

City of York

Local system review report

Health and Wellbeing Board

Date of review:
30 October to 3 November 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission (CQC) the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

- Head of local system review programme: Ann Ford, CQC
- Lead reviewer: Nicola Kemp, CQC

The team included:

- Two CQC reviewers
- One CQC analyst
- One CQC Expert by Experience
- One CQC inspection manager (pharmacy)
- One CQC Head of Integrated Care

- One CQC Manager for Integrated Care
- Five specialist advisors (two current directors of adult social services, one previous CCG director of nursing, one GP, and one former local government director of social services)

How we carried out the review

The local system review considered system performance along a number of 'pressure points' on a typical pathway of care with a focus on older people aged over 65.

We also focused on the interface between social care, general medical practice, acute and community health services, and on delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive?**

We have then looked across the system to ask:

- **Is it well led?**

Prior to visiting the local area, we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information.

We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as people who use

services, their families and carers. The people we spoke with included:

- System leaders from City of York Council (the local authority), the Vale of York Clinical Commissioning Group (the CCG), York Teaching Hospital NHS Foundation Trust, the Yorkshire Ambulance Service NHS Trust, Tees, Esk and Wear Valleys NHS Foundation Trust.
- Health and social care staff including social workers, GPs, discharge teams, and reablement teams
- Healthwatch York, and voluntary and community sector (VCS) representatives
- Provider representatives
- People using services, their families and carers at a local dementia involvement group. Minds and Voices, a carers group and service user support group.
- We reviewed 13 care and treatment records and visited 13 services in the local area including an acute hospital, intermediate care facilities, care homes, GP practices, urgent care and out of hours GP service.

The York context

Demographics

- 17% of the population is aged 65 and over.
- 94% of the population is categorised as White.
- York is in the 20% least deprived local authorities in England.

Adult Social Care

- 25 active residential care homes:
 - 1 rated Outstanding
 - 18 rated Good
 - 6 rated Requires improvement
- 15 active nursing care homes:
 - 10 rated Good
 - 4 rated Requires improvement
 - 1 currently unrated
- 30 active domiciliary care agencies:
 - 24 rated Good
 - 3 rated Requires improvement
 - 3 currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) of people of all ages living in York LA were almost entirely at the following NHS acute hospital trust:

York Teaching Hospital NHS Foundation Trust (RCB)

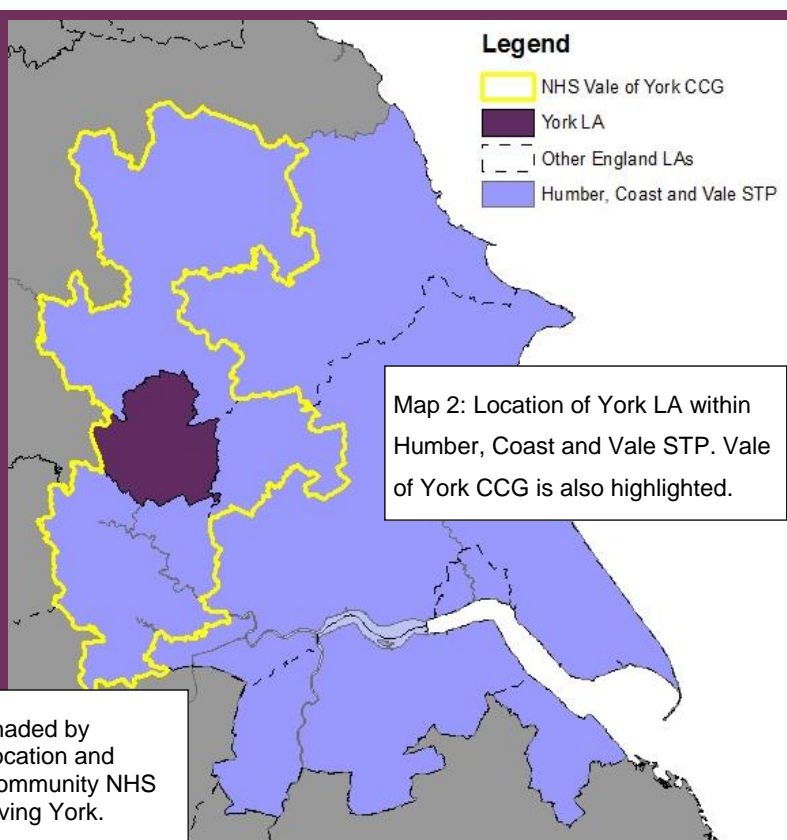
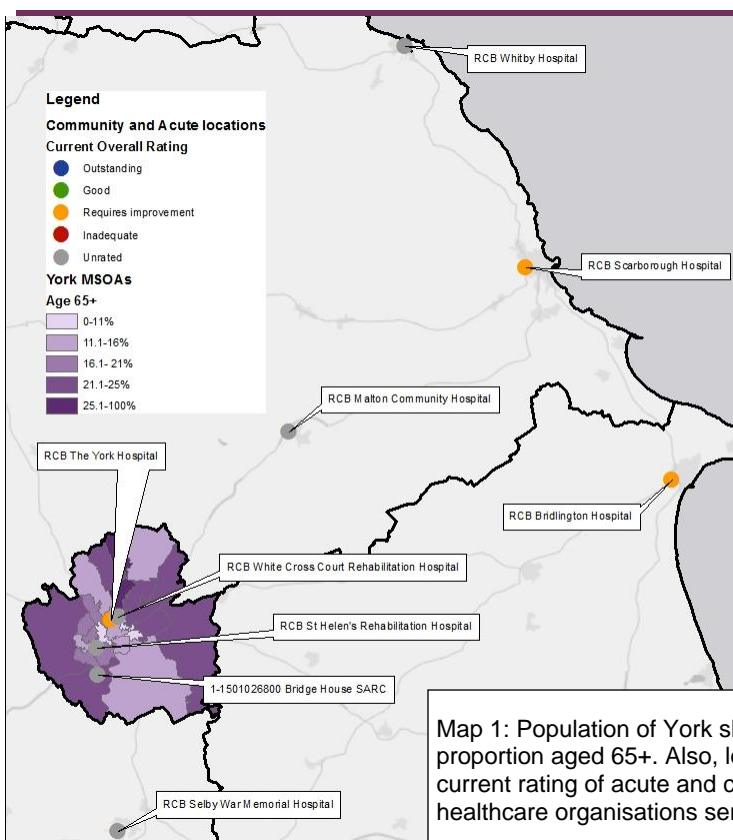
- Received 92% of admissions of people living in York LA
- Admissions from York made up 33% of the trust's total admission activity
- Rated Requires improvement overall.

The trust is also the main provider of community services within the area.

GP Practices

- 19 active locations, all rated Good

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of York shaded by proportion aged 65+. Also, location and current rating of acute and community NHS healthcare organisations serving York.

