methodology to support delivery of improvement events, and enhance planning and service delivery skills;
- Rolling out this approach with partners such as City of York Council and acute providers to give a consistent approach to service improvement;
- Providing senior improvement support to clusters of primary care providers to explore innovation at scale and partnership working across the Vale of York locality;
- Identifying a programme management structure for key work themes and improvement projects;
- Standardising the project management approach to service improvement to ensure accurate planning, reporting and evaluation of improvement projects;
- Delivering projects through a team approach which includes a dedicated finance and governance lead to support the transformation and efficiency agenda.

Research

Objective: Opportunities for accessing and leading research to improve healthcare systems for all

Research is essential to support continuous improvements in quality, efficiency and patient outcomes across healthcare.

As a member of the Academic Health and Science Network our aim is to increase participation in research studies and clinical trials by our GP practices and local providers, contributing to Excessive Treatment Costs.

We are committed to using evidence-based research in our service developments and improvement interventions, drawing on experience and best practice internationally and within the UK. We work with the Academic Health Science Network to support this approach and develop our knowledge base.

All research and clinical trial work is overseen by the Clinical Quality Group within the CCG.

The CCG also has a Clinical Effectiveness and Research Group established which co-ordinates with the local CSU Horizon-Scanning and Impact Assessment Groups to identify new guidance, best practice, innovation and research relevant to the CCG's strategic initiatives.

The CSU also host the Northern and Yorkshire Primary Care Research Network and works with our GP practices to mobilise research studies.

Sustainability

We have committed to a Sustainable Development Management Plan (<http://www.valeofyorkccg.nhs.uk/about-us/delivering-sustainability/>) which addresses the financial, environmental and social sustainability of health care services the CCG commissions.

We ensure that every policy and service improvement initiative is reviewed from a sustainability perspective at both committee and Governing Body level.

Sustainability Objectives:

Domain	Actions:
Governance	<ul style="list-style-type: none"> • Embed sustainability within the CCG's policies and procedures and reinforcement of Board level commitment and responsibility. Raise awareness of sustainability across the workforce through organisation development. • Work with strategic partnerships (e.g. Health and Wellbeing Boards) to support sustainable development and better prepare and adapt to the predicted effects of a future changing climate. • Complete the Good Corporate Citizenship Self-Assessment Tool to set a baseline and identify opportunities for improvement. • Review the plan on an annual basis and report on sustainability in the CCG Annual Report
Travel	<ul style="list-style-type: none"> • Identify opportunities to reduce car usage by staff and patients: encouraging active travel; promoting low carbon models of care; encouraging the use of remote communication in place of face to face meetings and encouraging home working.

Procurement	<ul style="list-style-type: none"> • Commission health services which are environmentally, socially and economically sustainable. • Through the contracting processes ensure that the providers of services commissioned by the CCG are complying with national and local requirements on sustainability, including carbon reduction
Facilities Management	<ul style="list-style-type: none"> • Minimising impacts on the environment (reduce energy and water demand, minimise waste) and supporting the local community and economy.
Workforce	<ul style="list-style-type: none"> • Respond to local employment conditions and needs and proactively building a skilled local workforce, promoting the health and wellbeing of employees through our HR policies.
Community Engagement	<ul style="list-style-type: none"> • Understanding the local community and involving its members in decision making and scrutiny, the planning and delivery of healthcare and supporting a strong and sustainable local economy. • Identify innovative solutions from engagement.
Buildings	<ul style="list-style-type: none"> • Consider all relevant sustainability issues in the design and operation of new or refurbished buildings to reduce waste, energy and resource use e.g. promoting active travel, expanding green and natural spaces.
Adaptation	<ul style="list-style-type: none"> • Contribute to the development of strategic multi-agency plans for responding to emergencies in partnership with the Local Health Resilience Partnership (LHRP).
Models of Care	<ul style="list-style-type: none"> • Collaborate with cross sector partners to prevent illness, promote health and develop sustainable joint service plans. • Tailor healthcare so it is closer to home. • Work with cross sector partners and individuals to reduce inequalities.

The Climate Change Act 2008 is a long term legally binding framework to reduce carbon emissions, mitigate and adapt to climate change. Organisations are required to meet the following UK Climate Change Act Targets - reduction in CO₂e by 2050 (1990 baseline):

- **34% by 2020**
- **50% by 2025**
- **80% by 2050.**

In addition the NHS has a separate short-term NHS target of 10% reduction by 2015 based on a 2007 baseline.

We are making some progress towards reducing our carbon emissions as an organisation, for example, we are now located in West Offices, a building with excellent sustainable design, construction and operation in a central location, which promotes active travel and public transport use. We also have a Sustainability Impact Assessment in place for staff to use when developing policy, Governing Body reports, services or projects, to consider positive and negative effects on financial, environmental and social sustainability.

As the major health commissioner, we have a role to play in promoting sustainability across the whole local health system, for example, through our membership of Health and Wellbeing Boards. Sustainability is aligned with a number of our and our partners' strategic objectives, specifically, integrating care and support and reducing health inequalities.

Equality and Diversity

Equality is a core principle of the NHS Constitution and embedded into the Health and Social Care Act 2010. What is more, as a public sector organisation we have a duty under the Equality Act 2010 to promote equality and eliminate discrimination and foster good relations. For more information please see our Equality, diversity and Human Rights strategy and implementation Plan 2013-2017, which is available on our website (<http://www.valeofyorkccg.nhs.uk/about-us/equality/>).

Our equality objectives are:

- To provide accessible and appropriate information to meet a wide range of communication styles and needs
- To improve the reporting and use of equality data to inform equality analyses
- To strengthen stakeholder engagement and partnership working
- To be a great employer with a diverse, engaged and well supported workforce
- Ensure our leadership is inclusive and effective at promoting equality

These objectives have been informed by evidence gathered from previous engagement activity, review of a wide range of documents and internal self-assessment using the Equality Delivery System.

We are also committed to a wider set of ambitions to embed equality within the organisation and our commissioning activity. This includes:

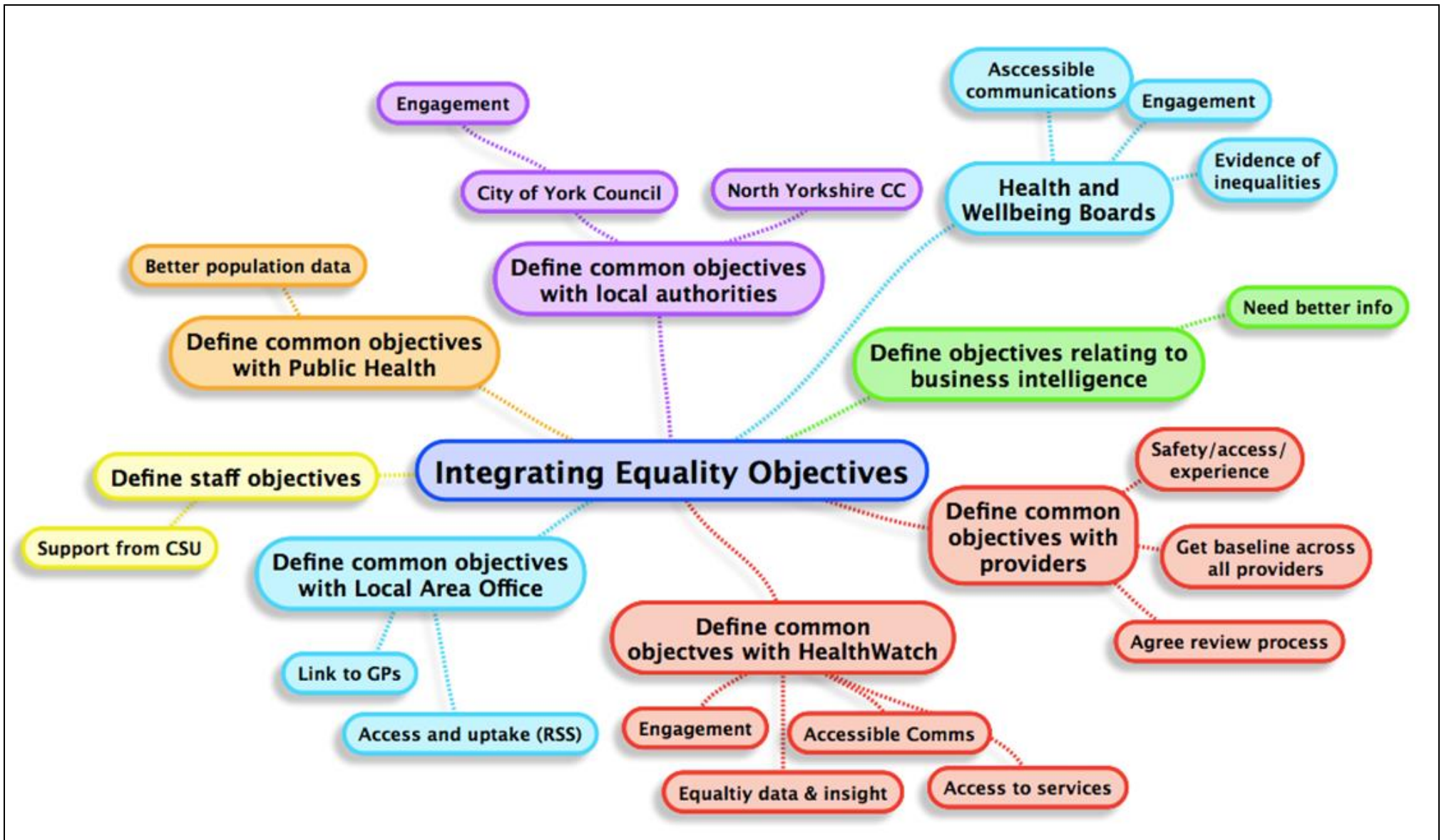
- Reducing health inequalities – a strategic ambition for us and the Health and Wellbeing Boards across our area.
- Committing to exploring the implementation of the living wage within our organisation and procurement.
- Developing the Joint Strategic Needs Assessments with local authorities to improve our understanding of our population.
- Further embedding equalities within our organisation development programme

We measure the equality impact of our decisions, through Equality Impact Assessments, to carefully consider the impact of the decisions we make on the population or on our staff, particularly for people who share protected characteristics.

We provide a range of health information on our website to promote equality, rights and diversity for our population and staff, for example:

- Health advice during Ramadan
- Health commissioning and race equality
- Lesbian, Gay, Bisexual and Trans Public Health Outcomes
- Women's voices on health and barriers to Primary Care

The diagram below shows the partners we will work with to embed our equalities objectives across all our work programmes.



Equality Impact Assessment

1.	Title of policy/ programme/ service being analysed
	<p>My Health, My Life, My Way NHS Vale of York Clinical Commissioning Group Integrated Operational Plan 2014-2019</p>
2.	Please state the aims and objectives of this work.
	<p>The Integrated Operational Plan includes the following Strategic Initiatives:</p> <ol style="list-style-type: none"> 1. Integration of Care 2. Person Centred Care 3. Primary Care Reform 4. Urgent Care Reform 5. Planned Care 6. Transforming mental health services 7. Children and Maternity 8. Cancer and End of Life <p>And the following objectives:</p> <ul style="list-style-type: none"> ▪ People will be supported to stay healthy through promoting healthy lifestyles improving access to early help and helping children have a healthy start to life ▪ People will have more opportunities to influence and choose the healthcare they receive and shape future services. ▪ People will continue to have good access to safe and high quality healthcare services ▪ When people become ill, they are treated in a timely manner with access to expert medical support as locally as possible ▪ Where people have long-term conditions they are supported to manage those conditions to give them the best possible quality of life ▪ When people are terminally ill, the individual and their families and/or carers are supported to give them the best possible quality of life and choice in their end of life care. ▪ A move to 'Care Hubs', providing increased access to health promotion, care and support services, including GPs, pharmacies, diagnostics (e.g. scans/ blood tests), community services, mental health support and social care and community and voluntary services.

	<ul style="list-style-type: none"> ▪ High quality mental health services for the Vale of York, with increased awareness of mental health conditions, improved diagnosis and access to complex care within the local area. ▪ A sustainable and high quality local hospital providing a centre for urgent and emergency care and planned care for a wide range of conditions and elective operations, maternity and other specialisms within the Vale of York. ▪ Access to world class highly complex and specialist care provided through specialist centres across the country. ▪ Opportunities for accessing and leading research to improve healthcare systems for all
3.	Who is likely to be affected? (e.g. staff, patients, service users)
	<p>The CCG represents patients registered with 32 GP Practices across the Vale of York area, equating to a population of 336, 330 residents.</p> <p>Equality is a key theme running through all the CCG's policies, strategies and plans and where possible we aim to improve access for our population, for example, increasing access to IAPT for all patients.</p> <p>The Integrated Operational Plan is wide ranging and encompasses the totality of the CCG's work and future ambitions to improve care and support over the next five years. There are a number of programmes of work and specific projects that will deliver this strategic plan. As part of the CCG's project management framework an Equalities Impact Assessment (EIA) is completed for all our projects. For the projects that are already being initiated, an EIA is in place. For those projects or interventions that have not yet evolved, an EIA will be completed for each one during the Business Case development stage to assess how people or groups might be affected by any proposed changes to the health services we commission.</p>
4.	What sources of equality information have you used to inform your piece of work?
	<p>By being involved in the three Joint Strategic Needs Assessments across the Vale of York area, the CCG can gain a thorough understanding of its population – deprived communities, protected groups, and health and wellbeing need. This is particularly relevant to our ambition to reduce health inequalities.</p> <p>The CCG has a duty under the Equality Act 2010 to promote equality and eliminate discrimination and foster good relations. Our Equality, Diversity and Human Rights Strategy & Implementation Plan 2013-2017 includes the following objectives:</p> <ol style="list-style-type: none"> 1. To provide accessible and appropriate information to meet a wide range of communication styles and needs 2. To improve the reporting and use of equality data to inform equality analyses 3. To strengthen stakeholder engagement and partnership working 4. To be a great employer with a diverse, engaged and well supported workforce 5. Ensure our leadership is inclusive and effective at promoting equality

	<p>These objectives have been informed by evidence gathered from previous engagement activity, review of a wide range of documents and internal self-assessment using the Equality Delivery System.</p>
5.	<p>What steps have been taken ensure that the organisation has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics</p>
	<p>The analysis of equalities is embedded within the CCG's project management framework. Every project must have a business case, with a completed EIA attached, for approval by the Quality and Finance Committee before they can be initiated. We are keen that equality impact assessment becomes embedded in the planning of our improvement work programme. This process will ensure that the CCG has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics.</p> <p>Engagement and consultation with our stakeholders, especially patients and the public is also fundamental to our planning and project management. This enables us to fully explore the impacts of any proposed changes for our population, with those who will be affected.</p>
6.	<p>Who have you involved in the development of this piece of work?</p>
	<p>Stakeholder involvement:</p> <p>Our Integrated Operational Plan is based on extensive engagement with a range of stakeholders: staff, service users, patients and voluntary sector representatives. We have a well-established programme of engagement, 'Let's talk health' and we work closely with the three Healthwatch organisations across our area and more formally through our Patient and Public Engagement Steering Group (PPE), Patient and Public Groups (PPGs) in primary care with lay representation. To date we have engaged with our stakeholders on the following themes to plan improvements to services:</p> <ul style="list-style-type: none"> ▪ Community Services ▪ Diabetes ▪ GP Out of Hours Service ▪ Long Term Conditions ▪ Mental health ▪ Neurology ▪ Palliative and End of Life Care ▪ The Better Care Fund (health and social care services) ▪ The CCG's Integrated Operational Plan for 2014-19.