Map 2: Location of York LA within Humber, Coast and Vale STP. Vale of York CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- The City of York had experienced historical challenges in close partnership working and lack of trust at system leadership level. These challenges included frequent changes of senior staff and interim posts both in the local authority and in the Vale of York CCG. This situation had improved over the 12-month period prior to our review, with new substantive leaders being appointed, including a new accountable officer for the CCG. Additionally, due to the differing financial status of the local authority, CCG and NHS Hospital Trust, there was a nervousness of system leaders to move to more joined up working.
- The relationship challenges had been apparent in the agreement of the Better Care Fund (BCF) in the period 2015/16, where the BCF had not been agreed by system partners and had to be agreed via the national assurance and escalation process. For the 2017/19 BCF agreement which had recently been submitted, all system partners had agreed and signed off a joint plan within the deadline. However, the plan did not meet NHS England expectations on two key areas. Firstly, NHS England was not satisfied that the requirements on minimum financial expenditure on social care protection were met. Secondly, NHS England required local partners to agree a target for the reduction in delayed transfers of care which was based on known errors in the data, resulting in a target of zero delays. Work was ongoing with NHS England to sign this plan off at the time of our review. Following our site visit we have received formal notification that the plan has now been agreed.
- Work was required to develop a wider system vision for the Humber, Coast and Vale Sustainability and Transformation Partnership (STP), which had a large footprint. The STP did not capture with any relevance the challenges within the City of York area. As a result, work was required to develop a wider system vision for the STP and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements. The recent appointment of a new STP lead presented an opportunity for this work to progress at pace.
- The Health and Wellbeing Board (HWB) had recently gone through a refocus, where the appropriate representation across the local system had been identified, strong leadership was in place and the board had reset its priorities and articulated a clear, shared vision. While organisational visions were not yet aligned to the same objectives, recent changes to the Health and Wellbeing Board and to leadership across the system was providing an opportunity to strengthen the position of the board and develop a more collaborative strategic approach across organisations.
- The joint health and wellbeing strategy was underpinned by the Joint Strategic Needs

Assessment (JSNA) and the Annual Public Health Report. However, there was limited evidence that the JSNA had been robust enough to fully underpin subsequent strategy development.

- The extent to which the high impact change model, one of the national conditions for the BCF, had been implemented was limited. A self-assessment undertaken by the local system confirmed there was additional work required to implement all elements of the model.

Is there a clear framework for interagency collaboration?

- There was not a clear framework for interagency collaboration across the health and social care interface. There had been a whole system review of similar services to look at a collaborative, integrated multidisciplinary approach or learn from other similar initiatives completed in 2015. This led to a complex discharge working group being formed, which reported to the A&E delivery board. The 'One Team' project had been developed which brought together the community response team, the primary care short term care service, the local authority reablement services and voluntary sector wellbeing support services to simplify referral pathways (for both step up and step-down referrals), to ensure people received the right service first time and maximise capacity within available resources. However, we found there was confusion by system leaders and front line staff about the roles of these services and the review that was completed. Work was required to streamline these services into a coherent strategically and operationally integrated way.
- Historically, relationships across the system had been poor with a high level of mistrust and limited joint working. There had been frequent changes in senior roles and numerous interim appointments in both the CCG and the local authority. However, more recently there had been some substantive appointments made. Relationships were now strengthening and there was a greater appetite for collaboration, leaders were seen as establishing permanency and having a positive impact on developing relationships and trust across the system; although there was still work to do in this regard. There were strong positive links with the voluntary sector and relationships with the wider provider market were improving.
- The City of York Council is part of the Humber, Coast and Vale Sustainability and Transformation Partnership (STP), which covers a very large geographical area, where the footprint includes six CCG areas and six local authority areas. Senior leaders raised concerns about the impact of the STP for the City of York. System leaders across the City of York did not feel there was added value from the STP due to the challenges of the footprint. Additionally, the Vale of York CCG covered three local authorities and York Teaching Hospital NHS Foundation Trust. Due to the large footprint covered by the STP, York Teaching Hospital NHS Foundation Trust and the CCG, it was difficult for the City of York system to have its voice heard in these wider systems to benefit the people of York.

- Adult community health services were managed by York Teaching Hospital NHS Foundation Trust, following a merger in 2011. There was a lack of integration with the district nursing teams across the system, particularly due to some of them working on a different IT system to the GPs and other community services.
- Due to the differing financial status of the organisations, there was a level of mistrust in this regard. The local authority had been able to balance its budget over a number of years, whereas the York Teaching Hospital NHS Foundation Trust had recently gone into deficit and the CCG had been in significant deficit for a number of years.

How are interagency processes delivered?

- On the whole, interagency working in York was underdeveloped. There was a growing willingness for interagency collaboration at a high level, however frontline delivery of services was still very siloed. There were similar, separately commissioned services that led to duplication of effort and potential inefficiencies. In addition, the lack of a central information and advice system led to unnecessary referrals and multiple points of entry to the health and social care system that made the system difficult to navigate for people using services. The 'One Team' had recently been established with a view to co-locate these services but further work was required in this area.
- There was limited evidence that the priorities in the high impact change model, one of the national conditions for the BCF, had been implemented in any meaningful way. A self-assessment by the system showed the system was in a very early stage of implementation.
- There were few opportunities or mechanisms in place to support frontline staff to work across organisational boundaries.
- There were mechanisms in place to consult with wider system partners, including providers and voluntary sector organisations. The voluntary sector in particular was very well engaged and was providing good services that were highly valued by those people receiving them.
- There were opportunities provided for the inclusion of care home and domiciliary care providers. In the main providers were positive about the contribution they could make in the system. They were invited to provider forums where they felt their voice was heard.

What are the experiences of frontline staff?

- There was confusion among front line staff, managers and providers in relation to the various service offers and which services they could refer into. Examples of this included the rapid access team, the community response team, the Human Support Group social care reablement service and the integrated care team.
- Frontline staff reported feeling well engaged and supported within their own organisations. They were aware of the reporting and governance structures within their own organisations but not on a system wide level and were not always clear about the overall responsibility for performance at a system level.
- We saw some good examples of multidisciplinary team working in single services but this was not replicated widely.
- Frontline staff were dedicated to providing a high quality person-centred approach to care. However, the demand for services was often greater than the capacity to deliver, due to the nursing and care staff vacancies within the City of York.

What are the experiences of people receiving services?

- It was difficult for people using services, their families and carers to find out what services were available in the City of York area as there was not one portal or place where this information could be accessed. From the focus groups involving people who use services, we heard the experience of people receiving services in the City of York area varied considerably.
- People's involvement in discharge planning varied. We saw evidence in the records we reviewed that people and those close to them were involved in discharge planning. However, we heard from people who use services, their families and carers and other providers that people did not feel involved and discharge planning seemed rushed at the point when the person was deemed as medically fit for discharge.
- Some people using services expressed concerns that, when they were admitted to hospital, there was a lack of communication with adult social care providers, which had resulted in people continuing to be charged for care they were not receiving.
- We found evidence that people were not being appropriately discharged at weekends due to the lack of seven-day services across the system. Nursing/care homes and the hospice were very reluctant to accept people who were discharged between Friday afternoon and Monday morning due to incidents of poor discharge that had occurred at weekends where

people were discharged with no medication or discharge summaries.