	<p>Please refer to the Annex ‘You Said We Did’ document within our Integrated Operational Plan for a summary of engagement activity.</p> <p>The Integrated Operational Plan is a strategic plan which sets out the CCG’s vision for the next five years. This EIA is focused on the strategic aims and objectives within this plan. Those projects that are already underway have an EIA in place and will be for any future projects or interventions to explore any positive or negative impacts in more depth.</p>
<p>7.</p>	<p>What evidence do you have of any potential adverse or positive impact on groups with protected characteristics? Do you have any gaps in information? Include any supporting evidence e.g. research, data or feedback from engagement activities</p> <p>(Refer to if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)</p>
<p>Disability People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)</p>	<p>Consider building access, communication requirements, making reasonable adjustments for individuals etc</p>
<p>The delivery of our strategic initiative ‘Transforming mental health services’ within our Integrated Operational Plan will have a positive impact for people with mental illness.</p> <ul style="list-style-type: none"> ▪ IAPT psychological therapies services currently have long waiting times and the inpatient estate at Bootham Park Hospital requires redevelopment. We plan to transform our mental health services in the local area to enable a greater parity of esteem between mental and physical health and ensure that timely, safe and quality care is equally as accessible as care for physical illness or injury. <p>This will be an area for investment for the CCG in the next five years, with a complete review of the model of provision and the supporting estate to ensure that it is fit for purpose.</p> <p>We are currently working with City of York Council to carry out a ‘deep dive’ into mental health need across York. This information will inform our transformation of mental health services.</p>	
<p>Sex Men and Women</p>	<p>Consider gender preference in key worker, single sex accommodation etc</p>

The Integrated Operational Plan highlights the following findings relevant to men's health and women's health:

- Respiratory disease shows the gap between male and female coming together.
- Cancer - the gap between men and women is getting wider.
- A significant gap between men and women in CVD though this gap is closing.

We have an ambition to reduce the potential years of life lost (PYLL) from causes considered amenable to healthcare by 15%, which will be driven by our strategic initiatives set out earlier in this document.

Across the Vale of York there are significant differences in life expectancy for men (and women to a lesser extent) depending on where they live. The CCG is committed to working with partners, including Health and Wellbeing Boards to reduce health inequalities, not only between men and women, but between the most and least deprived populations.

Some examples of our current improvement interventions which are addressing key local health inequalities include reducing emergency admissions (urgent care – Emergency Care Practitioners, liaison psychiatry), frail elderly (integration / Care Hubs) and neurology (Planned Care).

Race or nationality People of different ethnic backgrounds, including Roma Gypsies and Travelers	Consider cultural traditions, food requirements, communication styles, language needs etc
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The Vale of York population is majority white British (95%) and report their religious beliefs as Christian (64%) or of no religion (26%). There is a number of other significant ethnic groups including, Asian (2.2%), mixed race (1%), black (0.4%) and travellers & Roma Gypsy communities. There is also a diverse range of religious beliefs, including Muslim (0.7%), Buddhist (0.4%), Sikh (0.1%) and Jewish (0.1%). We need to plan effectively for the different cultural, social and health needs of our community to everyone to achieve the best health and well-being.

Age This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc
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Our Quality Assurance and Improvement function includes a focus on proactive safeguarding for both children, young people and adults deemed as vulnerable.

The CCG is increasing the capacity within both the children's and adults safeguarding teams to ensure there is the capacity to deliver a robust model of proactive assurance across the Vale of York. The CCG as the accountable health organisation for safeguarding have:

- An Executive lead on the Governing Body for safeguarding
- A GP lead on the Governing Body for safeguarding adults and children

- Are permanent members of the Local Safeguarding Children and Adult Board

Safeguarding is also embedded within all the work of the CCG, staff training and a full list of relevant policies are in place.

Children and Maternity is one of the CCG's strategic initiatives, supporting people to stay healthy through promoting healthy lifestyles, improving access to early help and helping children have a healthy start to life. Following the appointment of a Clinical Lead for Children and Maternity, we will start to scope this initiative over the next year.

It is also evident that we have an ageing population, which will have an impact on the care and support we will need to commission in the future. Our strategic initiative to integrate care is particularly relevant here to ensure that the local health and social care system is fit for purpose and sustainable to provide the right care to the right people at the right time.

The Workforce profile across the Vale of York suggests an aging workforce, especially in relation to General Practitioners and Practice Nurses. Building on the work of W. Edwards Demming we are committed to the idea of the 'joy of work' and implementing this across our Care Hub model. This new approach will enhance the working environment and encourage key staff to defer retirement plans, new staff to join and bridge the potential staffing gap over the next few years.

Trans

People who have undergone gender reassignment (sex change) and those who identify as trans

Consider privacy of data, harassment, access to unisex toilets & bathing areas etc

None.

Sexual orientation

This will include lesbian, gay and bi-sexual people as well as heterosexual people.

Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc

None.

Religion or belief

Includes religions, beliefs or no religion or belief

Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc

None.

Marriage and Civil Partnership

Refers to legally recognised partnerships

Consider whether civil partners are included in benefit and leave policies etc.

(employment policies only)	
None	
Pregnancy and maternity Refers to the pregnancy period and the first year after birth.	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
None.	
Carers This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
Supporting carers is a key theme throughout the Integrated Operational Plan, for example we want to improve the quality of life carers and young carers and ensure they are involved in the planning and delivery of care and support. This is particularly relevant to two of our strategic initiatives; Integrated Care and Person-centred Care.	
Other disadvantaged groups This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc.
To reduce health inequalities, the CCG is also responding to the recommendation from the JSNAs to work with local service providers to ensure that they record information on protected characteristics about their staff and clients / patients such as age, disability, gender re-assignment, marriage and civil partnership, pregnancy / maternity, race, religion and belief, gender and sexual orientation, in order to inform service provision to reduce health inequalities. http://www.healthyyork.org/the-population-of-york/specific-population-profiles/lesbian,-gay,-bisexual-and-transgender-(lgbt)-population.aspx	
8.	Action planning for improvement The Integrated Operational Plan aims to improve services and access to them for patients, carers and the public, therefore having a positive impact across our population. The integrated Operational Plan is a strategic document setting out the five year vision for the CCG. Some projects are already underway to achieve this vision, which already have an EIA in place, including actions for improvement and any future projects or interventions will include an EIA as part of their business case before they can be initiated.

Sign off
Name and signature of person / team who carried out this analysis Helen Sikora
Date analysis completed 24 June 2014
Name and signature of responsible Director Rachel Potts, Chief Operating Officer
Date analysis was approved by responsible Director

Annex 1: High level summary of all Improvement Interventions

NHS Vale of York CCG Improvement Interventions 2014/15 & 2015/16				KEY	SCOPING EXPLORATION DESIGN MOBILISATION DELIVERY												MILESTONE 1/8 month Review	15/16			
Programme	QIPP Project Leads	Mar-2014	Apr-2014		May-2014	Jun-2014	Jul-2014	Aug-2014	Sep-2014	Oct-2014	Nov-2014	Dec-2014	Jan-2015	Feb-2015	Mar-2015	Q1		Q2	Q3	Q4	
Current 14/15 Improvement Interventions Being Delivered	QIPP	Other																			
Direct Access Diagnostics - Pathology	QIPP		Transactional	LS																	
Telehealth	QIPP		Person-Centred Care	IS																	
Stoma care	QIPP		Planned Care	BC																	
Gluten free products	QIPP		Planned Care	BC																	
Sip feeds	QIPP		Planned Care	BC																	
Dressings	QIPP		Planned Care	BC																	
Quick Six (Medicines Management)	QIPP		Planned Care	BC																	
Neurology	QIPP		Planned Care	AB																	
Referral Support Service	QIPP		Planned Care	AB																	
Improving Length of Stay	QIPP		Transactional	LS																	
Diabetes	QIPP		Planned Care	AB																	
MSK Tender	QIPP	Phone	Planned Care	AB																	
Orthopaedic procurement	QIPP	Phone	Planned Care	AB																	
Mental health & LD procurement	QIPP	Phone	Mental health	PH																	
Out of Hours Procurement	QIPP	Phone	Urgent Care	BC																	
Care Hub Selby	QIPP	ACP	Integrated Care	PH																	
Care Hub PMO	QIPP	ACP	Integrated Care	IS																	
Care Hub City and Vale Federation	QIPP	ACP	Integrated Care	PH																	
Care Hub Pocklington	QIPP	ACP	Integrated Care	PH																	
UCP (York and N Yorks)	QIPP	ACP	Integrated Care	BC																	
Street Triage (York & NY)	QIPP	ACP	Urgent Care	JR																	
Hospice at Home (York & NY)	QIPP	ACP	Integrated Care	PH																	
Psychiatric Liaison	QIPP	Telephone	Mental Health	BC																	
Feed Zero Length of Stay	QIPP		Childrens	BC																	
Front Door Geriatrician for ED	QIPP	Telephone	Urgent Care	BC																	
Community Based IV Service	QIPP		Integrated Care	BC																	
Minor illness / Minor Injury training for Paramedics	QIPP		Urgent Care	BC																	
W/DI practical service improvement with Primary Care	Enabling		Primary Care	SM																	
Risk stratification & Care Planning	Enabling		Primary Care	SM																	
Direct Access Diagnostics: Reducing primary care variation: via specialty-led training & education	Enabling		Primary Care	SM																	
Further extension of Referral Support Service (RSS)	Enabling		Primary Care	SM																	
Prescribing: various other medicines management productivity	QIPP		All	SO																	
IAPT: extension of capacity to support delivery of target	Investment	Telephone	Mental Health	PH																	
IMPROVEMENT INTERVENTIONS CURRENTLY IN SCOPING PHASE:																					
Conditions register expert consulting	QIPP		Transactional	LS																	
Full Service and Spec Review	QIPP		Transactional	LS																	

Current 14/15 Improvement Interventions Being Delivered	QIPP	Owner	Category	Sub-category	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
High Cost Drugs / P&R excluded drugs	QIPP		Transactional	LS										
Application of contract principles	QIPP		Transactional	LS										
Full date quality review	QIPP		Transactional	LS										
Readmissions review / audit refresh	QIPP		Transactional	LS										
Management of internally generated demand (Consultant, Consultant referrals)	QIPP		Transactional	LS										
Benchmarking practices and incentives	QIPP		Transactional	LS										
Direct Access Diagnostics - Radiology	QIPP		Transactional	LS										
Relative Care Price & Contract Review	QIPP		Transactional	LS										
Critical Care Review	QIPP		Transactional	LS										
Date validation and Audit	QIPP		Transactional	LS										
Community Transport	QIPP		Integrated Care	BC										
Children's Asthma	QIPP		Childrens	PH										
Gastro: explore outliers & constipation/coherence	QIPP		Primary Care	SM										
CVD (hypertension & prevention)	QIPP		Planned Care	SR										
Community Pharmacy: initially minor ailments/treatments	QIPP		Integrated Care	JBU /B										
Ophthalmology Service Review	QIPP		Planned Care	AB										
Cancer / EoL Pathway Review	QIPP		Cancer / EoL	PH										
Dementia: increase diagnosis rates (increase knowledge and skills of practice staff, increase efficiency of screening, coding and links to memory clinics and care navigator)	QIPP		Mental Health	PH / LS										
Doctor First - Avoiding unnecessary face to face contact	QIPP		Person-centred Care	SM										
Low backpain pathway	QIPP		Primary Care	HW										
Diagnostic Trailers, Mobile units	QIPP		Integrated Care	AB										
Equipment Services to support discharge	Enabling		Integrated Care	JH										
Nutrition and Care Homes	QIPP		Integrated Care	CD										
Spinal Injuries	QIPP		Planned Care	AB										
Near Patient Testing	QIPP		Primary Care / Integrated Care	SR										
Mobile Dentistry Service to Residential Homes	QIPP		Primary Care	IS										
Prescribing - repeat medications	QIPP		Planned Care	BC										
Breast Disease / Pain	QIPP		Primary Care	SR										
Emergency Health Care Plans (EHCP) Children's and Family Act Implementation: Implications of Care Bill		History	Children's & Maternity	PCU										
Child and Adolescent Mental Health Services Strategy Review			Children's & Maternity	PCU										
Maternity Commissioning Strategy			Children's & Maternity	PCU										
Looked After Children Services			Children's & Maternity	PCU										
Children with Lower Respiratory Tract Infections Review	QIPP		Children's & Maternity	PCU										
CHC Price Re-negotiation for care packages (Pilot)	QIPP		Children's & Maternity	PCU										
Review of dementia prescribing	QIPP		Mental Health	PCU										
Review of high cost mental health prescribing	QIPP		Mental Health	PCU										
Autism Pathway review			Mental Health	PCU										
PCU Management Cost Reduction	QIPP		Mental Health	PCU										
MH OOC Placements	QIPP		Mental Health	PCU										
Addictions: brief interventions for over-drinking and binge drinking	QIPP		Person-Centred Care	PCU										
Joint assessments of young people with CHC/ SEN/ Personal budgets before 18 years to manage enduring needs more jointly between health and social care	QIPP		Mental Health	PCU										

Current 14/15 Improvement Interventions being Delivered	QIPP	Other																		
Survivorship Work			Cancer / EOL	CCG / CSU																
Recovery Package and enhanced patient education			Cancer / EOL	CCG / CSU																
End of Life Pathway Review	QIPP		Cancer / EOL	PH																
Cancer pathway review and service redesign			Cancer / EOL	CCG / CSU																
Cancer Diagnostics Review (link to West Yorkshire review)			Cancer / EOL	CCG / CSU																
Review of Asthma prevalence in under 5 years (health inequality)			Children's & Maternity	PCU																
Autism Assessment: pathway review to increase capacity			Children's & Maternity	PCU																
Weight Management (focus on Selby population)			Person-Centred Care	CCG / CSU																

Annex 2: Summary of all Improvement Interventions 2014-15 to 2015-16

The detail outlined below covers the first 2 years of the Strategic Plan and the programmes of work which have been prioritised and agreed for taking forward – these are either in delivery or currently being scoped to understand potential impact. Many of these are already well developed and progressing against their project plans. Many of the programmes will run for 3-five years (e.g. integration) and whole system change will be driven through them.

Strategic Initiative 1: Integration of Care

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Emergency (Urgent) Care Practitioners (York & N Yorks) (BCF)	ECP's will clinically manage patients who have Urgent Care needs as close to home as appropriate, rather than conveying to hospital. The scheme will focus on 'Assess and Treat'; 'Assess and Refer'; and 'Assess and Convey' to alternative sites where appropriate.	1,343.9	Reduce A&E attendances and unplanned admissions at YTHFT. Reduce ambulance transfers to A&E and admissions at YTHFT.	Service specification completed and signed off – June 2014. Recruit and train ECP's. New pathway put in place – Sept 2014. 3 month service review – Dec 2014.	Successful recruitment and sustained employment of ECP's.	Agreement of risk share with YAS. Support from providers is not received.	390.7	AP	BC	YAS
Care Hub Selby (BCF)	The "community hub" model provides proactive and community-centred care for populations of around 50,000-	Year 1: 572.1 (FYE: 1,682.9)	Delivered in parallel with nationally-defined outcomes through the better care fund and local plan submitted, in addition to local	Formal approval of MoU and agreement to collaborate from Selby District GPs – June 2014.	CCG five year Strategic Plan. National integration strategy and	Significant and complex change programme.	Year 1: 280.8 (FYE: 591.9)	AP	PH	YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	<p>100,000. The community hub model combines all resources of public sector, independent sector and community assets to deliver joined-up care and improved outcomes for the population it serves.</p> <p>YTHFT are working with 7 GP practices to lead this integration pilot in Selby for their population of c. 73,000 patients.</p>		quality and performance metrics across a broad spectrum of care activities.	<p>Develop workforce plan and initiate recruitment. Case managers in post - August 2014.</p> <p>Development of the community hub implementation plan. Launch community hub model – Oct 2014.</p> <p>Community Services procurement 2015/16</p>	<p>policy – Better Care Fund.</p> <p>Stakeholder and partner support.</p> <p>Financial and operational support.</p> <p>Provider programme lead.</p> <p>NHS Accelerate potential programme.</p>					
Care Hub PMG (BCF)	<p>Priory Medical Group is the provider lead for this integration pilot in York for their population of c. 55,000 patients.</p>	Year 1: 150.0-450.0.	As above.	<p>Programme plan and case submitted - Mar 14.</p> <p>Model initiated - April 14.</p> <p>Model implemented - June 14.</p> <p>Model evaluated and refined - June 14 onwards.</p>	As above.	As above.	Year 1: 261.4	AP	RI	Priory Medical Group