- Older people's transfer home or to a new place of residence was often delayed due to a lack of adult social care provision, care packages and patient choice.
- Reablement services were not effective in the City of York, with 87.6% of people who received a reablement package through the City of York local authority in 2016/17 still requiring either long term support or further reablement.
- There was no single shared case record within the City of York system. This resulted in people having to repeat their story. There was a poor history of sharing data and business intelligence across organisations in the system. An example of this was several GP practices used a different system to the district nursing teams and as such, GPs did not always know when district nurses had visited a person using services or what intervention they had delivered.

Are services in the City of York well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, inter-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

Services across the system interface were not previously well led but there had been significant improvement. We found grounds for optimism in this regard with recent changes to the Health and Wellbeing Board presenting a real opportunity for the system to move forward in a positive way. The Health and Wellbeing Board had a clear, well-articulated vision but, as this vision was recently formulated, it was not yet well embedded across the City of York area. There were strong, positive links with the voluntary and community sector and the wider provider market. Historically, there had been some challenges with relationships across the system, but this was very much an improving situation at the time of our review. A jointly, system-wide winter plan had been developed with system partners and submitted to NHS England.

Strategy, vision and partnership working

- The City of York had experienced historical challenges in close partnership working and lack of trust at system leadership level. These challenges included frequent changes of senior level staff and interim posts both in the local authority and in the CCG. This situation had improved over the 12-month period prior to our review with new leaders being appointed, including a

new accountable officer for the CCG.

- The wider system outside of the City of York area was complex in terms of geography, and the diverse range of strategic and operational systems did not support a natural affiliation to the city. Challenges included the large geographical area of the STP, the large CCG footprint which included three local authorities, and the York Teaching Hospital NHS Foundation Trust footprint, which covered the areas of York, Easingwold, Malton, Selby, Bridlington and Scarborough. This made it very challenging for the City of York area to have the desired degree of influence on change within the wider systems.
- The City of York was part of the Humber, Coast and Vale Sustainability and Transformation Partnership (STP). The Humber, Coast and Vale footprint covered six CCG areas and six local authority areas. Senior leaders raised concerns about the impact of the STP for the City of York as it was felt the STP footprint was over a large social geography and was much more fragmented than other STPs nationally. A new STP lead had been recently appointed to address some of the challenges within the area. System leaders across the City of York did not feel there was added value from the STP due to the challenges of the footprint.
- The STP had similar priorities to many other STPs nationally, including moving people closer to their home, dealing with demand, supporting frail older people, workforce and the role of primary care. We heard from system leaders and the newly appointed STP lead that, at a local level, partners had implemented what they wanted to achieve, irrespective of the STP and linked in with the STP for specific issues, for example workforce challenges.
- The relational challenges were apparent in the agreement of the Better Care Fund (BCF) in the period 2016/17, where the BCF had not been agreed by system partners and had to be agreed via the national assurance and escalation process. However, for the 2017/19 BCF agreement which had recently been submitted, all system partners had agreed with the proposal submitted.
- For the BCF submission for 2017/19, system leaders had agreed and signed off a joint plan within the deadline. However, the plan did not meet NHS England expectations on two key areas. Firstly, NHS England was not satisfied that the requirements on minimum financial expenditure on expenditure on social care protection were met. Secondly, NHS England required the City of York to agree a target for the reduction in delayed transfers of care which was based on known errors in the data, resulting in a target of zero delays. Work was ongoing with NHS England to sign this plan off at the time of our review with a meeting scheduled with system partners to discuss.
- The complex discharge task and finish group, which comprised senior managers from across system partners, was overseeing the implementation of the high impact change model, one of

the national conditions for the BCF. However, the extent to which this had been achieved was limited. Work had been undertaken to introduce a discharge to assess approach during 2016 and to reduce delayed transfers of care, but seven day services were not operating across the system. In addition, the local NHS acute trust needed to develop a robust approach to discharge planning; this was underdeveloped at the time of our review. A recent self-assessment of the high impact changes indicated that work was required on the effective implementation of all elements of the model.

- A jointly produced, system-wide winter plan had been developed with system partners and submitted to NHS England. There was strong partnership working at the A&E delivery board where this plan had been completed. However, not all key partners felt they had been involved with the winter plan, including care homes, nursing homes, domiciliary care and a number of GP practices. Frontline staff were aware of the winter plans for their own organisation but were not always aware of a system-wide plan. There was a lack of resource commitment for the implementation of the winter plan from the Vale of York CCG at the time of our review. However, following the review we were informed that resource commitment was subsequently in place.
- The Health and Wellbeing Board (HWB) following a recent refocus now had appropriate representation from across the local system and had articulated a clear, shared vision. While organisational visions were not yet aligned to the same objectives recent changes in leadership were providing an opportunity to develop a more collaborative strategic approach across organisations.
- We found a real appetite for greater collaboration across the system and some strong, positive links with the voluntary sector and the wider provider market continuing to improve. Voluntary sector representatives also attended the Health and Wellbeing Board which allowed a voice for and challenge by the people of the City of York.
- There was a strong vision for the future from the local authority in terms of York older people's accommodation programme, which aimed to maintain people's independence and build resilient communities through the provision of high quality housing for families, older people and people living with dementia. The vision supported the aims of the 'Future Focus' strategy to "prevent, delay and manage care needs differently by working with residents to maintain independence and promote resilience". This programme was also aligned to the CCG strategy. This was the overarching vision to support older people in the future.

Involvement of people who use services, their families and carers in the development of strategy and services

- York Teaching Hospital NHS Foundation Trust had recently closed Archways, a rehabilitation unit, which had resulted in people and staff having to move to different services. This closure had resulted from a review of services and a move to more community focused rehabilitation

in people's usual place of residence. It was felt the communication about this could have been better, particularly in terms of the notice periods that were given.

- Feedback from this was provided in a Healthwatch York report to the Health and Wellbeing Board. In this, it was recommended that the Health and Wellbeing Board commit to embedding co-production as the method for any further major service change in York. The Health and Wellbeing Board signed up to this approach. This prompted additional work around co-production in York, including sharing best practice from work already undertaken in York. One such example of best practice was the work previously undertaken by the City of York Council in making changes to their care homes. City of York Council established a steering group with representatives from a wide range of charities and organisations working with older people. They undertook engagement work with residents, their families and carers. In the process of this work, a number of care homes were closed. The council also evaluated the impact of these closures on the individuals affected, to make sure they could continue to learn lessons for any future changes.
- The older people's accommodation programme had engaged closely with the York Older People's Assembly (YOPA) and had good community buy in for the new developments. YOPA were promoting the work of the programme across their network of people and professionals and had held a stakeholder open day. This had led to 25 one bedroom apartments and two bedroom bungalows in development, including lounges, dining facilities, secure gardens, assisted bathing facilities and other amenities to benefit the health and wellbeing of residents. The homes were let as secure tenancies by the local authority housing team and eligibility was determined by a combination of care, health and housing assessment and adjudicated by a joint allocations panel.
- There was a lack of representation of people using services on the locality boards. However, the community and voluntary sector was very well involved with the locality board in the City of York. The locality board had developed its vision, values, principles and unplanned care project initiation document and were exploring how to bring the voice of people who use services into this work. In addition, the community and voluntary sector has had opportunities for influencing and developing the health and wellbeing strategy, particularly the 'Ageing Well' part.
- The CCG held engagement activities over the summer of 2017, which included 'big conversations' and picked up issues around GP access, waiting times in hospital, including delayed transfers of care and mental health. This engagement event involved more than 500 residents, but was led by the CCG and not with the involvement of system partners. Information was presented to them on the key challenges of the CCG and views were sought from people who use services, their families and carers. These views were analysed and work was being undertaken at the time of our review to formulate an action plan to implement the key actions.