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Care Hub City and Vale Federation (BCF)	Possibility to introduce a 3rd Care Hub as a 2nd phase to the Priory integration pilot. Currently in discussions with the local providers, and scoping is being carried out.	TBC	Delivered in parallel with nationally-defined outcomes through the better care fund and local plan submitted, in addition to local quality and performance metrics across a broad spectrum of care activities.	Currently in scoping stage. Further milestones to be agreed.	As above.	Would be assessed and managed throughout development.	TBC	AP	PH	TBA
Care Hub Pocklington (BCF)	Possibility to introduce a 4th Care Hub. Currently in discussions with the local providers, and scoping is being carried out.	TBC	As above.	As above.	As above.	As above.	TBC	AP	PH	TBA.
Hospice at Home (BCF)	An expansion of the current Hospice at Home scheme to give more capacity to the team to cover weekend support for patients and carers on the EOL pathway.	810.0	Reduction in acute activity for patients on the EOL pathway. Increase of patients on the EOL pathway being cared for at home. Increase in number of patients who die in their place of choice.	If is invested in, 4 month trial to see if expected outcomes are delivered – Oct 2014. If desired outcomes are achieved will move from trial to full implementation – Nov 2014.		Concerns regarding capacity to deliver; costs of service and return on investment.	270.0	AP	PH	

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
			Increase in patient and carer experience.							
Community Service Review (Procurement)	On-going review of all community services in preparation for evaluation of integration pilots and future reprocurement.	TBC		Evaluation of Care Hubs and tender – 2015/16. Service start – 2016/17.						YTHFT
SCOPING										
Equipment Services to support Discharge	Improving efficiency of the Equipment Services to improve the delays of discharge.	Enabling & some potential savings	Discharge delays reduced. Patient Experience, due to better running of the equipment service.	Meeting to be held with the local commissioners to establish a working group to improve the efficiency of the equipment service – June 2014.	Integration pilots.		0.0	TBA	JH	YTHFT and other TBC
Diagnostic Mobile Units (CATS)	Procure a mobile care unit to provide a seven	TBC; but potential	Supports delivery of one of the five year strategic	TBC when Business Case presented.	Collaboration with local CCG's	Requires change to traditional in-	0.0	TBA	AB	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	<p>day (8am – 8pm) mobile outpatient care service which is easily accessible to GP's and patients.</p> <p>Ability to deliver provision where the demand is, and there is also flexibility to deliver services tailored to the commissioners requirements.</p>	large savings.	aims: Reduce elective activity by 20% by 2018/19.		<p>making any potential procurement more attractive to providers.</p> <p>Integration pilots.</p> <p>Community Service Review & Procurement.</p>	hospital outpatient care model.				
Community Pharmacy	<p>58% of those over 60 suffer from at least one long-term condition (LTC). LTCs risk being unmanageable without a significant change to the way care is provided - pharmacists can be integral to this change.</p> <p>Community pharmacists could provide an alternative triage point for many of the common ailments currently</p>	TBC	<p>Reduction in A&E attendances.</p> <p>Increased capacity and expertise in the system.</p> <p>Patient experience, patients being treated more locally.</p>	Currently in scoping stage.	<p>Included in EOI for co-commissioning of Primary Care (CCG & NHSE).</p> <p>Aligns with Care Hub approach.</p> <p>Community Services Review.</p> <p>LMC support strong.</p>		TBC: Investment needed for training.	S'OC & Hazel Marsden	JR	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	dealt with by out-of-hours services and Accident and Emergency departments.									
Community Based IV Service	<p>Review the pathway for Bronchiectasis patients to assess suitability for home IV antibiotics.</p> <p>Patient assessment will be undertaken as well as the relevant diagnostic testing. This assessment (including physiotherapy assessment) should be undertaken by the specialist advanced nurse practitioner and take no more than 2 days (48hours) to complete. As part of the assessment, the specialist nurse has discussions with the patient to check their suitability for home IV</p>	TBC	<ul style="list-style-type: none"> - Enables early discharge and frees up acute hospital beds - Prevents hospital admissions - Patients recover more quickly in their own home environment and can return to home life, work and school more quickly - Reduced risk to patients of developing nosocomial infections - Encourages patient choice 						BC	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	antibiotics. The plan is to discharge home these suitable patients within 48hours.									
Nutrition and Care Homes									CD	
Community Transport									BC	

Strategic Initiative 2: Person-Centred Care (Self Care, Wellbeing and Prevention)

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Telehealth	Service decommissioned secondary to a full service evaluation.	180.0	Service reviewed with GP Practices and public in line with quality and outcome considerations.	Service decommissioned; Cost Savings Realised (£168k); Project close-down – April 2014. Remaining unit locations defined-July14.		Existing users of Telehealth equipment managed in line with assessment of on-going needs.	0.0	CCG	RI	Tunstall
Doctor First	Reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions.	TBC	<ul style="list-style-type: none"> - Reduced face to face interactions - Faster & more convenient services - Improving choice and patient satisfaction. 	Establish a working group with Trust & CCG representatives to agree implementation plan and milestones – June 2014.	Provider engagement.	System connectivity.	TBC	TBA	SM	TBA
SCOPING										
Weight Management	Introduce a weight management programme with the key components highlighted from NICE guidance to be included, to tackle obesity. Specific focus on targeting obesity levels in Selby.	TBC	<ul style="list-style-type: none"> - To be compliant with NICE guidelines. - Improve the health of overweight and obese people. - Effective services available to support people in the long term. 		Work with local authority to deliver well-being plan (includes reducing obesity prevalence).		TBC	TBA	TBA	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Addictions: Binge Drinking and Over Drinking.	Interventions to be implemented for binge drinking and over drinking.	TBC					TBC	TBA	PCU	TBA

Strategic Initiative 3: Primary Care Reform

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Low Back Pain Pathway	To implement a pathway for the small cohort of patients who could potentially suffer with motor loss as a result of low back pain.	0.0	<ul style="list-style-type: none"> - To standardise a pathway in primary care for patients who suffer from low back pain, with associated motor loss. - To improve the quality of care received for those suffering from low back pain and prevent potential long term damage by the early detection and treatment of motor loss. 	Pathway launch event - July 2014.	Partnership working with the MSK, Pain, Radiology and ED teams at York Teaching Hospitals Foundation Trust.	Small cohort of patients to target for launch event.	0.0	SO'C	HW	PH
WDID Service Improvement	Project being carried out at 4 GP Practices using Lean methodology to create efficiencies within the practices, to enable GP's to free up some of their time to work on additional activities.	0.0	<ul style="list-style-type: none"> - Better use of resources at GP Practices. 	4 GP practices to be reviewed – July 2014. Roll out Lean methodology across more practices – September 2014 onwards.	GP engagement.	GP take up and adoption.	30.0	TM	SM	TBA
Risk Stratification &	System tool used by GP's to identify	0.0	<ul style="list-style-type: none"> - Better management of 	System to go live June 2014.	GP engagement.	GP take up and	0.0	TM	SM	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Care Planning	patients at high risk of hospital admission.		high risk patients. - Supports care plans for patients. - Reduce hospital admissions.		Successful implementation of the system tool.	adoption.				
Diagnostics Direct Access	Undertake GP practice diagnostics demand benchmarking triangulated with outpatients demand to identify best practice and outliers. Provide training to primary care clinicians to eliminate waste and ensure appropriate diagnostics are carried out. Conduct a joint demand efficiency review to eliminate waste and duplication of tests.	TBC	- Improve knowledge of Primary Care clinicians to maximise value from the service. - Provision of a sustainable and affordable service.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.			0.0	TM	SM / LS	TBA
SCOPING										
Mobile Dentistry Service to Residential	The CCG will commission a dedicated dental service for care	TBC	Ensure that patients maintain their optimum level of health.	Currently in scoping stage.	Sufficient numbers of patients in these homes		TBC	TM	RI	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Homes	<p>and nursing home residents that builds on international evidence with local support from the Local Dental Network.</p> <p>This initiative is in response to the currently unmet need of this group of patients.</p> <p>Evidence suggests that poor oral hygiene leads to malnutrition which in turn leads to weight loss and decline in physical wellbeing. This can push an already compromised older person into an irreversible decline.</p>				<p>to make the provision of a mobile dental unit a viable proposition.</p> <p>Forms part of the portfolio of schemes within our “Co-commissioning Primary Care” with NHSE submission.</p>					
Breast Disease / Pain	Local criteria for breast pain referrals to be updated to enable a shift from these patients being managed in secondary care to	TBC: Greater than 50.0	- Reduction in new breast pain referrals, outpatient attendances and mammogram activity.	Currently in the scoping stage.			0.0	TM	SR	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	be predominantly managed in primary care.		- Patient's anxiety to be better managed.							
Near Patient Testing / Anticoagulation	Introduce near patient testing to be based in the Community / Pharmacists / GP Practices.	TBC: Potential for large savings to be made	- Patient experience: closer to home. - Release capacity at YTHFT.	Currently in the scoping stage.	LES agreements for anti-coagulation monitoring with 32 GP Practices.		TBC	TM	SR	TBA
Gastroenterology	Exploring what areas of Gastro activity can be managed better in primary care. Initially the focus will be on the management of constipation.	0.0	Improve knowledge of Primary Care clinicians to maximise value from the service.	Data analysis to start being carried out to identify high activity areas – July 2014.	GP engagement.	Lack of GP engagement.	0.0	TM	SM	TBA

Strategic Initiative 4: Urgent Care Reform

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Street Triage (York & N Yorks) (BCF)	This scheme sees Mental Health professionals working with NY Police to provide timely and appropriate interventions to individuals at their contact point with the police. The scheme will operate at 14:00 to 23:59 seven days per week.	450.0	<ul style="list-style-type: none"> - Reduction in A&E attendances - Reduction in S136 detentions - Improved outcomes for mental health patients in crisis 	<ul style="list-style-type: none"> - Recruitment, interviews and training – June 2014. - Operations commence – August 2014. - 3 month review – Nov 2014. 		<ul style="list-style-type: none"> Unable to recruit staff to posts. Inability to agree operational model between LYPFT and NYP. 	198.8	AP	JR	NY Police LYPFT CYC
Out of Hours Procurement	On-going re-procurement of the GP Out of Hours service.	0.0	More effective, efficient service, meeting NQR's to improve patient service.	<ul style="list-style-type: none"> - Provider engagement May 2014. - Development of service specification – May 2014. - Tender period and evaluation June/July 2014. - Contract Awarded Oct 2014. - Contract start date April 2015. 		Lack of interest in contract from providers.	0.0	AP	BC	YTHFT ED and Capital Planning Dept.
SCOPING										
Emergency Department Geriatrician	A significant number of patients enter ED	TBC	Improve patient experience.	Currently being scoped.	Care Hub approach	Unsuccessful recruitment to the	TBC	AP	BC	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	<p>every day who are frail elderly with a number of significant medical and care needs.</p> <p>Patients would be 'greeted' at the front door by experienced geriatricians who can recognise specific frailty markers.</p> <p>Patients would have fast-track access to therapy teams, outpatient clinics and to other holistic support.</p>		Reduce admissions, and bed days post admission.	Milestones to be agreed.		Geriatrician post.				
Minor Illness / Injury training for Paramedics	Providing training for YAS paramedics so they are able to treat a number of conditions (minor injury or illness) at the scene, reducing the need for transportation and ED attendance.	Potential for 153.00 TBC	<p>Reduction in A&E attendances.</p> <p>Increased capacity and expertise within the system.</p>	Training packages and competency frameworks set up to pilot this scheme. Dates TBC.			TBC	AP	BC	YAS

Strategic Initiative 5: Planned Care

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Stoma Care	<p>£1.5M budget currently directly attributed to Stoma Appliances across 25,000 items.</p> <p>Potential interventions with Trust/Stoma Nurse/associated companies and Hospice for joint working.</p>	150.0	<ul style="list-style-type: none"> - Increase in patient experience / satisfaction. - Reduction in wastage. - Appropriate prescribing undertaken. 	Implementation plan to be developed – commence Nov 2014.	<p>Prior work on gluten free products and dressings as example reviews and formulary updates.</p>	<p>Joint working with YTHFT and private suppliers.</p> <p>Patient choice.</p>	0.0	SO'C	BC	YTHFT
Gluten Free Products	<p>Review and update prescribing list initially followed by review of prescribing/supply route.</p> <p>Review with gastroenterology consultants to discuss criteria and to work with biopsy tests.</p>	62.0	<p>Provide clear pathway for future patients.</p> <p>Clear criteria around future prescribing.</p>	<p>Key recommendations from options paper agreed – April 2014.</p> <p>Implementation plan developed to include communications plan – July 2014.</p> <p>GP awareness complete and changes made – Sept 2014.</p>	<p>Patient satisfaction around clear tests and fair prescribing</p> <p>Public satisfaction around fair usage of NHS funds</p> <p>Evidence of other areas doing similar work.</p>	<p>Patient choice; dissatisfaction around tests required and limitation of products</p> <p>GP availability for tests</p> <p>Costs of testing</p>	0.0	SO'C	BC	YTHFT Dr. Gerry Robbins
Sip Feeds	£1.2M budget currently directly attributed to Sip Feeds; potential to work up scheme with	120.0	Clear pathways for patients to be assessed for treatment to support GP's and secondary	Implementation plan to be developed – Jan 2015.	Prior work on gluten free products and dressings as example reviews and	<p>Joint working with YTHFT and private providers.</p> <p>Patient</p>	TBC: 15.0 (for potential investment in a Dietician)	SO'C	BC	YTHFT Private Providers

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	dietician involvement, with a review of prescribing recommendations .		care staff. Greater patient management and integrated working.		formulary updates. Patient satisfaction around clear pathways. GP satisfaction around wastage of items.	choice; dissatisfaction around limitation of products.				
Dressings	Introduction of an Online Non Prescription Ordering System (ONPOS). Combined with increased formulary compliance through raising awareness of the existing Tissue Viability Handbook and Formulary, through running awareness sessions.	At least 125.0	<ul style="list-style-type: none"> - Reduction / prevention of re-admissions to secondary care. - Improved patient care, and patient experience. - Increased adherence to wound care formulary and a reduction in wastage. 	<p>Scheme approval at SMT – end June 2014</p> <p>Implementation phase – July/Aug 2014.</p> <p>Begin rollout - Sept 2014.</p>	<p>SMT approval.</p> <p>Buy in from Community Services and General Practices.</p> <p>Support from private provider to implement.</p>	<p>Lack of engagement from staff.</p> <p>Difficulties in using technology.</p> <p>Lack of support from private provider to implement.</p>	0.0	SO'C	BC	

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Quick Six (Medicines Management)	<p>Changed to a 'Quick Switch' scheme; a number of items have been identified which are either non-formulary or non-commissioned, or where cheaper generic alternatives have been identified.</p> <p>There is also a list of quality improvements to be adhered to with a financial incentive attached.</p> <p>The CSU prescribing team supports practices to do this.</p>	160.0	<ul style="list-style-type: none"> - Management of drugs that are unsafe or no longer supported. - Switch to generic equivalents where required. - Requirement for practices to engage with process promotes engagement. 	Incentive scheme to begin – June 2014.	<p>Previous work on incentive scheme during 2013-14.</p> <p>Prescribing website and newsletters.</p> <p>Payment for success.</p> <p>CSU Medicines Management team to support as well as new CCG pharmacy post.</p>	<p>Needs whole group sign up.</p> <p>Reluctance to change prescribing for long term patients.</p> <p>CSU support limited.</p> <p>Patient choice.</p>	0.0	SO'C	BC	Practices
Neurology	<p>Implementation of an integrated care pathway as agreed to address outcomes from NCS service redesign work. Implementing four pathways: Epilepsy, Motor Neuron Disease, Parkinson's Disease, and Multiple Sclerosis</p>	182.7	Reduction in elective and unplanned admissions.	<ul style="list-style-type: none"> - Completion of 4 condition integrated pathways- July 2014. - GP training of Neurology awareness – Aug 2014. - 3 month review / evaluation of the service – Dec 2014. 			TBC	S'OC	AB / JH	AH (Neurology Consultant YTHFT)

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Referral Support Service	<p>Introducing a Referral Support Service to supports patient referrals from primary care into secondary care in a more timely and efficient manner.</p> <p>GP reviewers are also introduced to triage referrals prior to being booked into secondary care.</p>	249.0	<ul style="list-style-type: none"> - Increased access for patients to the Choose and Book service – Patient Experience. - Improved efficiency and speed of the referral process. - Highest quality of safe care. - Eliminating any waste of resource. - Greater job satisfaction. - Reduction in referrals into secondary care. 	Service evaluation completed – Nov 2014.			TBC	S'OC	AB	
Further extension of Referral Support Service (RSS)	An expansion of the current RSS project looking at several new areas including: Gastroenterology, Cardiology and Neurology.	TBC	<p>Increased access for patients to the Choose and Book service.</p> <p>Improved efficiency and speed of the referral process.</p>	Reviewers for Gastro, Cardiology, and Neurology recruited – Sept 2014.			TBC; will be investment required to recruit to new posts.	S'OC	AB	
Diabetes	Provide a community based diabetes service based on an integrated care	152.7	Supports the delivery of an improved first to follow up outpatient ratio.	- Finance/ Contracting agreement with YTH – June 2014.			0.0	S'OC	AB / JH	VJ (Consultant), JM (Directorate)