Promoting a culture of inter-agency and multidisciplinary working

- There was not a clear framework for interagency collaboration across the health and social care interface. However, there were examples of joint working, such as the new system-wide safeguarding policy and the 'One Team' approach.
- The 'One Team' project brought together the community response team and primary care short term care service with local authority reablement services and voluntary sector wellbeing support to simplify referral pathways (for both step-up and step-down referrals), ensuring people received the right service first time and maximised capacity within available resources. Additionally, progress had been made on co-locating the teams by bringing them into the same building.
- Strategic work was being undertaken at the time of our review to develop the locality model that would bring a range of professionals working together in clusters, for example local area coordinators aligned with GPs. The intention was for social workers to move in to the locality model as well. This work was in its infancy and only operational in three areas at the time of our review but demonstrated the intention; to roll out this approach across the City of York in the next three to four years.
- There were several similar services in the City of York, including the community response team, the integrated care team and the services provided by the Human Support Group (HSG), all of which had very similar remits. The impact of this was that there were several services undertaking similar functions with no joined-up approach, which led to confusion and duplication in the system. There had been a whole system review in 2015, which had led to the complex discharge working group being formed, which reported to the A&E delivery board. The 'One Team' project had been developed which brought together the services into one building and with a daily meeting. However, we found there was confusion by system leaders and front line staff into the roles of these services and the review that was completed. Work was required to streamline these services into a coherent strategically and operationally integrated way.
- There was one main acute NHS trust serving the City of York; York Teaching Hospital NHS Foundation Trust. While the trust received around 92% of hospital admissions of people living in the City of York, it was serving a much larger population as admissions from the City of York only made up a third of the trust's total admissions.
- It was difficult to find out what services were available as there was not one portal or place where this information could be accessed. However, good working relationships were emerging between the trust and the local authority.

- Healthwatch York had joined up with the local authority's adults' commissioning team to take a joint approach to involving people who receive services in informing the definition of quality of provision in care homes. This approach aimed to prevent duplication in consultations. Healthwatch York had also recruited and trained volunteers to carry out the role of care home assessors to support observation visits that were undertaken in care homes.

Learning and improvement across the system

- We found evidence of learning at an individual organisational level; however it was less apparent that this learning was being shared across partner organisations within the local area.
- We were told of one incident where a person using services had been resuscitated against their will as the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form was not available to paramedics due to a misunderstanding from the nursing home, where a photocopied form had been sent out from the acute hospital. Whilst the incident had been reported by ambulance staff and a nursing home, practice across the system, in terms of photocopying DNACPR forms had not changed as a result, which could lead to the incident happening again.
- We saw evidence of learning across the system in relation to the Better Care Fund in terms of engagement and agreement at a senior level. The previous year's BCF had not been agreed by system leaders and was escalated and agreed on their behalf. However, for the 2017/19 submission, there was agreement across the system and system leaders had been well engaged in its development (although the agreement was subsequently challenged by NHS England).

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements with the system, focusing on collaborative governance, information governance and effective risk sharing.

The Health and Wellbeing Board was overseeing the governance of the Better Care Fund plan and the associated risk register. The financial position of the CCG was presenting a challenge across the system in terms of risk. There was not a joined-up approach to IT systems with several systems in use across organisations and plans were not in place to address this.

Overarching governance arrangements

- The Health and Wellbeing Board had oversight of the direction of health and social care in the City of York. The board had a number of sub committees that agreed local governance arrangements with involvement by all partners and with clear lines of accountability. Partners across the system recognised their own roles and accountabilities of their organisations within

the governance framework. Earlier in 2017, the Health and Wellbeing Board had been reviewed and had streamlined the formal reporting structure beneath it.

- The Health and Wellbeing Board published the City of York's joint Health and Wellbeing Strategy 2017-2022 in March 2017, which all partners had agreed. This set out aspirations for the way the City of York promoted and sustained the health and wellbeing of the whole community and particularly those people who needed care and support.
- The A&E delivery board covered the York Teaching Hospital NHS Foundation Trust footprint and reported to NHS Improvement North and NHS England. This board had the responsibility of developing and managing urgent and emergency care across the system. The board had introduced a complex discharge programme, overseen by the complex discharge task and finish group which comprised senior managers from across the partner agencies, focussing on operational actions to improve discharge pathways, implementing the high impact changes and reducing delayed transfers of care.
- We reviewed the 'living well with dementia' strategy and found that there was a lack of review and implementation dates so it was not clear when the strategy had been written, which partners were involved, or when actions identified would be implemented and who had responsibility in this regard.
- We heard from frontline staff and providers that they were unclear as to how to raise governance concerns and risks across the system. We heard of instances where concerns had been raised but no feedback had been given or no remedial action taken. An example of this included unsafe discharges to a nursing home.
- The response to the system overview information request identified that information from the local authority's quality assurance programme was shared with CCG colleagues and meetings took place between the quality and service improvement leads in the two organisations on a regular basis as an information sharing forum. The teams undertook joint visits where there were safeguarding concerns.
- The local authority and the CCG were working closely on care home contracts, including contractual elements regarding infection control and safeguarding. The scrutiny committee received a half yearly report on the quality of care services across the city.

Risk sharing across partners

- The programme governance of the Better Care Fund (BCF) was overseen by the Health and Wellbeing Board and included partner agencies beyond the formal BCF signatories. This included the hospital trust, the mental health trust, community and voluntary services, Healthwatch York and an independent care group. The Health and Wellbeing Board acted as

a forum for risk sharing and monitoring.

- The financial position of the CCG, under direction of NHS England, was presenting as a risk across the system, particularly in respect of joint investment in preventative initiatives. NHS England's CCG improvement and assessment framework 2016/17 gave the NHS Vale of York CCG a red rating for both its financial plan and its in-year financial performance. The CCG priority was focusing on meeting their current statutory duties rather than seeking long term saving goals, such as preventative measures. This presented a risk in respect of issues such as allocating sufficient resources to winter pressures.
- Financial challenge was a key risk identified by each organisation, including the CCG and York Teaching Hospital NHS Trust. These were shared with and considered by system partners in organisational planning. For the local authority, the financial risk was that both the acute trust and CCG were in financial deficit which impacted on options and collaborative working.
- The A&E delivery board was very active and had key partners involved to deliver the Better Care Fund plan and its governance arrangements. However, we found the risk management and risk sharing approach across the system was less well defined.