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	approach and closely link to development of NCTs.		Patient care is provided in a more convenient, community based setting for the patient.	<ul style="list-style-type: none"> - Launch CDT plus GP enhanced service launch event – Sept 2014. - GP sign up for enhanced services – Oct 2014. - Service Implementation – Dec 2014. - Formal service review – Mar 2015. 						Manager)
Musculoskeletal (MSK) Tender	<p>On-going re-procurement of the MSK service.</p> <p>The future service should provide a fully integrated MSK service, delivered through a hub and spoke model, with strong links to current and future orthopaedic pathways.</p> <p>Maximum use should be made of the interface with the Referral Support Service (RSS) to make sure patients</p>	0.0	<p>Patient experience.</p> <p>Efficiencies due to patients accessing the correct pathway first time.</p>	<ul style="list-style-type: none"> - Publish advert and PQQ – Jan 2015. - PQQ evaluation, Finalise specification and ITT documentation – Feb 2015. - Tender evaluation – Mar 2015. - Tender awarded – Q1 2015/16. - Mobilisation and service start – Q2 2015/16. 	Support from the RSS.	Lack of market engagement in the provision of the procured service.	0.0	S'OC	AB	YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	access the new service on the most appropriate pathway from the start.									
Elective Orthopaedic Tender	Procurement of the elective orthopaedic service currently provided at Clifton Park Hospital.	0.0	To be delivered from a community based setting to maintain accessibility for patients and carers.	<p>Publish advert and PQQ – Jul 2014.</p> <p>PQQ evaluation, Finalise specification and ITT documentation – Sept 2014.</p> <p>Tender evaluation – Oct 2014.</p> <p>Tender awarded – Dec 2014.</p> <p>Mobilisation and service start – Mar 2015.</p>		Lack of market engagement in the provision of the procured service.	0.0	S'OC	AB	Clifton Park Hospital
Ophthalmology Service Review								S'OC	AB	
Cardiovascular Disease (CVD) Hyper tension (prevention focus)	The Commissioning for Value pack identified CVD as an area with high potential to improve outcomes, quality and efficiency. The prevalence is significantly higher for stroke,	TBC: Potential for up to 157.0	<p>Reduction in LoS for CVD admissions.</p> <p>Early identification of atrial fibrillation.</p> <p>Improved commissioning and quality of hypertension</p>	<p>Currently in scoping stage.</p> <p>Milestones to be agreed.</p>			TBC	S'OC	SR	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	<p>hypertension, AF and CHD.</p> <p>The focus will primarily be on Hypertension.</p> <p>Provide more care and treatment in primary care and the community.</p>		services.							
Prescribing – Repeat Medications		TBC					TBC	S'OC	BC	
SCOPING										
Spinal Cord Injuries (SCI)	<p>Develop a proactive and preventative approach to enable people with SCI to live healthy, active lives.</p> <p>Develop an integrated care pathway that will integrate health and social services, specialised and CCG commissioning services.</p>	<p>TBC: Possible saving of up to 109.0 (based on £0.32 saving per head of population)</p>	<p>Reduce hospital admissions and length of stay when patients with SCI are admitted.</p> <p>Improvement in care will reduce avoidable harm.</p>	<p>Data analysis: identifying health and social care spend and activity – July 2014.</p> <p>Review of existing services completed & recommendations for implementation – Jan 2015.</p>			9.0	S'OC	AB	TBA

Strategic Initiative 6: Transforming Mental Health and Learning Disability Services

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Improving Access to Psychological Therapies (IAPT)	<p>Enable the CCG to strive towards achievement of the NHS England mandated target where a minimum of 15% per annum of those in need will be able to access psychological therapy services.</p> <p>Potential to involve voluntary sector in accessing additional capacity to achieve 15%.</p>	TBC	<p>Fewer people will be in contact with secondary mental health services.</p> <p>NHS England targets will be achieved.</p>	<p>Request to seek additional provision from the voluntary sector to enable us to achieve the national 15% target.</p> <p>Agreed to achieve local target of 8% with LYPFT - March 2015.</p>	Additional funding £290k to LYPFT	Approval of funding request £291-£500k subject to agreement of process and capacity modelling.	<p>Up to 500.0 to seek additional provision to achieve national target of 15%.</p> <p>290.0 to achieve the 8% with LYPFT.</p>	LB	Partnership Commissioning Unit (PCU)	LYPFT
Psychiatric Liaison	Provision of an integrated liaison service to meet service gap around working-age adult urgent mental health care.	TBC	Service gap filled to provide urgent / crisis care for adults not currently supported by the existing MHALT.	Trust to work alongside mental health partners to ensure service is well integrated and benefits realised – Sept 2014.	Link to Urgent Care agenda and Integration initiatives.		TBC	LB	BC (PCU)	WQ, SR (YTHFT)
Dementia Diagnosis Rates Improvement	<p>Pilot review of dementia coding in Primary Care to work towards the national target.</p> <p>Increase knowledge and</p>	0.0	Achieve national target of 2/3 of people with dementia identified and given appropriate support.	Run a GP education session to other practices – March 2014.			0.0	LB	PH (PCU)	LYPFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	skills of practice staff, increase efficiency of screening, coding and links to memory clinics and care navigator.									
Mental Health & Learning Disabilities Service Review and Procurement	On-going review and re-procurement of the Mental Health and Learning Disabilities service.	All opportunities for efficiency/ productivity gains to be explored	More effective, efficient service, to improve patient service.	<ul style="list-style-type: none"> - Start of procurement process Oct/ Nov 2014. - Tender evaluation Jan 2015. - Tender awarded and state of mobilisation Q1 2015. - Service start date Q3 2015. 	CCG Priority for Transformation- Care Hub Approach.	Lack of interest in contract from providers, and thus not a competitive tender.	0.0	LB	PH (PCU)	LYPFT
SCOPING										
Review of Dementia Prescribing								LB	PCU	
Review of High Cost Mental Health Prescribing								LB	PCU	
Autism Pathway Review								LB	PCU	
PCU Management Cost Reduction								LB	PCU	
Mental health Out of County Placements								LB	PCU	

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Joint assessments of young people with Continuing Healthcare / SEN								LB	PCU	

Strategic Initiative 7: Children's and Maternity

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Personal Health Budgets (PHB)	Offer of personal budgets to continuing healthcare (CHC) patients. Patients with Long Term Conditions (LTC) offered a personal budget by CCG.	0.0	Better use of existing funding in line with patient choice and control.	Offer from - April 2014. Patient right by – Oct 2014. CCG need to offer LTC patients a personal budget - April 2015.		Unclear processes.	0.0	EB	PCU	NYCC CYC YTHFT
Paediatric Urgent Care - Zero Length of Stay	Reduce unnecessary unplanned admissions with a zero length of stay for paediatrics under the age of five.	TBC	<ul style="list-style-type: none"> - Fewer attendances at A&E. - Fewer admissions once attended A&E. - Increased reassurance for parents about the correct pathway. 	Review, scoping and project plan – June 2015 Individual projects identified – Sept 2015 Testing and audit. Strategic overview.			0.0	AP	BC	TBA
Autism Pathway Review and Assessment	Increase children's autism diagnostic assessment capacity and reduce waiting times.	TBC	Quality clinical assessments which meet NICE guidance recommendations. NICE KPI 13 weeks from referral to first appointment achieved.	All new referrals will be seen within 13 weeks and meet national KPI – Sept 2014.	Increase funding into autism diagnostic assessment service from April 2014.	Recruitment of staff with appropriate level of skills and experience.	TBC	EB	PCU	LYPFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
SCOPING										
Emergency Health Care Plans (EHCP) (Children and Families Act 2014)	Health professionals must participate in the development of person centred EHCPs, according to the Children & Families Act Code of Practice statutory guidance for all health organisations.	TBC	Process of EHCP within 20 week timescale. Agreed outcomes across Education, Health and Social care. Person centred planning. Single process for families.	Outcome focused framework formed and agreed across all partners; including parent/children/Y P – From Sept 2014.	Pathfinder and regional champion for NYCC and CYC. Project Steering Groups which report to Children's Trust Board.	Health professionals adapting to change of process. Health profession have a reduced timescale from 26 to 20 weeks for EHCP process.	TBC	EB	PCU	NYCC CYC YTHFT
CAMHS Clear Pathway: Tiers 1 to 4 CAMHS	Review of Child and Adolescent Mental Health Service (CAMHS) Strategy and provision to ensure we have a comprehensive service in place.	TBC	Increasing preventative offer across schools CYC. Address patients' level of need more accurately, and deliver treatment in a more timely way.	Action plan to be implemented following sign off by CAMHS executive – TBC.			TBC	EB	PCU	NYCC CYC LYPFT
Children's Asthma	Review of Asthma prevalence in under five years (health inequality).	TBC					TBC	AP	BC	PCU
Looked After Children's Services	Enhanced health review/ assessments and health promotion service.	TBC					0.0	TBC	JH (PCU)	CYC NYCC ERYC

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Revised Maternity Commissioning Strategy	Includes development of a maternity dashboard.	TBC			Yorkshire and Humber Children's and Maternity Work Programme		0.0	TBC	JH (PCU)	S&R CCG ERY CCG HARD CCG
Continuing Healthcare Price Re-negotiation for care packages (Pilot)		TBC					TBC	EB	PCU	
Emergency Admissions for Children with Lower Respiratory Tract Infections	Commissioning for value packs for the CCG identified. Further exploration when children's packs from PHE are released.	TBC			Children's Packs PHE		0.0	TBC	JH (PCU)	CYC NYCC ERYC PHE

Strategic Initiative 8: Cancer, Palliative & End of Life Care

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
IN DELIVERY										
Palliative Care Review	<p>Joint review of Palliative Care services provided across Acute, Community and voluntary sectors to ensure the provision of current care packages are the most appropriate for the local population.</p> <p>Potential future procurement.</p>	TBC	<p>High quality care in the most appropriate setting for patients.</p> <p>Increased understanding of services available.</p>	<p>Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.</p>	<p>Price and contract review and exercise to be completed by CCG contracting team.</p>		TBC	JM	PH	TBA
Cancer and End of Life Pathway Review	<p>Review and redesign of cancer pathway.</p> <p>Potential future procurement.</p>				<p>Survivorship work and network plans.</p>					
SCOPING										
Survivorship Work	<p>Re-launch of national Survivorship Work including further risk stratification pathways and build upon research completed on breast / head and neck / colorectal / prostate cancer.</p>	<p>TBC (small potential for cost savings)</p> <p>Mostly quality improvements.</p>		<p>Currently at scoping stage.</p>			<p>TBC; but will require a level of investment.</p>	JM	CCG / CSU	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Recovery Package	Introduction of a recovery package and enhanced patient education.	TBC: Up to 50% reduction in follow up costs.	10% reduction in unplanned admissions to offset increases in new activity.	Currently at scoping stage.			TBC; but will require a level of investment.	JM	CCG / CSU	TBA
Service Redesign	Service redesign to be carried out in areas of high activity (e.g. Urology Service Redesign).	TBC		Currently at scoping stage.			TBC	JM	CCG / CSU	TBA
Cancer Diagnostics Review	A diagnostics review to be carried out with West Yorkshire.	TBC		Currently at scoping stage.			TBC	JM	CCG / CSU	TBA

Transactional Initiatives

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
Diagnostics Direct Access - Radiology	Price benchmarking work being undertaken to benchmark our local provider against other organisations.	375.0					0.0		LS	YTHFT
Direct Access Diagnostics – Pathology	<p>YTHFT to support and work collaboratively with the CCG to review and manage diagnostics direct access demand to ensure service remains sustainable</p> <p>Undertake GP practice diagnostics demand benchmarking triangulated with outpatients demand to identify best practice and outliers (will require data to be provided by the Trust)</p>		<p>Improve knowledge of Primary Care clinicians to maximise value from the service.</p> <p>Provision of a sustainable and affordable service.</p>	<p>Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.</p> <p>Further milestones to be agreed.</p>				TBA	SM	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	<p>Provide training to primary care clinicians to eliminate waste and ensure appropriate diagnostics are carried out</p> <p>Conduct a joint demand efficiency review to eliminate waste and duplication of tests [this is in addition to the Pathology price based QIPP separately discussed relating to price benchmarking]</p>									
Improving Length of Stay	<p>Undertake an efficiency review to identify and implement innovations to reduce length of stay for admitted patients.</p> <p>This is linked to the Discharge planning scheme recently undertaken.</p>	375.0	<ul style="list-style-type: none"> - Patients benefit by spending less time in hospital with less risk of cross infection. - Trust benefits through greater efficiency. - CCG benefits through 	<p>Establish a working group with Trust and CCG representatives to agree implementation plan and milestones - June 2014.</p> <p>Further milestones to be agreed</p>			0.0		LS	YTHFT

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
			reduced excess bed day expenditure.							
Critical Care Review	YTHFT and CCG to work collaboratively to review all aspects of the Critical Care Service and pathways to ensure the best quality and value for money services are provided to patients i.e. reviewing skills mix, bed numbers, researching best practice, review costings	TBC	Identification and implementation of best practice to benefit patient care.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.			TBC		LS	YTHFT
Application of Contract Principles	Rigorous application of all principles.	TBC	Optimisation of all contractual levers.	July 2014-March 2015					LS	YTHFT LYPFT
High Cost Drugs / PbR excluded drugs	High cost drugs information must be collected and provided at patient level including an indication of the condition drugs are prescribed for in order to enable commissioners to	TBC	Failure to provide patient and indication data will result in non-payment of high cost drugs given a reasonable period of time	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014.		Provider not implementing appropriate recording systems in a timely manner. This will result in non-payment of	0.0		LS	TBA

Improvement Initiative	Summary Description	Savings Impact (£000)	Quality / Outcome Impact	Milestones	Enablers	Barriers	Investment Required (£000)	Clinical Lead:	Improvement Manager:	Provider Lead:
	validate payment.		to implement appropriate recording systems (timescale to be agreed)			high cost drugs.				
Full Data Quality Review	Part of Data Quality Improvement Plan	TBC							LS	YTHFT
Outpatient Service Review	To undertake a joint process of clinically driven consultation to review and reshape the outpatient service. Consultants and GP's will be supported to engage and work collaboratively towards developing innovative solutions to managing demand and transforming current services		Improved quality and convenient provision of health services to patients Demand management and service sustainability.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014				TBA	TBA	TBA
Local Price Review	To undertake a joint process of consultation to review pricing and methodology applied		Transparenc y of costings. Enabling consideration of potential efficiencies and benchmarkin g exercises.	Establish a working group with Trust and CCG representatives to agree implementation plan and milestones – June 2014				TBA	TBA	TBA

Annex 3

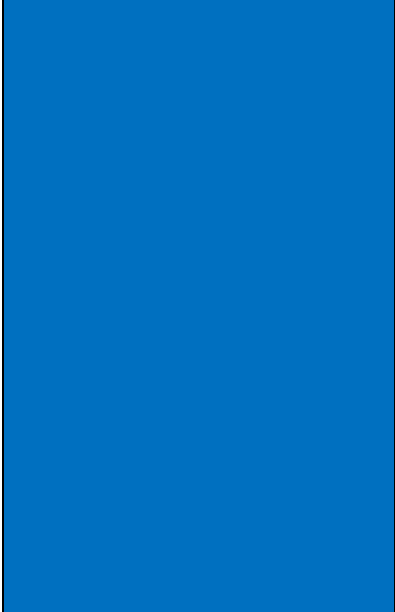
Summary of Patient Engagement Themes: 'You Said, We Did'