Information governance arrangements across the system

- Shared access to clinical systems was limited as there were multiple systems in operation across the system. This meant that multidisciplinary teams had to access multiple computers to log into provider systems to access and cross-reference information to help with care coordination. There was recognition in the system that this was a key risk factor but there had not been significant progress towards a single shared care record. Although a summary care record could be viewed by most professionals, these only contained basic information, such as a person's prescribed medication. We heard that GPs in the urgent care centre did not always have access to care records for people they were treating. Additionally, GPs working in the urgent care centre could not request any blood tests or investigations, such as X-rays. We saw evidence of the impact of this, where GPs could not access the information they needed, including medication recently prescribed.
- In the Better Care Fund submission for 2016/17, it was identified that there was an overarching information sharing protocol in place and system partners were beginning to sign up to data sharing agreements that sat below this. The CCG was continuing to promote the use of the NHS number as the common identifier across the health and care services and was confident the uptake was good. However more work was needed to fully understand how widely this approach was used throughout system partner organisations.
- Progress with the local digital roadmaps had been slow with a view that the local digital

roadmap (LDR) footprint should, ideally match the STP footprint and conversations had taken place to understand whether governance arrangements could support this. Embed (commissioning support) was working with the CCGs to develop universal capability delivery plans to support digital transformation.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

There was limited evidence to show system leaders working together around workforce. Developing the capacity and capability of the health and care workforce was recognised as a key challenge for the City of York, posing a risk to the future delivery of plans. There was a system-wide workforce strategy board led by the local authority which had variable attendance from all partners. There was limited evidence to show the impact of this strategy at the time of our review. There was no collaborative system-wide workforce strategy.

System level workforce planning

- The City of York adult care workforce strategy 2017/20 identified some of the key challenges faced in the City in relation to workforce, and outlined the vision, key priorities and the delivery plan. The workforce strategy had been written by the local authority but identified key partners who were represented on the strategy group, however this did not include the ambulance trust. There was not a collaborative, system-wide workforce strategy recognised by leaders across the parts of the system.
- The local authority workforce planning was linked to the STP where senior leaders were members of the STP workforce development strategy group and fed this into the local adult workforce strategy. However, this was seen as a challenge to implement locally due to competing organisational pressures and the lack of strategic direction at STP level with a limited scrutiny and oversight. For example, we were informed that due to the financial situation of the CCG, there was a greater focus on managing this rather than on the recruitment and retention of staff.
- The recruitment and retention of sufficient numbers of health and care staff was widely recognised as a challenge for the system. The City of York is an affluent area with full employment and a high cost of living. Providers have faced increasing competition for attracting staff from the retail and tourist industry. A shortage of suitably skilled care staff was impacting on people's discharge from hospital when they required support in their own homes. The recruitment challenges were predominantly in domiciliary care.

- The staff turnover rate at York Teaching Hospital NHS Foundation Trust between July 2016 and June 2017 was below the national average in all professional groups with the exception of medical and dental staff, where turnover was 8.3% at the trust compared to 7.6% nationally.
- Medical staff recruitment was challenging in some specialty areas. Within York district hospital there were nine permanent A&E consultants, plus two locums in post from an establishment of 15. Additionally, the acute trust had experienced challenges in recruiting to some medical consultant posts and was looking more creatively at rotating staff across the hospital sites. Medical staff shortages were reported to have an impact on providing seven day services and hospital discharges at weekend.
- Recruitment of GPs within the City of York was not highlighted as a concern as GP posts could be recruited to in a timely manner and there were no current vacancies. There was limited evidence of new ways of working for some GPs within the City of York, in terms of recruitment of nurse practitioners and paramedics.

Developing a skilled and sustainable workforce

- There were some examples of health and social care organisations working together to address workforce challenges. An example of this was the local authority linking with acute trust recruitment fairs with the aim to draw on the high rate of applications the trust received for healthcare assistants. Nurse associates, who rotated around the trust, community and adult social care were in post at the time of our review. The Yorkshire Ambulance Service NHS Foundation Trust had also offered placements to nurse associates.
- There was a high level of staff turnover in the City of York, with Skills for Care estimates of staff turnover in adult social care in 2015/16 in the City of York being 32.5% compared to 27.4% nationally and 29.3% across comparator areas. However, this was an improvement from the financial year of 2014/15 where the estimated turnover rate for the City of York area was significantly higher than nationally (42.2% in the City of York area, compared to 25.8% nationally and 27.3% across comparator areas). There had been a recruitment campaign across the City of York, which was encouraging people into the care sector.
- Skills for Care estimates of staff vacancies in adult social care in the City of York in 2015/16 showed there was a higher vacancy rate in the City of York area than the national average and comparator areas (9.1% in the City of York, compared to 7% nationally and 7.3% across comparator areas). This was a large increase on the vacancy estimates for the local authority in 2014/15, when the City of York's rate was lower than both the national average and comparator average (5.6% in the City of York, compared to 6.3% nationally and 6.2% in comparator areas). Reasons given to explain this high vacancy rate were full employment in the city and the high cost of living, which proved challenging to attract people into lower paid

job opportunities. The system leaders need to have a sense of urgency to address the recruitment and retention problems as a priority.

Under the vision for 'Dementia York', the local authority had delivered person centred dementia care training to 98 care staff in provider services. In addition, a 'Virtual Dementia Tour', had been provided which had so far reached 307 local authority staff and 54 external provider staff. There was also a range of other training initiatives planned, all of which all included an element of person centred approach.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

The Health and Wellbeing Board took responsibility for the system oversight of commissioning. Across the local system a Head of Joint Commissioning had been appointed and a joint commissioning strategy approved and a draft action plan had been developed. Due to the financial challenges within the system there was apprehension about moving towards shared commissioning by system partners. Such apprehensions require remedial action before the system can move forward in an integrated way.

Strategic approach to commissioning

- In January 2017, the Health and Wellbeing Board approved the joint commissioning strategy. The joint plan to implement this strategy remained in draft form at the time of our review but was subsequently approved at the Health and Wellbeing Board on 9 November 2017. This formalised the commitment of the local authority and the CCG to align and pool budgets, where appropriate, and to form a joint commissioning unit in preparation for integration by 2020. A head of joint commissioning in June 2017.
- The CCG had run large engagement events during the summer 2017 where people who use services, their families and their carers were asked what the priorities were for them in terms of commissioning. As part of this engagement more than 500 people were consulted and at the time of our review the CCG was in the process of formulating an action plan as a result of the findings. The events focused on enabling the public to share their views on health and social care in the area, specifically around what they saw was working well and what they wanted to see commissioned differently in the future.
- NHS England introduced a new CCG improvement and assessment framework in 2016/17 which provided a greater focus on assisting improvement alongside NHS England's

statutory assessment function. The framework covered indicators in four domains, including 'better health', 'better care', 'sustainability' and 'leadership'. Against this framework the Vale of York CCG was given an overall rating of inadequate and it was placed into special measures.

- The terms of reference for the Health and Wellbeing Board stated the board would take responsibility for the quality of all commissioning arrangements and would provide joint leadership across the city to create a more effective health and wellbeing system through integrated working and joint commissioning. The health and wellbeing strategy was underpinned by the Joint Strategic Needs Assessment (JSNA) and the Annual Public Health Report.
- A strategic approach had been taken by the local authority to develop a closure programme of a number of their care homes and develop extra care schemes to promote independent living. This had led to the older people's accommodation strategy being developed which promoted independent living and would provide 900 new units by 2020. Other examples of commissioning focused on maintaining people in their usual place of residence included a sensory hub (for anyone with any degree of sight loss, hearing loss or both), an older person's community service, the community wellbeing service and services for carers.
- Within the response to the SOIR, completed prior to our review, it was identified that the JSNA informed planning for commissioning and includes emergency admissions trends. This aligns somewhat with our analysis of hospital admissions from care home postcodes, which showed that between October 2015 and September 2016 the rate of hospital admissions from care homes in the City of York for diagnoses relating to accidents and injuries was above the national and comparator averages (419 per 100,000 aged 65+ in the City of York, compared to 392 nationally and 399 across comparator areas). However, at the time of our review, we identified that the JSNA was outdated and was in the process of being re-written with a view to it being presented in a different way.
- Information given to us following our visit on site identified that the JSNA demonstrated that people in the City of York experienced more emergency hospital admissions due to falls than the national average. This was specifically among women aged over 80 years. It also identified that the nursing care home use in the City of York rose above the national average in the last reporting period and was significantly higher than the comparators. This is also corroborated by our analysis of ASCOF data which showed that in both 2015/16 and 2016/17 the rate of admission to residential and nursing care homes for older people in the City of York was above the national and comparator averages.
- Overall the system had significant financial challenges. While this was putting services

under pressure it also meant that the system was beginning to recognise it needed a different whole system approach and to adopt a joined-up strategy around a different way of commissioning, centred on a prevention and demand management approach. However, this was in its infancy at the time of our review.

- There was recognition by system leaders and front-line staff in the system that providers and commissioners had a history of difficult relationships around continuing healthcare (CHC), leading to delays in reaching agreements. There had been a lack of shared assessments or trusted assessors, unresponsive processes and disagreements around funding. We saw evidence of ambitions to move towards a single commissioning process but due to the CCG's financial position, this was not as timely as would be expected. The management of CHC had recently returned to the CCG from a commissioning support unit and this greater level of control was expected to enable the system to make improvements to the CHC process.

Market shaping

- The City of York faced significant challenges in relation to the social care market in terms of available capacity and affordability. Due to financial pressures and old buildings being no longer fit for purpose, the number of residential beds had reduced by 13% between April 2015 and April 2017 and as at September 2017 there were 625 residential care home beds in the City of York, 210 fewer per population aged 65 and over than the comparator group average and 318 fewer per population than the national average. However, nursing home beds had increased by 4% over the same period, and at September 2017 our analysis showed there were 1004 nursing home beds in the City of York, 85 more per population aged 65 and over than the comparator group average and 164 more per population than the national average. There was also a strategic move by the local authority to close residential beds and replace them with extra care provision, and a move by health partners to move care into the community, for example by closing beds in Archways intermediate care facility.
- Although there was increased provision of nursing home care had enabling greater access to nursing care in the community, limited social care capacity overall was putting pressure on other parts of the system, including care packages and care home availability.
- Our analysis of data showed the number of domiciliary care agency locations in the City of York had increased by 6% between April 2015 and April 2017, but the number of locations per population remained slightly below national and comparator averages (30 in the City of York, compared to 34 in comparator areas and 34 nationally).
- Data collected by CQC as part of our business as usual inspections showed that 42% of residential and nursing home beds in the City of York were fully self-funded, which was above both comparator and national averages (33% and 37% respectively). This higher

proportion of self-funders created a buoyant market where providers were not reliant on the local authority to exist; they could charge higher prices and be selective about the clients they supported. Conversely, CQC's data on funding of domiciliary care agencies showed a higher percentage of funding in the City of York came partly or fully from the local authority (69%) which was also above comparator (63%) and national (64%) averages.

- The Older People's Housing Scheme was seen as a strategy for shaping the future service provision to meet the needs of older people. For example, there was a significant emphasis on increasing the volume of high quality provision for people living with dementia and supporting self-funders through mixed tenure.
- Work-streams and programmes funded by the previous year's BCF (2016/17) had been reviewed by the system with a number of these being retained and new schemes had been added over the next two years of the plan (2017/19). Retained schemes included community facilitators, human support group (reablement), urgent care practitioners, telecare and falls lifting, and out of hospital services commissioned by the CCG (increased by £1m to over £5.4m by 18/19). Retained schemes had a focus on admission avoidance and maintaining people in their usual place of residence.
- A number of the new schemes identified in the BCF were aimed at prevention and demand management, to support market capacity and enhance wellbeing, for example; social prescribing, information and advice services and self-support champions. Several new schemes related to supporting improvements in discharge arrangements including; escorted transport, increased reablement capacity, extended handypersons service and extended rapid access teams service. A new multi-agency project for seven-day working had been included in the plan, however it was not scheduled to start until 2018/19. The plan included a self-assessment of the high impact change model which demonstrated very low levels of implementation across all eight domains.

Commissioning support services to improve the interface between health and social care

- Future commissioning plans were focused on prevention, reduction, delay and management of need. At the time of our review these were still to be implemented and commissioning was fragmented and based on meeting national objectives and targets rather than taking a coherent system-wide approach.
- During our review, we were told that a big emphasis for the local authority was on the 'Future Focus' business case, which was in draft form. This business case identified that the local authority's adult social care system included a large number of teams, many hand-over points where people could fall through the gaps and a large volume of people within the system which was leading to blockages and capacity issues. The future focus

model was an adult social care transformation programme designed by the local authority with a focus to prevent, delay and manage care needs differently by working with residents to safely maintain independence and promote resilience through conversations, contacts, information and support in adult social care.

- The future focus business case was a clear, robust plan for the local authority journey. However, although part of the plan was around collaboration, it had been written for the local authority and system partners had not been included in its development.
- The local authority was in the process of commissioning a new social care reablement contract with the Human Support Group. Within this contract, there will be a shared set of metrics, for example response times, people using services' satisfaction, number of referrals and shared care packages. The aspiration was to move more of the funding out into that sector.
- There is detailed contract review in ASC and there have been developments already such as the shared dashboard for reablement / similar services, in line with the whole system review of intermediate care and reablement
- There was some confusion among staff in terms of differentiating between many of the services available. This included the community response team, the integrated care team and the Human Support Group social care reablement service, which all delivered very similar services but were commissioned by different organisations. There had been a system-wide review in 2015 but no subsequent pooling of resources of these teams to allow for differentiation of roles of the teams. However, some work had been undertaken in terms of bringing the teams to be colocated with daily meetings.

Contract oversight

- There was some evidence of an established system of contract review in adult social care and some developments for review of services which encompassed both health and social care, such as a shared dashboard for reablement services.
- Commissioners for health and social care had systems in place to monitor and respond to performance issues, however, this was in individual organisations rather than as a whole system.
- As an area, the City of York was in the bottom quarter of all local authorities for its CQC ratings for adult social care locations. While no locations were overall rated as inadequate, six residential homes and four nursing homes were rated as requiring improvement, which was a higher proportion than in comparator areas and nationally. This meant people in the City of York were at greater risk of receiving care that required improvement and it limited capacity in the market due to individual choice of better quality care. However, the CQC

ratings for primary medical services were in the top 10% nationally. All GP practices in the City of York had been rated as good overall.