Strategic Initiative	You Said	Your Suggestions	We Did / Plan To
Palliative and End of Life Care	Discharge planning needs to be more co-ordinated – should include carer support and education.	<p>Healthcare professionals should be able to signpost to appropriate voluntary services.</p> <p>Carers included in the care plan for their friends/relatives.</p> <p>24 hour support telephone line for support and signpost patients to services.</p>	<p>Working together to develop a “patient passport” to support hospital discharge planning with care homes/end of life forum.</p> <p>The CCG supports Carer Awareness Sessions with GP practices to help them identify carers and their needs and this will be continued.</p> <p>Telephone support services are not currently available 24/7 however information is available online through various websites.</p>
Emergency Care Practitioner Expansion	<p>Care is still considered to be disjointed and disparate and ultimately it feels that there are some gaps in the system.</p> <p>The concept of a total care/one stop shop (or at the very least a seamless transition of care) fits in with the lifestyles/ expectations of patients with accessibility being a key driver of its success.</p>	<p>Care should be provided ‘closer to home’ wherever possible to prevent unnecessary attendances, ED waits and admissions.</p> <p>Yorkshire Ambulance Service currently employs a number of skilled practitioners who could be put to better use.</p>	<p>Pro-active case management and admission avoidance are going to be part of the 2014-15 GP contracts set out by NHS England.</p> <p>Ensuring everyone over the age of 75 and also people with complex conditions will have a named GP responsible for co-ordinating their care implies this process will involve care planning across services.</p> <p>ECP’s will support the principle of joined up care as well as maintaining people in their homes where possible. They have access to referral pathways for other services.</p> <p>The establishment of a universal training package for ECP’s across the UK will mean that there will be consistent skills and a clear career path for paramedics to progress.</p>
Psychiatric Liaison Provision	<p>Mental Health should be a key area of strategy and focus for the CCG.</p> <p>Access to services needs to be improved.</p> <p>Current age limitations restrict patients from receiving the appropriate treatment needed.</p>	<p>Should introduce seven day services not 9-5 services, as current.</p> <p>Remove age limitation on services.</p>	<p>We are working with the Partnership Commissioning Unit (PCU) to develop our Mental Health strategy. The feedback received to date will continue to influence the development of future services. We plan to hold further engagement events specifically for Mental Health services as part of this process.</p> <p>Work is on-going around Psychiatric liaison with the Acute Trust to ensure that people with mental health problems are managed by people with appropriate skills in the best</p>

			<p>environment for them.</p> <p>As part of the community services engagement we are asking the public their views on extending services and the best options for doing this, this will inform future service delivery.</p> <p>In line with the local joint strategic needs assessments, we will be reviewing the demands of different age groups on services to determine how we might tailor services appropriately to age groups.</p>
<p>Diabetes</p>	<p>There is lack of a holistic approach.</p> <p>No mention of prevention and education to try and prevent patients getting on the diabetes ladder.</p> <p>There is no clear way of getting hold of general information or to ask questions.</p>	<p>Level 2 should have equivalent access to services as those under hospital care.</p>	<p>Developed the redesigned model within a strong partnership of commissioner, provider, service user, voluntary sector/charity.</p> <p>Equality of access to appropriate services a central tenet of the service redesign.</p> <p>Prevention is within the auspices of the primary care element of the new model, supported by the new Community Diabetes Team and the development of a service user specific education programme.</p> <p>Development of 'Your Diabetes' website provides information for the public and professionals. Intrinsic will be a forum platform that allows questions to be raised and answered.</p>
<p>Neurology</p>	<p>From the 2013 Quality Audit: 130 service users and professionals' opinions were obtained regarding current service provision. Issues and suggestions raised included:</p>	<p>Clear navigation required for advice and information about services and care.</p> <p>Clear care pathways, roles, and responsibilities, and referral routes are needed for professionals to work efficiently and improve patient pathways.</p> <p>Specialist and community rehabilitation needed that promotes self-management, independence,</p>	<p>Commissioned Neurological Commissioning Support (NCS) to facilitate a partnership approach (involving CCG, providers, service users and cares) to developing Integrated Care Pathways for:</p> <ul style="list-style-type: none"> - Epilepsy - Parkinson's Disease - Multiple Sclerosis - Motor Neurone Disease

	<p>The CCG was made aware that a local uncommissioned MND charity provider was about to fold, leaving a case load of patients at risk of losing on-going care.</p> <p>The Big Conversation (April 2014) included eighty service users, carers' health and social care professionals and representatives from the voluntary sector debating and discussing what the four condition pathways should look like in the future specifics included:</p>	<p>and personal support at the earliest stage possible.</p> <p>Services for the future to be delivered in a different way that is proactive not reactive and does not replicate what has gone before.</p> <p>Closer to home, encourage more self- management, innovation and embrace IT solutions.</p>	<p>CCG agreed to commission local community provider to continue care of existing caseload, maintaining continuity by transferring nursing staff from MND charity.</p> <p>Specific identified priorities included:</p> <p>Within 3 months: Communication – creating a list of key contacts of professionals. Working with the ambulance service, meet with 111 and paramedics to get emergency care plans flagged on patient address. Reinstate newly diagnosed course for Parkinson's and MS (MSS locally would support cost).</p> <p>6 months: Flag neurology patients when they are admitted to hospital. Develop mandatory neurology training for GP's. Provide more information for carers and a carer pathway. Pilot the Epilepsy Action self-management course. Set up neurology training for Practice nurses.</p> <p>12 months: Key worker assigned as first point of contact for patients. NICE guidelines should be leveraged to include reviews by Neurologist/ Care of the elderly physician and nurse specialists. Specialist nurses trained to undertake blood monitoring and attend nurse prescribing course.</p>
Elective Care Procurement	<p>Elective Orthopaedics procurement - patients have recorded very high satisfaction rates in on-going surveys, 99% reporting "excellent" or "very good".</p>		<p>Aim to maintain this level of service for newly procured service.</p>
Referral Support Service	<p>Only want to go to hospital if it's absolutely necessary.</p>		<p>Patients are treated in the best possible ways by their GPs before referral (and this can prevent the need to go to outpatients).</p> <p>Patients get all the right tests done before they see a</p>

	<p>Don't want to make unnecessary trips to the hospital.</p> <p>Getting an outpatient appointment is not a smooth process.</p>	<p>Improve the appointment process for outpatient appointments.</p>	<p>specialist.</p> <p>Booking appointments are done at a time and place convenient for the patient (Patients are contacted by telephone within two days of the RSS receiving their referral to book a hospital appointment).</p>
<p>Cellulitis, Bronchiectasis and Community IV</p>	<p>From what we are to believe care in the community was the way health care was going with benefits to patients to be seen at home and not in hospital which was supposed to be beneficial for their recovery?</p> <p>If primary and secondary care are expected to reduce hospital admissions and enable early hospital discharge, surely more resources are needed in the community to make process sustainable.</p> <p>Is a lack of co-ordination of care.</p> <p>Access to services needs to be improved.</p>	<p>Should have a single point of contact for co-ordination of care.</p> <p>Introduce seven day services, not just a 9-5 service like at current.</p>	<p>We are working to expand the range of services in the community to benefit patients and increase their independence and benefit their recovery.</p> <p>Same as above.</p> <p>The CCG are working with York Teaching Hospital and the Yorkshire Ambulance 111 service to set up a Single Point of Access (SPA) for GP's so that communication between community services and GP's is improved; this will run for 6 months and then we envisage this will be expanded to include the hospital and possible social care to join up all the different pieces of work that currently go on to support these patients.</p> <p>As part of the community services engagement we are asking the public their views on extending services and the best options for doing this, this will inform future service delivery.</p>
<p>GP Out of Hours Service</p>	<p>Out of hours service particularly from students' point of view is not a priority until it's required.</p>		<p>A single telephone number for out of hours services where you would be put through to the appropriate service.</p>

	<p>Students also need easy access to sexual health services and dental services.</p> <p>There is confusion about what's available in terms of out of hours services, and about how to make contact with the appropriate service. One person described waiting up to three hours for a GP to ring back only to be told to go to hospital.</p> <p>How best to get the message across? Students don't want leaflets - social media is a better option.</p>		<p>More/clearer information about what services are available out of hours.</p> <p>'Get in early with comms and engagement – when I have required out of hours service in the past I've gone straight to A&E when other existing services could have helped but I wasn't aware of them.'</p> <p>Information needs to be delivered clearly to students, particularly about changes to or new services – could be via Student Union. The SU offered to hyperlink from their welfare web page.</p>

Annex 4 Summary of Patient Engagement Approaches

Patient surveys	The CCG has provided the opportunity for all stakeholders to take part in surveys about the re-design of services and to understand their opinions on a range of topics
Patient representation in project delivery	Through the design and delivery of projects, the CCG encourages a member of the local community to act as patient representative and give views that are representative of the wider population. Recent work includes the delivery of the Referral Support Service which is due to be launched mid-September.
Patient and public forums	As for surveys, the CCG has provided the opportunity for all stakeholders to take part in events and forums that discuss services and to understand their opinions on a range of topics
Engagement events	<p>These are an important element in our two-way conversations with stakeholders to understand their views about services and their experiences of them. The CCG is using a range of approaches to optimise engagement with our communities and is working hard to develop new ways to listen to members of the community not usually represented or heard through traditional methods. Approaches include forums, meetings, world cafes, open space events and training with members of the community to support them hosting conversations with different stakeholder groups and individuals.</p> <p>Topics discussed at recent stakeholder engagements include:</p> <ul style="list-style-type: none"> ▪ GP Out of hours service ▪ Dermatology services ▪ Diabetes service re-design ▪ Mental health and learning disability Discover! programme ▪
Patient and public newsletter	Providing updates on the CCG's progress and to announce future plans, the newsletter is distributed to current members of the CCG and to stakeholder organisations.
Communicating with stakeholders	Staying in touch and providing information to our partners, staff, provider organisation, local community organisations, practices etc
Engaging through social media	Providing opportunities give views and engage with the CCG, Twitter and re-tweets by partners helps to raise awareness of ways to get involved
Engaging through the CCG's website	As for social media – our website provides the full detail behind our work and ways to get involved. (The website is under review and will undergo improvement in Q3.)

Annex 5 - Glossary of terms

NHS Vale of York Clinical Commissioning Group (CCG)

NHS Vale of York CCG is an NHS organisation that commissions (plans and buys) healthcare services for the residents of the Vale of York. CCGs were established under the government's Health and Social Care Act 2012 and replaced Primary Care Trusts (PCTs). NHS Vale of York CCG is made up of all the GP practices in the local area and is led by a Governing Body.

Accident and Emergency (A&E) or Emergency Departments (ED)

A&E or ED departments assess and treat patients with serious injuries or illnesses.

Acute Liaison Psychiatric Service (ALPS)

ALPS is a critical service integral to all acute hospitals. Services comprise multidisciplinary teams skilled to integrate mental and physical healthcare in people whose mental health problems arise in, or have an impact on management of, physical illness and symptoms.

Acute services

Medical and surgical treatment provided mainly in hospitals.

Better Care Fund

In June 2013, as part of the Government's Spending Round, a £3.8 billion pooled fund was announced to promote joint working between the health service, and social care in 2015/16. The Better Care Fund includes existing NHS and social care funding, which will be jointly invested as the biggest ever financial incentive for health and social care to work together and improve outcomes for people.

Care Hub

A Care Hub is a team of health and social care practitioners working together from different organisations and disciplines. The Care Hub team could include a nurse, social care worker, GP, occupational therapist, pharmacist, and a Counsellor from a local provider. Care Hubs will be based in a community setting, such as a local GP surgery.

Care pathway/patient pathway

A care pathway (also sometimes called a patient pathway) is a diagram, drawn by healthcare professionals, of a patient's journey through care for a particular health condition. The pathway is developed so that, at each stage, the patient is getting the appropriate care. If that care does not work, the patient will continue on the care pathway to the next stage. Care pathways are designed to get the patient to the appropriate care smoothly.

Children and Adolescent Mental Health Services (CAMHS)

CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

Children's Trust

Children's Trusts bring together all organisations responsible for delivering children's services in order to improve the lives of children and young people in the local area. They aim to deliver better services and strengthen responsibility and accountability amongst a range of partners through the development of an agreed local strategy.

Choose and Book

Choose and Book is a service that lets you choose your hospital or clinic and book your first appointment. When you and your GP agree that you need an appointment, you can choose which hospital or clinic you go to. You will also be able to choose the date and time of your appointment.

Commissioning

Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a cycle of work from understanding the needs of a population and identifying gaps or weaknesses in current provision, to procuring services to meet those needs.

Commissioning intentions

Commissioning intentions are developed every year. They describe the changes and improvements to healthcare that the CCG wants to make for the year ahead and what we expect to commission (or 'buy') to achieve these changes. The CCG's commissioning intentions are shared widely with providers and stakeholders and are then developed into a commissioning strategy plan for the year ahead.

Commissioning Support Unit (CSU)

A Commissioning Support Unit (CSU) is an organisation that provides services to CCGs. CCGs can decide on the services they wish to obtain through CSUs e.g. commissioning, IT services, medicines management, information analysis. The CSU providing services to the CCG is North Yorkshire and Humber Commissioning Support Unit.

Community health services

Community health services are NHS services provided outside a hospital. Community health staff include district nurses, health visitors, community midwives, district dietitians, chiropodists and community psychiatric nurses.

CQUIN

CQUIN stands for Commissioning for Quality and Innovation. CQUIN is a payment framework which allows commissioners like the CCG to link a proportion of providers' income to the achievement of locally agreed quality improvement goals.

Delayed transfers of care

A Delayed Transfer of Care is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons. Timely transfer and discharge arrangements are important in ensuring that the NHS effectively manages emergency pressures. The arrangements for transfer to a more appropriate care setting (either within the NHS or in discharge from NHS care) will vary according to the needs of each patient but can be complex and sometimes lead to delays.

Elective care

Elective care is pre-arranged, non-emergency care, including scheduled operations. It is provided by medical specialists in a hospital or another care setting. You will usually be referred by your GP.

Emergency placements

An Emergency Placement is the placement of a Looked After child in foster care or residential care (including Secure Accommodation) made without the usual planning and/or thorough assessment process having taken place because of the need to ensure the safety and the welfare of the child immediately.

Health and Wellbeing Board (HWB)

The Health and Social Care Act 2012 established Health and Wellbeing Boards as forums where leaders from the NHS and local government can work together to improve the health and wellbeing of their local population and reduce health inequalities.

There are three Health and Wellbeing Boards in the Vale of York area. These are based in York, East Riding of Yorkshire and North Yorkshire and are made up of elected members of the local council, Directors of Public Health, Adult Services, Social Care Services, Children's and Young People Services, members of the CCG and a representative of Healthwatch.

Board members work together to understand the health and social care needs for the respective areas, they agree priorities and help to ensure that council and CCG plans and buy services in a more joined up way.

Health and Wellbeing Boards are responsible for carrying out the Joint Strategic Needs Assessment (JSNA) and developing a joint strategy (the Health and Wellbeing Strategy) for how these needs can be best addressed.

Health and Wellbeing Strategy

Health and Wellbeing Strategies for York, East Riding of Yorkshire and North Yorkshire have been developed by the respective Health and Wellbeing Board (HWB). The strategy is an overarching plan to improve the health and wellbeing of children and adults and reduce health inequalities.

Health inequalities

Health inequalities can be defined as unfair differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different social classes. In The Vale of York there are health inequalities between people who live in different parts of the area and improving health where there is an inequality is a priority issue for the local Health and Wellbeing Boards.

Healthwatch

Established by the Health and Social Care Act 2012, Healthwatch is an independent consumer champion for people who use health and social care services. It works to ensure that views of the local community are heard and used to improve the experience and outcomes of health and social care services.

The Vale of York CCG works with three Healthwatch organisations. These are Healthwatch York, Healthwatch North Yorkshire and Healthwatch East Riding of Yorkshire.

Hospice at home

Hospice at home is an integral component of community end of life care bringing the skills, ethos and practical care associated with the Hospice movement into the home environment; putting the patient and those who matter to them at the centre of the care. Hospice at home services aim to enable patients with advanced illness to be cared for at home and to die at home, if that is their preference.

IAPT

The Improving Access to Psychological Therapies (IAPT) is an NHS programme of talking therapy treatments recommended by the National Institute for Health and Clinical Excellence (NICE) which support frontline mental health services in treating depression and anxiety disorders.

Integration of care

Promoting joint working between the health service, and social care and support to improve experiences and outcomes for people.

Joint Strategic Needs Assessment (JSNA)

A JSNA describes the future health, care and wellbeing needs of local populations and the strategic direction of service delivery to meet those needs. JSNAs are developed jointly between the Council and the CCG – providing a framework for health and social care to work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs. The JSNA is a key part of the commissioning cycle and informs the CCG's commissioning intentions. There is a JSNA for each local authority area.

KPIs

Key Performance Indicators. These are set out in contracts with our providers and help us to monitor their performance. Examples of KPIs include length of stay in hospital for a particular treatment or how satisfied patients are with the care they receive.

Long term condition

A long term condition is something that is controlled by medication and/or other therapies, including self-care and changes to lifestyle. This definition covers lots of different conditions such as diabetes, asthma, multiple sclerosis and pain.

NICE guidance

NICE stands for National Institute for Health and Care Excellence. NICE sets standards for quality healthcare and produces guidance on medicines, treatments and procedures.

NHS Constitution

The Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve.

NHS England

NHS England is an executive non-departmental public body of the Department of Health. NHS England oversees the budget, planning, delivery and day-to-day operation of the NHS in England as set out in the Health and Social Care Act 2012

Non-elective care

Non elective care is admitted patient care activity which takes place in a hospital setting where the admission was as an emergency/non-elective.

Out of hours

This term usually relates to access to Primary Care, for example a GP, in the evening, during the night or on a weekend.

Parity of esteem

Valuing mental health equally with physical health. Having access to Services which enable both mental and physical wellbeing to be maintained and ensuring that services assess and treat mental health disorders or conditions on a par with physical health illnesses.

Patient Participation Group (PPG)

A PPG is a group of patients who are interested in health and healthcare issues, and who want to get involved with and support the running of their local GP practice. Most PPGs include members of practice staff that and meet regularly to discuss services and facilities offered by the practice to its patients.

Person-centred care

Person-centred care is about ensuring the patient/client is at the centre of care and support services. This means that individual wishes and needs, life circumstances and health choices will be taken into account when planning care.

Personal health budgets

Personal health budgets are the allocation of NHS funding which patients/service users, after an assessment, are able to personally control and use for the services they choose to support their health needs.

Planned care

Planned care means services where you have a pre-arranged appointment. This includes things like being referred by your GP to see a physiotherapist or consultant or being sent for diagnostic tests such as an X-Ray.

Procurement

The process of specifying and buying goods or services. Procurement involves the evaluation of bids, and negotiation of contracts with health and social care service providers.

Providers/Service Providers

A provider or service provider includes anyone who is commissioned to supply a health or social care service. GPs are primary care providers. Social care providers include social workers and home support workers. Hospitals are classed as Acute care providers or Secondary care providers.

Primary care

Primary care includes services provided by GP practices, dental practices, community pharmacies and high street optometrists (opticians). Most primary care services are commissioned by NHS England. The CCG is not involved in the commissioning of these services.

Quality premium

The Quality Premium is intended to reward clinical commissioning groups for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

QIPP

QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS. QIPP is often used to indicate a contribution towards achieving a financial gap (i.e. a saving or efficiency/ productivity gain)

Referral support service (RSS)

The Referral Support Service (RSS) is a local service managed by NHS North Yorkshire and Humber Commissioning Support Unit on behalf of NHS Vale of York Clinical Commissioning Group. The aim of the RSS is to get patient's to see the right person, at the right time, in the right place.

Secondary care

Secondary care is the service provided by medical specialists, either in a community health centre or a hospital. These services are provided by specialists for example, cardiologists, urologists and dermatologists and patients are referred to these specialists by their GP.

Self care / management

Self care means looking after yourself in a healthy way, whether it's brushing your teeth, taking medicine when you have a cold, or doing some exercise.

If you have a long-term condition, there are extra things you may need to consider, such as making changes to your diet, different types of exercise, different types of medication you may need to take, managing pain or fatigue.

Shared / Summary Care Record

Records are kept in all the places that care is received. Usually information you're your records can only be shared by letter, email, fax or phone. At times, this can slow down treatment and sometimes make it hard to access information.

Shared/ Summary Care Records are being introduced to improve the safety and quality of patient care. Because the Summary Care Record is an electronic record, it will give healthcare staff faster, easier shared access to essential information about you, and help to give you safe treatment during an emergency or when your GP surgery is closed.

System Resilience Group (SRG)

These are groups which are currently being established in June 2014 to plan the capacity (amount of care and treatment) required to be delivered for the local population by the local acute hospital throughout the year. These groups will plan capacity in both unplanned (emergency or non-elective) care and planned (elective) care. The SRG will have membership from local CCGs who commission services from the local acute hospital as well as the local acute hospital itself. These groups will report back to both Monitor and NHS England, the monitoring bodies for Foundation Trusts (the acute hospital) and the CCGs.

Abbreviations

CSU – Commissioning Support Unit

CYC – City of York Council

ED – Emergency Department

ERY CCG – East Riding of Yorkshire CCG

ERYC – East Riding of Yorkshire Council

HARD CCG – Harrogate and Rural District CCG

LYPFT – Leeds and York Partnership Foundation Trust

NHSE – NHS England

NYCC – North Yorkshire County Council

PCU – Partnership Commissioning Unit

PHE – Public Health England

S&R CCG – Scarborough and Ryedale CCG

YAS – Yorkshire Ambulance Service Trust

YTHFT – York Teaching Hospitals Foundation Trust

My Life, My Health, My Way: High quality care, in the most appropriate setting, to meet the needs of our population.

Our work will deliver a sustainable and high quality health service available to all to improve health and wellbeing across the Vale of York. Targeting Health inequalities, increasing parity of esteem between physical and mental health and providing local access to care. The CCG will provide system leadership.

You said, we did	Our strategic initiatives	Enabling work	Our improvement interventions	Outcomes																		
<p>Help people to stay healthy</p> <p>Provide people with the opportunity to influence and change healthcare</p> <p>Ensure access to good, safe, high quality services closer to home</p> <p>Support people with long term conditions to improve quality of life</p> <p>Improve health-related quality of life and end of life care</p> <p>Implement local 'Care Hubs' across the Vale of York</p> <p>High quality mental health services for the Vale of York, with increased awareness of mental health conditions</p> <p>Ensure local healthcare services are sustainable</p> <p>Ensure people have access to world-class complex and specialist care</p> <p>Support health research in the local area</p>	<p>Prevention, Self Care and Wellbeing: help people stay healthy through informed lifestyle choices, support people to self-manage long term conditions where possible</p> <hr/> <p>Integrated Care: coordinate health and social care services around the needs of patients to create a fully integrated out of hospital system of care</p> <hr/> <p>Primary Care Reform: improve the continuity of care and delivering services seven days a week through GP practices working together to support larger populations; enabling the Care Hub Model</p> <hr/> <p>Urgent Care Reform: improve and coordinate of all aspects of urgent care provision that ensure that patients are treated at home wherever possible</p> <hr/> <p>Planned Care: enhance the referral support service to ensure the right care is delivered for patients first time. Improve productivity of elective care</p> <hr/> <p>Transformed Mental Health: improve the management of people with mental health needs and improve their physical health through all new models of care across system</p> <hr/> <p>Children's and Maternity: give children the best start in life possible, promote healthy lifestyles and supporting self-management of their conditions</p> <hr/> <p>Cancer and End of Life: prevention, diagnosis and treatment; carers pathway</p>	<p>Co-commissioning of primary care with NHSE</p> <hr/> <p>Primary care improvement hubs</p> <hr/> <p>Workforce planning</p> <hr/> <p>IT connectivity across the system</p> <hr/> <p>Shared care record and individual care plans</p> <hr/> <p>Sophisticated Commissioning and Contracting</p> <hr/> <p>Procurement choice and market readiness</p> <hr/> <p>Estates and infrastructure</p> <hr/> <p>Clinical data review and analysis</p> <hr/> <p>Assistive technology (referral support; community equipment)</p> <hr/> <p>Research and innovation</p> <hr/> <p>Prescribing</p> <hr/> <p>Carers and voluntary sector</p>	<ul style="list-style-type: none"> • Drinking interventions and joint delivery of Alcohol Strategy and Wellbeing Business Plan with local authorities • Weight Management (Selby) • Smoking Cessation <hr/> <ul style="list-style-type: none"> • Piloting of four Care Hub Models • Community services review and procurement • Embedding urgent care, self-care and End of Life pathways in Care Hub Model • Patient transport services <hr/> <ul style="list-style-type: none"> • Referral support service and care plans for frail old people and complex needs • Out of Hours review and procurement • Doctor First; Risk stratification • Extended role of community pharmacy • Dentistry in residential homes <hr/> <ul style="list-style-type: none"> • Street triage and emergency care practitioners • Psychiatric liaison in A&E • Paediatric zero length of stay • Front door geriatrician <hr/> <ul style="list-style-type: none"> • Systematic service review and pathway redesign – ophthalmology, critical care review • New pathways of care in diabetes and neurology; System resilience: planning capacity • MSK and elective orthopaedic procurements <hr/> <ul style="list-style-type: none"> • Mental health service review and procurement • Autism review; dementia service development; IAPT expansion; prescribing • Bootham inpatient redevelopment <hr/> <ul style="list-style-type: none"> • Children and Families Act: Special educational needs • Regional work programme 2014-16 • Asthma, CAMHS and health reviews for looked after young people <hr/> <ul style="list-style-type: none"> • Palliative Care Review • Cancer Pathway Review and Survivorship 	<p>Quality outcomes:</p> <ul style="list-style-type: none"> • Delivering on the NHS Constitution • Enhanced quality and safety of care • Improved patient experience of care outside of hospital (12%) • Increase in number of people having positive experience of hospital care <p>Health outcomes:</p> <ul style="list-style-type: none"> • Reduce the potential years of life lost (15%) • Reduced emergency hospital admissions (by 14%) • Increase in proportion of older people living independently at home following discharge • Improve the health-related quality of life of people with LTCs • Improving physical health of those with mental illness (parity of esteem) • Reducing Falls • Improve dementia diagnosis <p>Impact on activity 2014/15:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #0056b3; color: white;"> <th style="width: 80%;">Elective</th> <th style="width: 10%;">-£</th> <th style="width: 10%;">27,757</th> </tr> </thead> <tbody> <tr> <td>First appointments</td> <td>-£</td> <td>335,863</td> </tr> <tr> <td>Follow-up appointments</td> <td>-£</td> <td>816,443</td> </tr> <tr> <td>A&E</td> <td>-£</td> <td>782,357</td> </tr> <tr> <td>Non-elective</td> <td>-£</td> <td>1,489,179</td> </tr> <tr style="font-weight: bold;"> <td>Total</td> <td>-£</td> <td>3,451,600</td> </tr> </tbody> </table> <p>Impact on finances:</p> <ul style="list-style-type: none"> • Delivering on the NHS Constitution • Financial sustainability of the Vale of York health economy. • Increase productivity of secondary elective care (target 20% by 2018/19) • Ensuring Value for Money for every £ spent. • Contribution of QIPP schemes of £5m to financial gap of £9.4m 	Elective	-£	27,757	First appointments	-£	335,863	Follow-up appointments	-£	816,443	A&E	-£	782,357	Non-elective	-£	1,489,179	Total	-£	3,451,600
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Our values will underpin everything we do: Quality • Governance • Engagement and co-design • Prioritisation • Equality • Sustainability • Empathy; Integrity • Respect • Courage

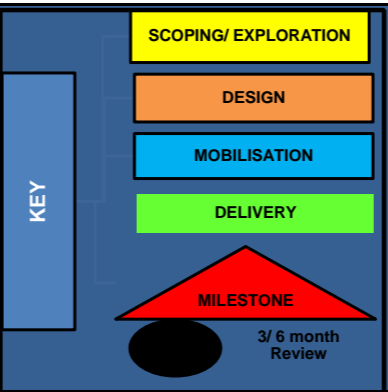
2014/15 - 2015/16
Laying the foundations

2016/17 - 2017/18
Embedding and extending

2018/19
Financially sustainable system

NHS Vale of York CCG Improvement Interventions

2014/15 & 2015/16



QIPP = potential contribution to financial gap;
DELIVERY = anticipated impact on outcomes/ activity

Programme	QIPP Project Leads	Mar-2014	Apr-2014	May-2014	Jun-2014	Jul-2014	Aug-2014	Sep-2014	Oct-2014	Nov-2014	Dec-2014	Jan-2015	Feb-2015	Mar-2015	15/16			
															Q1	Q2	Q3	Q4
Current 14/15 Improvement Interventions being Delivered	QIPP	Other																
Direct Access Diagnostics - Pathology	QIPP		Transactional	LS														
Telehealth	QIPP		Person-Centred Care	RI														
Stoma care	QIPP		Planned Care	BC														
Gluten free products	QIPP		Planned Care	BC														
Sip feeds	QIPP		Planned Care	BC														
Dressings	QIPP		Planned Care	BC														
Quick Six (Medicines Management)	QIPP		Planned Care	BC														
Neurology	QIPP		Planned Care	AB														
Referral Support Service	QIPP		Planned Care	AB														
Improving Length of Stay	QIPP		Transactional	LS														
Diabetes	QIPP		Planned Care	AB														
MSK Tender	QIPP	Procure	Planned Care	AB														
Orthopaedic procurement	QIPP	Procure	Planned Care	AB														
Mental health & LD reprourement	QIPP	Procure	Mental health	PH														
Out of Hours Procurement	QIPP	Procure	Urgent Care	BC														
Care Hub Selby	QIPP	BCF	Integrated Care	PH														
Care Hub PMG	QIPP	BCF	Integrated Care	RI														
Care Hub City and Vale Federation	QIPP	BCF	Integrated Care	PH														
Care Hub Pocklington	QIPP	BCF	Integrated Care	PH														
UCP (York and N Yorks)	QIPP	BCF	Integrated Care	BC														
Street Triage (York & NY)	QIPP	BCF	Urgent Care	JR														
Hospice at Home (York & NY)	QIPP	BCF	Integrated Care	PH														
Psychiatric Liaison	QIPP	Trajectory	Mental Health	BC														
Paed Zero Length of Stay	QIPP		Childrens	BC														
Front Door Geriatrician for ED	QIPP	Trajectory	Urgent Care	BC														
Community Based IV Service	QIPP		Integrated Care	BC														
Minor Illness / Minor Injury training for Paramedics	QIPP		Urgent Care	BC														
WDID practical service improvement with Primary Care	Enabling		Primary Care	SM														
Risk stratification & Care Planning	Enabling		Primary Care	SM														
Direct Access Diagnostics: Reducing primary care variation: via speciality-led training & education	Enabling		Primary Care	SM														
Further extension of Referral Support Service (RSS)	Enabling		Primary Care	SM														
Prescibing: various other medicines management productivity	QIPP		All	SO														
IAPT: extension of capacity to support delivery of target	Investment	Trajectory	Mental Health	PH														
IMPROVEMENT INTERVENTIONS CURRENTLY IN SCOPING PHASE:																		
Conditions register expert consulting	QIPP		Transactional	LS														
Full Service and Spec Review	QIPP		Transactional	LS														

Current 14/15 Improvement Interventions being Delivered	QIPP	Other																		
Recovery Package and enhanced patient education			Cancer / EOL	CCG / CSU																
End of Life Pathway Review	QIPP		Cancer / EOL	PH																
Cancer pathway review and service redesign; Survivorship Work			Cancer / EOL	CCG / CSU																
Cancer Diagnostics Review (link to West Yorkshire review)			Cancer / EOL	CCG / CSU																
Review of Asthma prevalence in under 5 years (health inequality)			Children's & Maternity	PCU																
Autism Assessment: pathway review to increase capacity			Children's & Maternity	PCU																
Weight Management (focus on Selby population)			Person-Centred Care	CCG / CSU																

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Health Overview and Scrutiny Committee**2 July 2014**

Report of the Assistant Director Assessment and Safeguarding

Safeguarding Vulnerable Adults Annual Assurance**Summary**

1. This is the third annual report to Health Overview and Scrutiny. The report outlines the arrangements in place to ensure that City of York Council is able to discharge its responsibilities to keep vulnerable adults within the City protected from violence and abuse, whilst maintaining their independence and well-being. Health Overview and Scrutiny are asked to consider whether the Council can be assured that these arrangements are satisfactory and effective.