- The CQC area ratings score for core services in acute hospitals was below the median across England and worse than 11 of its 15 comparators. York Teaching Hospital NHS Foundation Trust was the main acute trust that served the City of York and had been rated as required improvement overall. Community health services for adults were rated as good overall.
- The local authority undertook annual monitoring visits of service providers. These were appropriate to the services provided and comprised an observation visit as well as a quality assurance visit, if required. Visits included consultation with the people who were using these services. A report was subsequently shared with the provider to ensure any recommended improvements were made.

How do system partners assure themselves that resources are being used to achieve sustainable high-quality care and promoting people's independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high-quality care and promoting people's independence.

There were not robust processes in place for the system to be assured that resources were used to achieve sustainable high-quality care. There was a shared vision articulated in the Better Care Fund, however spending in the health and social care systems did not reflect joint priorities. A full safeguarding peer review had been completed which identified there were limited resources in relation to safeguarding.

- There were not robust processes in place for the system to be assured that resources were being used to achieve sustainable high-quality care. Spending in health and social care systems did not reflect joint priorities. Although there was a shared vision that was articulated in the Better Care Fund plan, this did not translate into shared granular operational plans. System leaders dealt with financial pressures by engaging in commissioning strategies to support their own priorities and did not fully consider how priorities could be addressed jointly to achieve the best outcomes for people using services. There was a lack of trust at senior leadership level due to historical financial deficit at CCG level.
- The BCF plan aimed to commission specific services and schemes to build capacity where it is needed most. However, resources in the City of York are stretched, limiting the scale and scope of developments. Commissioners and providers worked together to review the effectiveness of previous schemes to ensure value for money when preparing for the 2017/19 plan. The older people's community services contract was re-commissioned and awarded to

Age UK, from the City of York Council and CCG base funding, outside of the BCF.

- The Health and Wellbeing Board undertook a piece of work to look at the cost of care with an independent care group which represented a large percentage of the care providers. There were challenges for the health and social care system, which included the loss of local authority funding and the significant financial deficit of the CCG. This was reported to have made the negotiations of the BCF challenging, however this also showed improved relationships across the system for the agreement this year.
- System partners did not have assurance that resources were being used effectively within safeguarding. This was evident within a full safeguarding peer review completed in early 2017, which showed that safeguarding work was very stretched due to a lack of resources. There had been a significant rise in the number of referrals over previous years, seeing a rise from 800 to 1200 referrals over a four-year period. Of these only 300 were identified as valid referrals, but it was recognised as a timely process to review each of them.
- Some work was being undertaken to evaluate new initiatives to ensure they were an effective use of resources, for example the local area coordinator pilot, social prescribing, falls pilot and future focus test sites.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in the City of York safe?

There were some services in place designed to maintain people safely in their usual place of residence, however there was not a consistent approach to this and no single point of access. Maintaining the wellbeing of a person in their usual place of residence was seen as a key priority in the City of York. However not all initiatives provided a seven-day service. Although GPs referred fewer people into A&E in the City of York, a higher proportion of these referrals were discharged without follow up indicating that they could have been better supported elsewhere.

There were plans in place to further support people to remain in their usual place of residence, including the future focus plan, which was an adult social care transformation programme designed by the local authority with a focus to prevent, delay and manage care needs differently.

- There were some initiatives in place in the City of York to maintain people safely in their usual place of residence. For example, the integrated care team had been established using monies from the Better Care Fund (BCF) and the focus for this team was to maintain people in their usual place of residence. The team had daily multidisciplinary meetings, which included GPs. However, we were advised that the focus of the team was on delayed transfers of care rather than admission avoidance. This team had full IT access to all relevant systems in the City of York to ensure they could view a full medical history for each person using services. At the time of our visit, front line staff reported this team did not provide a seven-day service, although we were informed after the review that seven day services were provided.
- Urgent care practitioners (UCP) had been commissioned by the CCG to predominantly focus on keeping people safe in their usual place of residence. Data supplied by Yorkshire Ambulance Service NHS Trust showed the non-conveyance rate for people who had been seen by an UCP was 77.4% compared with 43.3% of calls who had not seen an UCP.
- Our analysis showed that between January and March 2017 a lower percentage of people aged over 65 years living in the City of York who attended A&E had been referred there by a GP, compared with comparator areas and the national average. Despite this, a significantly high percentage of those in the City of York referred to A&E by a GP were discharged from A&E without follow-up (34% between January and March 2017 compared to 17% nationally and 18% across comparator areas). Potentially, this meant that more of those referrals could have been managed in the community, at or closer to people's usual place of residence.
- The development of asset-based community social work demonstrated positive benefits of the future focus model. The future focus model was an aspiration at the time of our review and was an adult social care transformation programme designed by the local authority with a focus to prevent, delay and manage care needs differently by working with residents to safely maintain independence and promote resilience through conversations, contacts, information and support in adult social care. This would ensure more residents would be able to remain safely in their usual place of residence. However, this model was in its infancy so no positive impact could yet be demonstrated.
- Data from the asset-based community social work showed that 38% of people who received a home visit from the intensive support service did not go on to need a service. A recent pilot identified that 100% of respondents said the advice and information had made a positive impact.
- A new system-wide safeguarding policy had been written in the City of York. Work was currently underway to roll this out across the system. All the care homes in the City of York

had a contract with the local authority which included safeguarding and liaison with the safeguarding team.

- Within the case tracking we found some evidence that people at increased risk of falls had been referred to the falls clinic but the majority of cases reviewed did not show any indication of how frailty or people at risk had been identified within the community. This was a more significant risk as the hospital staff could not see GP records.
- There was a lack of sharing of IT systems within the City of York. We saw that GPs working in urgent care frequently had no access to any medical records for the people they were seeing. This presented a particular challenge in terms of identifying what medication the person using services had been prescribed.

Are services in the City of York effective?

The strategic vision for the future for the local authority provided a positive narrative and outlined new ways of working to improve the outcomes for the people of the City of York. However, we found there was not a seamless approach to information sharing with several IT systems in operation across the City of York. There was a lack of service provision for GPs outside of core working hours. Access to the out of hours GP services was via appointments made from the 111 service. There were several similar community services which caused confusion for frontline staff.

- Data from March 2017 showed there were no GP practices in the City of York offering full provision of extended access to GPs (the comparator average was 16% and national average 22.5%), although a comparatively high percentage (73%) offered 'partial' provision. A more nuanced, patient-weighted analysis of this data showed that the availability of extended GP access in the City of York was only a little below the level across comparator areas and the England average (46.7% compared to 48.6% and 49.6% respectively). Nevertheless, this presented a risk that if people could not access their GP they would use A&E as an alternative.
- We attended an urgent care centre, which had GP input and an out of hours GP service. We found these services were effective in diverting people away from A&E services and had a low admittance rate to hospital. However, referral into the out-of-hours service was via the 111 service and we saw evidence that there were sufficient numbers of appointments available to meet the demand. It was difficult for people who use services to make any routine appointments to see a GP, out of work hours, which was significant given full employment rate in the city.
- There was confusion among service users, their families and carers and providers in terms of alternatives to going to see a GP. A number of residents of the City of York did not know whether there was a walk-in centre or minor injuries unit in the City of York. Additionally, there was also confusion among staff in terms of differentiating between some of the

services available, including the community response team, the integrated care team and the Human Support Group (HSG) social care reablement.