Background

2. Safeguarding Adults responsibilities have been defined in 'No Secrets' (Department of Health 2002) and 'Safeguarding Adults' (Department of Health 2005). In 2005 the Association of Directors of Adults Social Services (ADASS) produced guidance and standards for the delivery of Safeguarding responses.
3. These guidance documents will be superseded in April 2015 when the Care Act is implemented, but this annual report covers the activities undertaken during the past year and so the 2005 ADASS standards have been used as the framework for the assurance information provided within Annex A.
4. One of the standards requires partner agencies to assure themselves of the safeguarding arrangements within their organisation on an annual basis. This report is intended to enable that to happen within the Council. Other partner organisations will report through their own governance arrangements.

5. Operational safeguarding practice is guided by the Multi Agency Safeguarding policy and procedures, which together with a Quick Guide, are available for both the public and professionals at: http://www.safeguardingadultsyork.org.uk/index.php?option=com_content&view=article&catid=36&id=48&Itemid=67
6. Annex B provides an update on the specific actions identified in last year's assurance report to Health Overview and Scrutiny. It also contains information from the York Adult Safeguarding Board Strategic Action plan.
7. Annex C provides the Strategic Action plan agreed by the York Adults Safeguarding Board.
8. Annex D provides the Performance Report on Safeguarding Vulnerable Adults activity for 2013-14.
9. From April 2015 the Care Act requires each local authority to:
 - Make enquiries, or ensure others do if it believes an adult is, or is at risk of, abuse or neglect. The enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect and if so by whom,
 - Set up a Safeguarding Adults Board,
 - Arrange where appropriate for an independent advocate to represent and support an adult who is subject to a safeguarding enquiry where the adult has substantial difficulty in being involved in the process and where there is no other appropriate adult to help,
 - Co-operate with each of its relevant partners to protect adults experiencing or at risk of abuse or neglect.
10. These duties apply to anyone over the age of 18 at risk of abuse or neglect because of their needs for care and support. The level of needs is irrelevant and the adult does not need to have eligible needs for care and support, or to be receiving any particular service from the local authority for the safeguarding duties to apply.
11. Six key principles will underpin all safeguarding work:

- Empowerment – “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens”
- Prevention – “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help”
- Proportionality – “I am sure that the professionals will work for my best interest, as I see them and will only get involved as much as needed”
- Protection – “I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able”
- Partnership – “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me”
- Accountability – “I understand the role of everyone involved in my life”

12. Training for all Councillors in respect of Adult Safeguarding will be offered as part of the Councillors’ Training Plan.

Options

13. **Option 1** Health Overview and Scrutiny Committee could confirm they are satisfied with the arrangements for Safeguarding Vulnerable Adults, based on the current performance and proposed new improvement activity, set out in Annex A, which is already underway.

14. **Option 2** Health Overview and Scrutiny Committee could identify areas where they believe further assurance is needed for the Council to be confident that it is undertaking its responsibilities on Safeguarding Vulnerable Adults satisfactorily.

Analysis

15. Annex A uses the same ADASS standards as last year and confirms that York has the key elements in place to ensure that vulnerable adults are safeguarded in York. There will be changes needed in the coming year, to ensure the Board can meet the statutory duties and comply with the final guidance from the Care

Act. The Board has established a Task and Finish Sub group to identify and recommend changes needed, by the December 2014 Board meeting.

16. Good progress has been made on the Action Plan outlined to this committee last year, as set out in Annex B.
17. This has been a year of consolidation for the Adults Safeguarding Board after the previous year's changes in both health organisations and in the Police. Our Independent Chair of the Adult Safeguarding Board has been in post for just over a year now, and has made good progress in ensuring our links are strengthened across the city, including with other Strategic boards, and with our neighbouring authorities. Board meetings are well attended, with active engagement of all partners, and with feedback taken at the end of each meeting about 'What Worked Well' and 'Even Better If'. This feedback is included in the minutes of the meeting and is publicly available.
18. The Annual report, published in January 2014, and available on the Board's website (www.safeguardingadultsyork.org.uk) outlined the key areas of activity of the board. The report covers the whole of the calendar year for 2013 and so some of the activity was reported to this committee in last year's assurance report.
 - Monitoring progress on the development of a Place of Safety (Section 136 Suite) in York
 - Development of new protocol on domestic homicides, between the Community Safety Board, Adult and Children's Safeguarding Boards
 - The review of our multi agency policy and procedures
 - Implementation of the ADASS National Safeguarding Adults Competency Framework
 - Implementation of the recommendations following the Winterbourne View review and concordat
 - Engagement with the University of York Social Policy Research Unit (SPRU) project looking at Safeguarding Adults and Personal Budgets
 - Establishment of a new sexual assault referral centre in York

- Regular reviews of the progress made on the strategic action plan, on the delivery of multi agency training, and of performance information from the Abuse of Vulnerable Adults (AVA) return
19. Operationally the safeguarding activity in the City has increased over the last year, with nearly 50% more referrals received and investigations completed.
20. This has stretched the capacity of the team, and there have been times when both management action and investigations have taken longer than we would wish. Management capacity was increased as planned, by increasing the Assistant Service Manager post to become full time (through the re-use of existing resources)
21. Work is now underway to review processes to be as streamlined as possible and ensure we use the resources we have in the most effective way possible. This is being undertaken with support from regional colleagues through the Sector Led Improvement programme. Whilst this work is done a temporary additional care manager post has been added to the establishment to ensure that investigations can be allocated.
22. Performance issues to be addressed over the coming year will be:
- Understanding and addressing the reasons for the high number of 'No further action under safeguarding' in cases where allegations have been substantiated
 - Reducing the number of 'not known' whether individual have capacity to make choices in respect of the safeguarding processes
23. Other areas for action in the coming year will be:
- Task and Finish Group to identify and make recommendations for the operation of the Adult Safeguarding Board in light of Care Act
 - Agree shared understanding of thresholds for safeguarding investigations with partners
 - Review the Serious Case Review Protocol and develop a Lessons Learned protocol

- Maintain the links with other Strategic Boards and develop further joint work
- Annual review of multi agency procedures and internal procedures
- Continue to work to the LGA Making Safeguarding Personal programme at Bronze level.
- Review the Adult Safeguarding website and information available for the public

Council Plan

24. The proposals within this report relate to the Council Plan priority to ensure those who are most vulnerable are protected.

Implications

Financial

25. There are no financial implications to this report. Safeguarding activity is undertaken within agreed budgets.

Human Resources (HR)

26. There are no HR implications.

Equalities

27. Safeguarding activity is important to all protected communities of interest. The performance report indicates a relatively high number of referrals in respect of people with a learning disability.

Legal

28. There are no legal implications.

Crime and Disorder

29. All of the issues and actions relating to Safeguarding Vulnerable Adults contribute to the Safer Communities agenda. Specifically Safeguarding has strong links with the Domestic Violence agenda and to Hate Crime. The Independent Chair of the Safeguarding Adults Board, and the Council's lead officer for safeguarding have both joined the new Domestic Violence Strategy Board.

Information Technology (IT)

30. There are no IT issues relating to this report.

Property

31. There are no property issues relating to this report.

Risk Management

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

Recommendation

33. No specific recommendation is made, as the purpose of this report is to allow Health Overview and Scrutiny to determine if they are assured of the arrangements for Adult Safeguarding within the Council.

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Paul Edmondson- Jones
Director Health and Well being

Report Approved

Wards Affected: All

19/6/2014

For further information please contact the author of the report

Annexes:

Annex A: Adult Safeguarding Assurance Questions

Annex B: Action Plan Update

Annex C: Adult Safeguarding Board Strategic Action Plan 2014-17

Annex D: CYC Performance report 2013-14

Annex E: Acronyms

Annex A Assurance questions

Requirements	Evidence of arrangements in place	Improvements planned
Clear and identifiable lead for Safeguarding Adults at senior level	<p>Director of Health and Wellbeing is a member of Safeguarding Adults Board.</p> <p>Assistant Director Assessment and Safeguarding holds operational and strategic lead for adults safeguarding agenda</p>	
Multi agency partnership with all statutory agencies represented, with Terms of Reference	<p>Safeguarding Adults Board meets quarterly. Terms of Reference in place. Membership includes Cabinet Member for Health and Community Engagement, Director Health and Wellbeing, Assistant Director Adults Assessment and Safeguarding, health commissioners, NHS and Independent health providers, Police, and Independent Care Group, CVS and Healthwatch York</p>	<p>Task and Finish sub group set up to review membership and TOR in light of Care Act Guidance (received in draft form 6/6/14).</p> <p>Any changes to be agreed at December Board meeting</p>

	<p>Chair addresses any attendance concerns through agencies</p> <p>Since last July there has been just 1 absence by a senior CYC representative at the Board meeting</p>	
Clear links with Local Strategic Partnership	<p>Chair and CYC Lead officer now sit on the new City of York Domestic Violence Board</p> <p>Chair has attended Health and Wellbeing Board to present the Annual report</p>	Maintain the links and develop further joint work
Appropriate support and co-ordination in place for Safeguarding Adults Partnership	<p>Independent Chair, joint funded by CYC, Vale of York Clinical Commissioning Group and Police.</p> <p>Kevin McAleese jointly appointed with effect from April 2013 Administrative support provided by the Assistant Director's support assistant.</p> <p>Assistant Director Assessment and Safeguarding and Group and Service Manager support the Board</p>	Review of support to all partnership Boards, including Safeguarding Adults Board has been jointly commissioned by Directors of Health and Wellbeing and Director of Children's Services Education and Skills.

<p>Multi Agency policy and procedures and strategic plan in place and regularly reviewed</p>	<p>Multi Agency policy and procedures available on York Safeguarding Adults website (www.safeguardingadultsyork.org.uk)</p> <p>Procedures were reviewed by a multi agency task group and revised procedures agreed in December 2013.</p> <p>A three year strategy was agreed in March 2014, based on the Local Government Association (LGA) and ADASS guidance issues in March 2103. This is also available on the York Safeguarding Adults Board website . An action plan sits alongside the strategy</p>	<p>Strategic Plan will be reviewed to ensure it complies with new Care Act guidance</p>
<p>Serious Case protocol in place</p>	<p>This is in place and available on the website (link above). Protocol updated in March 2013 to reflect joint approach to Domestic homicide Reviews, with Community Safety and Children’s Safeguarding Board</p>	<p>Protocol will be reviewed by the Board’s Task and Finish sub Group , in line with Care Act Guidance</p>

<p>Annual review of partners progress by Partnership</p>	<p>Assurance Framework for the Board was developed in 2012, to ensure all partner agencies have appropriate governance and operational arrangements in place.</p> <p>The Board's Annual report was published March 2013 with review of activity, progress, and confirmation of assurance from all partners</p> <p>This report to HOSC and any recommendations from HOSC will constitute the CYC report for 2014</p>	<p>Next year's Annual Report for the Board will include reports from partners on their activity and progress</p>
<p>Consultation arrangements with service users on policy and procedures</p>	<p>Health watch York is now a full member of the Board and will enable greater involvement of residents in the development of policy and procedures.</p> <p>CYC Safeguarding team are involved in 'Making Safeguarding Personal' approach, and have signed up to the LGA programme at Bronze level.</p>	<p>Engagement through Health watch for policy and procedure review and development</p>

	<p>This will move practice toward an outcome based approach, which starts by finding out what the alleged victim wishes to happen.</p>	
<p>Active promotion of Safeguarding within the community and links to crime prevention and MAPPA (Multi Agency Protection Panel Arrangements)</p>	<p>Dedicated website www.safeguardingadultsyork.org.uk with information for residents and professionals – content reviewed early 2013.</p> <p>Quarterly monitoring of site usage by the Safeguarding Board shows over a thousand visitors a month on average, and multiple pages visited.</p> <p>Connect to Support information website signposts people to Safeguarding support and advice</p> <p>Safeguarding Manager is a member of MAPPA Panel</p> <p>Police team now based in West Offices and closer working as a multi agency hub is developing</p>	<p>Website review and Information development planned for this year</p>

<p>Internal safeguarding policy and procedures regularly reviewed and in line with multi agency procedures</p>	<p>Internal procedures reviewed in line with revised multi agency procedures</p>	<p>Annual check of multi agency procedures planned by December and review of internal procedures aligned with this</p>
<p>Clear management arrangements in place to respond to safeguarding concerns</p>	<p>Dedicated Safeguarding team in place since November 2011. Accountable through Service Manager and Group Manager to Assistant Director Assessment and Safeguarding.</p> <p>All alerts are considered by a Manager. All investigations are undertaken by Care Managers from the Safeguarding Team.</p> <p>Investigations are planned and overseen, on a rota basis, by service managers from across adult social care.</p> <p>Capacity remains an issue with high levels of alerts being received by the team. There have been delays in some complex investigations in the last year.</p>	<p>Streamlining of processes and management actions is under way and should be complete in September</p>

	<p>Additional temporary capacity has been added to the team, whilst work to streamline processes is undertaken, with support through the regional sector led improvement programme.</p> <p>We have recently addressed the need for more timely liaison with the police on some alerts, and feedback has been that this has immediately improved</p>	
<p>Policy and procedures to reduce the risk of safeguarding and abuse incidents</p>	<p>Policies and procedures are in place for in house services regarding: Serious incidents, accidents, health and safety, challenging or violent behaviour, personal and intimate care, moving and handling, control and restraint medication, handling customers' money, risk assessment and management.</p> <p>Similar procedures are required of all commissioned services as part of service specifications.</p>	

<p>Criminal Record Bureau (CRB) and Protection of Vulnerable Adults (POVA) checks undertaken on relevant staff and volunteers, professional registration monitored and staff code of conduct setting standards of expected behaviour</p>	<p>HR advice in place for checks for CYC staff on employment and provide reminders for updating checks.</p> <p>Professional registration for social lies with liaison with Health Care Professions Council (HCPC). Professional registration is reviewed through supervision and annual appraisals by line managers.</p> <p>Notifications and HCPC reports are made by the Safeguarding manager where agreed through Safeguarding Conferences.</p>	<p>Social work re-registration will take place September – December 2014</p>
<p>Workforce development and training strategy in place and staff undertaking required safeguarding training</p>	<p>Framework for training is based on the roles of alerter, referrer, investigator, and conference chair. CYC Workforce Development Unit has developed Strategy and programme for all partners. Training report reviewed at each Board meeting.</p>	<p>Review training offered to ensure it supports a more personalised approach and shares lessons learned from Making Safeguarding Personal programme with all partners</p>

	<p>New training provider secured 2012, with improved feedback from course participants.</p> <p>National Safeguarding Competency framework has been mapped against Council and Social Work frameworks, and integrated wherever possible. Training plan for CYC staff to reflect competency framework.</p> <p>Annual appraisals ensure staff are undertaking required training, and feed in to training plans.</p> <p>Multi agency work underway to support partners adopt the Competency Framework within their own workforce strategies</p>	
<p>Support and advice available to customers using Direct payments to employ their own staff</p>	<p>Direct payment customers offered one off payment to undertake necessary checks.</p> <p>Support available from ILS (Independent Living Scheme) on employment good practice.</p>	<p>York is part of a national research project looking at Safeguarding and Personalisation agendas in three local authorities expected to report in 2014.</p>

<p>Safeguarding requirements of contracted providers clear and monitored</p>	<p>Integral part of specification, including policies and procedures to prevent abuse.</p> <p>Commissioners and contract team informed of alerts/referrals involving commissioned providers with joint investigations where quality of care concerns. Repeat concerns addressed through contract monitoring and improvement plan requirements.</p>	
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Safeguarding Assurance Report 2014

Annex B

Safeguarding Assurance Action plan update

This paper summarises the action set out in last year's assurance report to HOSC

Action	Update
Board TOR to be reviewed in light of Care Bill	Task and Finish sub group set up in March 2014. Draft guidance available 6 June 2014 and next meeting for the group is planned for 20 June
Representation on Board from Healthwatch to be explored	Healthwatch now a member of the Board. Whilst their membership is not a requirement under the Care Act, York's Board has proposed that Healthwatch, CVS and Independent Care Group will remain core members of the Board to ensure community and provider engagement and involvement
Maintain the links with other Strategic Boards and develop further joint work	Independent Chair formally presented the Annual Report to Health and Wellbeing Board. Chair and Assistant Director are members of the Domestic Violence Board. Agreement that Assistant Directors for Adults and Children will be 'observers' at the opposite Safeguarding Boards
Updating of multi agency procedures	Completed and agreed at March 2014 Board

Internal procedures will be reviewed again once the Multi Agency procedures been agreed	Completed
Sign up to the LGA Making Safeguarding Personal programme at Bronze level.	<p>Achieved. Project has led to changes in documentation and process to ensure that people who are subject to a safeguarding enquiry are asked what they want to happen to make them feel safer.</p> <p>National research into personalised outcomes now underway</p>
Increase management capacity in CYC Safeguarding Team	Assistant Service Manager post, which was 0.5 FTE has been increased to full time, within existing budgets
First stage implementation of National Competency Framework for CYC staff	Competency Framework has been mapped to the Council's Behaviour Standards and to the Social Work Reform Board competency framework for social workers, so that it can be considered in the annual Performance reviews
Review finance model for multi agency training	Still under consideration, but as part of a wider review of workforce development offer to partners
Ensure progress of Winterbourne Review programme	<p>Six monthly reports received by the Board.</p> <p>Reviews of all hospital based York residents who have behaviours which challenge and a learning disability or autism diagnosis have been undertaken.</p> <p>Three people have been discharged from hospital. Three people will move when appropriate plans are agreed, and two people are not considered clinically able to move at present but will be kept closely under review.</p>

	<p>CYC has reviewed all people in out of area placements in addition to the people in hospital settings and will be developing a commissioning plan over the next three months to support up to 28 people return to live closer to home. This programme will take 2-3 years to achieve</p>
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**City of York Adult Safeguarding Board Strategy
April 2014- March 2017 ACTION PLAN**

	Objective	Action	Timescale for completion	Lead
A				
A1	Ensure key strategic plans evidence that adult safeguarding is a priority and is being addressed.	Partners to identify key strategies and include in annual reports to Boards	March 2015	All
A2	Ensure a robust interface with Community Safety Plans	Engage with Domestic Violence strategy Board. Improve information sharing on Domestic Abuse Engage with Community Safety Board regarding Hate Crime, safe Places etc	March 2015 March 2016	Chair and CYC safeguarding Lead

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A3	Influence Joint Strategic Needs Analysis and Health and Wellbeing strategy	<p>Feed messages from this strategy to JSNA refresh</p> <p>Annual review of performance indicators for key strategic messages on need</p>	<p>March 2014</p> <p>March 2015</p> <p>March 2016</p>	CYC safeguarding Lead
A4	Ensure a robust interface with the Health and Wellbeing Board.	Standing item on Safeguarding Board agenda – items from and to HWB	From March 14	Chair
A5	Ensure that Adult Safeguarding Board members, and non – Executives, Board Members and Councillors of partner organisations understand their role in safeguarding and have attended basic awareness training.	<p>Members of Partner Boards to monitor through annual assurance reports to Board</p> <p>Each partner agency to consider in their competency framework</p> <p>Introduce Adult Safeguarding Board Development Days – minimum 1 per year</p> <p>Training needs review for Board members</p> <p>Induction training for new Board members</p>	<p>March 2015</p> <p>March 2015</p> <p>March 2015</p> <p>June 2014</p> <p>September 2014</p>	<p>All</p> <p>All</p> <p>Chair</p> <p>All</p> <p>CYC</p>

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A6	Assurance that all partners present an Annual Safeguarding Report to their relevant governing body	Partners to advise Board when Annual report received by their Board. Summary of reports in Annual Adult Safeguarding Board report	Annual Annual	All Chair
B				
B1	Ensure that all partners are signed up to, and working in line with Multi agency procedures and practice	Annual check for changes and updates Full review every 3 years Seminar/event for voluntary sector groups Development day to consider thresholds and demand	December 14, 15 16 December 16 March 15 March 215	All CYC CYC and Voluntary sector Chair
B2	Share learning from practice, Lessons Learned and Serious Case Reviews	Review of serious case review protocol Develop a lessons learned protocol	March 15 March 15	Board sub Group Board sub Group Chair

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		Continue with regular agenda item on each Safeguarding Adult Board meeting to share case studies	ongoing	
B3	Senior level, regular, attendance at Board from all partners.	Attendance reported in Annual Safeguarding Board report	Annual	All/CYC
B4	Ensure a shared approach to understanding and managing risk of abuse in safeguarding	MCA/DolS training – monitor uptake and feedback Board development day on responding to self neglect concerns	Quarterly reports to Board March 16	CYC Chair
B5	Ensure best use of resources to meet growing demand and shared priorities	Development of the multi agency safeguarding hub with police and children’s safeguarding Develop virtual network for safeguarding advisors in partner agencies Review of thresholds for referrals	Sept 14 March 15	CYC Police All

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		Board development day to look at use of resources across agencies	March 16	Chair
C				
C1	Raise awareness and empower community to keep people safe	Review of Adult Safeguarding Adults website	March 15	CYC
		Annual radio or Press interview/article on Adult Safeguarding	Annual	Chair
		Develop information for the community	March 15	CYC
		Ensure housing and support providers, drug and alcohol service, A&E can access alerter training	Annual review of training attendance	CYC
C2	Reduce risk of harm through effective and intelligent commissioning	Winterbourne concordat assurance	6 Monthly updates	Partnership Commissioning Unit (PCU) and CYC
		Sponsor work between health and social care commissioners and contract managers on sharing intelligence on quality of providers,	June 15	CYC/PCU/CCG

		<p>Ensure that Contract monitoring has a focus on safeguarding and dignity and any shortfalls in standards are addressed</p> <p>Commissioning and contracting with regulated providers includes Care Quality Commission (CQC) registration guidance in relation to safeguarding.</p> <p>Ensure commissioners review their training needs regarding safeguarding and quality assurance</p> <p>Consider arrangements for commissioning of advocacy services</p>	<p>March 15</p> <p>Annual assurance</p> <p>Annual assurance</p> <p>June 15</p>	<p>CYC/PCU/CCG/NHS England</p> <p>CYC/PCU/CCG/NHS England</p> <p>CYC/PCU/CCG/NHS England</p> <p>CYC/PCU/CCG</p>
C3	Workforce development plans to develop quality provision	Work with city wide Workforce Strategy Group to ensure training delivered on:	March 15	CYC

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		<ul style="list-style-type: none"> • Managing challenging behaviour and reducing incidents between residents • Medication management • Reduce risks of pressure sores • Dignity agenda <p>Review themes and areas of risk emerging from performance data to continue to inform training plans</p>	Sept 14	CYC
D				
D1	Commit to an outcome focus for safeguarding activity	Engagement in Making Safeguarding Personal Programme	March 15	CYC
D2	Enhance and improve user 'voice' in all the Board does	<p>Improve links with Healthwatch York and Safeguarding Board</p> <p>Develop proposals for greater user involvement</p>	<p>March 15</p> <p>March 15</p>	<p>Chair and Healthwatch York</p> <p>Healthwatch York</p>

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D3	Ensure people with personal budgets in health and social care are supported to manage safety and risk at the same time as preserving the right to choice and control	Consider evidence from the Research underway with York University on Safeguarding and personalisation	March 15	CYC
D4	Empower people to be able to make good choices about quality care and support	Continue to develop information for public on care and support choices	March 15	CYC

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Annex D

Safeguarding Adults Performance Report

April 2013 – March 2014

Introduction:

1. This is the performance report of adults safeguarding activity in City of York Council for the year ending March 2014. It provides information which has been submitted to the Information Centre as the Safeguarding Adults Return.
2. The Safeguarding Adults Return replaces the 'AVA' (Abuse of Vulnerable Adults) return of previous years. Benchmarking data will not be available for 2013-14 until September.
3. Benchmarking information is available, and provided where possible for 2012-13, but this does not fully match the data used for 2013-14. The Health and Social Care Information Centre Comparator report for 2012-13 is available as a background paper.

SECTION 1. : Information about the victim and their circumstances

Number of referrals

Total	18-64	65-74	75-84	85-94	95+
342	105	33	86	108	10

This was a significant rise in the number of people where an investigation or enquiry was required. In 2012-13 we received a total of 214 referrals.

In 2012-13 we measured the number of repeat referrals. York compared well with both the national and comparator group authorities, with 7% of referrals being a further concern about the same person, compared to 17% nationally and around 14% for comparator authorities.

Primary Group

	Previously known to social Care	Previously not known	Total
Physical Disability, Frailty or Sensory Impairment	188	16	202
Of which were sensory impaired	8	0	8
Mental Health	34	7	41

Of which dementia	12	0	12
Learning Disability	44	0	44
Substance Misuse	1	0	1
Other vulnerable people	28	24	52

Although the categories for 2013-14 were slightly different the comparator report showed that again we had higher numbers of people with physical disabilities and learning disability needs referred, compared to the national and comparator authorities, and lower numbers of people with mental health needs.

Ethnicity

	Already known to the LA	Previously unknown to LA	Total
White	285	38	323
Mixed/Multiple	0	0	0
Asian/Asian British	3	1	4
Black/African/Caribbean/Black British	1	1	2
Any other ethnic group	0	0	0
Refused	0	2	2
Undeclared/Not Known	6	5	11

York's population is changing rapidly, with an estimated 11% of the population now likely to be from minority communities.

Population numbers for minority communities in York continue to be lower in the older age groups, who are more likely to be the subject of safeguarding alerts and referrals.

It is estimated there were 3 people over 85 of mixed ethnicity in 2010, 11 people of Asian origin over 85, 6 of Chinese origin and no Black or Black British over 85 (Projecting Older People Population Information System)

<http://www.poppi.org.uk/index.php?&PHPSESSID=mjcf3l8dt6gk3177f3vn73jhr0&arealD=8301&np=1> (accessed 16/06/14).

Based on these age sensitive population figures Safeguarding activity in York is still broadly in line with our diverse communities

Type of abuse

Type of alleged abuse or risk	Social Care support, paid, contracted or commissioned	Other	Total
Physical	45	58	103
Sexual	2	13	15
Psychological/Emotional	30	55	85
Financial and material	24	53	77
Neglect or acts of omission	51	27	78
Discriminatory	1	4	5
Institutional	4	5	9

These figures are taken from the concluded referrals during the year. There may be more than one type of abuse alleged for each individual referral.

Location of abuse

Location Of Abuse	Social Care support, paid, contracted or commissioned	Other	Total
Care Home	53	18	71
Hospital	3	14	17
Own home	57	86	143

Service within the community	0	1	1
Other	4	24	28

Section 2: Outcomes following safeguarding investigation

This data set is taken from cases that have been through an investigation and have been concluded. It does not take account of safeguarding issues alerted to CYC which have been dealt with at an earlier (initial assessment) stage in the process.

Conclusion	Social Care support, paid, contracted or commissioned	Other	Total
Fully substantiated	41	39	80
Partially substantiated	11	15	26
Inconclusive	33	42	75
Not substantiated	27	35	62
Investigation ceased at individuals request	2	9	11

The number of cases reaching a conclusion increased compared to previous years (146 in 2012-13 and 190 in 2011-12)

The percentage substantiated was lower this year at nearly 42%, compared to just fewer than 50% in 2012-13. Last year the England and Comparator group averages were around 35% of referrals substantiated.

29% of completed referrals were inconclusive last year. This is almost 10% higher than in the previous year and slightly higher than the England and Comparator Authority averages for 2012-13

Capacity to make informed choices

This is a new indicator, which considers how many people subject to safeguarding process lacked capacity, and how many of these people were supported by an advocate, family member or friend.

Number assessed as lacking capacity	18-64	65-74	75-84	85-94	95+
Yes	29	11	21	25	3
No	26	6	19	25	2
Don't Know	36	12	14	22	3
Supported by an advocate family member or friend	5	2	6	10	1

Of concern is the number of people where it is not known whether they have capacity and the low number of people considered not to have capacity who were supported by an advocate, family member or friend.

Action is planned for the coming year to improve capacity assessments.

The Care Act will require that we offer the support of an advocate to people subject to safeguarding processes who lack capacity and do not have someone who can safely support them through the process.

Serious Case reviews

No Serious case reviews were undertaken last year

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Safeguarding Adults Assurance report 2014

Annex E Acronyms

ADASS	Association of Directors of Adult Social Services
SPRU	University of York Social Policy Research Unit
AVA	Abuse of Vulnerable Adults information return
LGA	Local Government Association
TOR	Terms of Reference
NHS	National Health Service
CVS	Council for Voluntary Services
CYC	City of York Council
HOSC	Health Overview and Scrutiny
MAPPA	Multi Agency Public Protection Arrangements
HCPC	Health Care Professions Council
ILS	Independent Living Scheme

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Health Overview & Scrutiny Committee Work Plan 2014-2015

Meeting Date	Work Programme
28 May 2014	<p>Themed approach</p> <ol style="list-style-type: none"> 1. Presentation by City of York Council Head of Transformation about her work around Adult Social Care 2. Be Independent report about the development of this new Community Interest Company and how it provides community equipment loan and telecare service <p>Scrutiny and Task Group reports:</p> <ol style="list-style-type: none"> 3. Men's Health Scrutiny Review 4. Possible Topics for Scrutiny Review during the Municipal Year <p>Managing the Business</p> <ol style="list-style-type: none"> 5. Work Plan Update
2 July 2014	<p>Themed approach:</p> <ol style="list-style-type: none"> 1. Attendance of Cabinet Member for Health and Community Engagement 2. Year End Finance & Performance Monitoring report 3. Annual Report on Carer's Strategy. 4. Update reports on proposals for mental health services in York including: <ul style="list-style-type: none"> • Proposals for improving inpatient child and adolescent mental health services in York (LYPFT) • The future vision of mental health services across York and the interim solutions for Bootham Hospital to date (CCG) 5. CCG report on five-year strategy for integrated health care in York. <p>Scrutiny and Task Group reports:</p> <ol style="list-style-type: none"> 6. Safeguarding Vulnerable Adults Annual Assurance Report

	<p>Managing the Business</p> <p>7. Work Plan Update (including forthcoming Scrutiny Reviews)</p>
10 September 2014	<p>Themed approach:</p> <ol style="list-style-type: none"> 1. 1st Quarter Finance and Performance Monitoring Report 2. Annual report to the Committee from Chief Executive at York Teaching Hospital NHS Foundation Trust. 3. Annual report from Chief Executive of York Ambulance Service <p>Scrutiny and Task Group reports:</p> <ol style="list-style-type: none"> 4. Update of implementation of recommendations arising from Personalisation Scrutiny Review 5. Update report on provision of medical services for travellers and the homeless <p>Managing the Business</p> <p>6. Work Plan Update</p>
15 October 2014	<p>Themed approach:</p> <ol style="list-style-type: none"> 1. Annual report to the Committee from the Chief Executive of Leeds and York Partnership NHS Foundation Trust <p>Scrutiny and Task Group reports:</p> <ol style="list-style-type: none"> 2. Six monthly Quality Monitoring Report – Residential, Nursing and Homecare Services <p>Managing the Business</p> <p>3. Work Plan Update</p>
26 November 2014	<p>Themed approach:</p>

	<p>1. 2nd Quarter Finance and Performance Monitoring Report</p> <p>Scrutiny and Task Group reports:</p> <p>2. Health & Wellbeing Board Update Report</p> <p>Managing the Business</p> <p>3. Work Plan Update</p>
17 December 2014	<p>Themed approach:</p> <p>1.</p> <p>Scrutiny and Task Group reports:</p> <p>2.</p> <p>Managing the Business</p> <p>3. Work Plan Update</p>
14 January 2014	<p>Themed approach:</p> <p>1.</p> <p>Scrutiny and Task Group reports:</p> <p>2. Health & Wellbeing Board Update Report</p> <p>Managing the Business</p> <p>3. Work Plan Update</p>
18 February 2014	<p>Themed approach:</p> <p>1. 3rd Quarter Finance and Performance Monitoring Report</p>

	<p>Scrutiny and Task Group reports:</p> <ul style="list-style-type: none"> 2. Health & Wellbeing Board Update Report <p>Managing the Business</p> <ul style="list-style-type: none"> 3. Work Plan Update
25 March 2014	<p>Themed approach:</p> <ul style="list-style-type: none"> 1. <p>Scrutiny and Task Group reports:</p> <ul style="list-style-type: none"> 2. Six monthly Quality Monitoring Report – Residential, Nursing and Homecare Services 3. Annual report on Carers’ Strategy 4. Health & Wellbeing Board Update Report <p>Managing the Business</p> <ul style="list-style-type: none"> 5. Work Plan Update 6. Draft Work Plan for 2015-2016