- The average level of GP funding per patient in the City of York was £154.10 for the period 2015/16. This was much higher than the comparator averages (£142.63) and the national average (£139.64). The GP funding in the City of York had increased in the previous three years.
- The development of an asset-based community social work programme demonstrated potential positive benefits of the future focus model. This would ensure more residents would be able to remain safely in their usual place of residence.
- A five-year contract for community response, social alarm and telecare services had been commissioned by the local authority. This was predominantly targeting admission avoidance. This service focused on maintaining people in their own home through a community alarm service providing bespoke technology solutions and equipment. The service provided self-funded customers weekly visits for 12 weeks, wellbeing visits and would identify any changing circumstances which they would subsequently report back to adult social care. Non-self-funding customers in receipt of reablement were offered received four weeks' service free of charge.
- Within the BCF 2017/19, there were plans to increase seven day services to enable people to remain in their usual place of residence. There was a plan to increase the service provision of the rapid assessment and treatment service (RATS), which provided support for the hospital rapid assessment team. Additionally, there was the 'ways to wellbeing service', a social prescribing service, delivered by York Council for Voluntary Service in partnership with the local voluntary and community sector. It was envisaged that the service would reduce the use of GP appointments for social issues.
- In both 2015/16 and 2016/17 a slightly higher rate of people aged 65 and over in the City of York had their long-term support needs met through admission to a residential or nursing home compared to the national and comparator averages (648 per 100,000 in the City of York in 2016/17 compared to 615 across comparators and 611 nationally).
- A utilisation management review commissioned by the Vale of York CCG identified the system to be "hospital centric". The review was undertaken by Greater Manchester Academic Health Science Network and was commissioned to illuminate contributors to reduced performance at York Teaching Hospital NHS Foundation Trust in order to support a focussed action plan to improve and sustain acceptable level of A&E performance. The review found that the "hospital-centric" nature of the system was partly due to limited community-based alternatives. However, when producing its Medium Term Financial

Strategy, the CCG identified that in 2016/17 it was forecast to spend 5% less on acute care per head than the Sustainability and Transformation Partnership (STP) average.

- The rapid assessment team was a well-established, integrated health and social care team made up of social workers and therapists who worked alongside medical and nursing colleagues to prevent the need for older people to be admitted to hospital. This service had recently been expanded to work from 8am to 8pm, seven days per week. The team reported avoided admissions for 80% of the people they reviewed out of a total of 2039 people seen between April and October 2017.
- Within the response to the SOIR, system leaders told us they needed to improve the level of take up of direct payments and personal health budgets and that this was recognised as a key challenge for the area. The CCG identified it faced a challenging target for personal health budgets, which were focused primarily on continuing health care (CHC) and it was felt many providers and staff did not widely understand them. There was no coherent plan to increase the uptake of more personalised options for purchasing care and supporting the informal workforce in the City of York. However data showed there was a larger number of personal health budgets in the City of York compared to both the national and comparator areas (5.82 per 50,000, compared to 1.52 and 3.28 per 50,000 respectively). Additionally, there were a lower number of direct payments in the City of York compared to nationally (3.82 per 50,000, compared to 5.82 per 50,000 nationally). Data for the first quarter of 2017/18 showed the rate of personal health budgets per 50,000 people in the Vale of York CCG was 2.42 direct payments per 50,000 population in the Vale of York CCG in quarter one of 2017/18, which was below the England average of 3.63 per 50,000 population.
- The housing workforce plans aligned strategically with the wider prevention agenda. An older person's housing options worker had been appointed, funded through the housing budget. Their role was to advise and support older people to secure housing that meets their needs, enabling them to live independently for longer. The housing team had been restructured to enable an increased staff resource on the front line, which supported local area coordination. Furthermore, additional occupational therapists had been employed to facilitate more timely assessments for adaptations.
- An NHS England initiative 'react to red' had been piloted with four care homes in the City of York. Within this initiative, pressure ulcer prevention awareness training was delivered within the homes with a focus on prevention. There was a plan to extend this initiative to domiciliary care and carers at home and to roll this out across all 45 care homes providers in the Vale of York. The initiative was planned to be cascaded over a six-month period with an aim to have engaged all homes in the Vale of York CCG by May 2018. There was no formal plan to roll this out to domiciliary care agencies at the time of our review. Our analysis of hospital admissions from care homes for pressure ulcers between October

2015 and September 2016 showed there was a lower rate of admissions per 100,000 population aged 65+ compared to comparator areas or the national average (89 per 100,000 in the City of York, compared to 154 across comparators and 161 nationally).

Are services in the City of York caring?

There was a real commitment to provide people with a person-centred approach to support and care that enhanced their sense of wellbeing. There was mixed evidence to show whether people were well engaged in decisions made to support maintaining the person in their usual place of residence. The voluntary and community sector was well engaged and provided a range of services designed to maintain people in their usual place of residence.

- The voluntary and community sector was active and well engaged in the City of York and provided a range of services designed to maintain and improve people's health, well-being and independence. However, there was more that could be done to bring information about these services together in one place for people to access. For example, we heard that people were contacting statutory services for needs that could be met in the voluntary and community sector. There were plans in place to improve access to information and advice and refresh a directory of services, alongside plans to expand the community connector role across the city.
- Additional work was also undertaken by the City of York, in line with national work, to gain the views of older people using services, which included an annual social care survey, the carers' survey and specific individual pieces of work such as a review of advice and information services in 2016, by an external partner.
- Healthwatch York had produced recent guidance for people living with dementia detailing information about groups and clubs for people living with dementia and their carers including music and singing groups, reading groups and physical activity groups. The City of York Council provided funding for a co-ordinator for the York Dementia Action Alliance, which had an action plan with 4 work streams. These work streams reflected the themes that emerged through the Joseph Rowntree Foundation work on living well with dementia, and the work they funded Healthwatch York to do, gathering the views of people with dementia on how to make York a more dementia friendly city. However, while there was a North Yorkshire wide dementia strategy in place developed with large numbers of residents across the county, its main focus was on North Yorkshire County Council and it did not appear to have local ownership or accountability that applied to implementation specifically for the people of the City of York.
- ASCOF data showed the proportion of people aged over 65 years using adult social care services who said they were satisfied with their care and support had declined from 67 in 2013/14 to 61% in 2016/17. This was lower than both the comparators and nationally (both 62).

- NHS Outcomes Framework data 2011-17 showed the experience of health-related quality of life for people with long-term conditions in the City of York was consistently better than comparator areas and nationally (0.74 in the City of York, compared to 0.69 nationally and 0.73 in comparator areas). Although this did drop more in line with comparator areas in 2016/17.
- The new local authority housing scheme reflected local needs, focusing on high quality, non-segregated provision for people living with dementia and a range of health and social care services and opportunities for social interaction built into the scheme. For example, through community and sporting spaces that will support people to live independently.

Are services in the City of York responsive?

Services in the City of York were responsive and had been developed and delivered to proactively maintain people in their usual place of residence, particularly if their usual place of residence was a care home setting. However there was evidence to suggest there was an increased focus on delayed transfers of care rather than admittance avoidance.

- The rate of attendances at A&E for people over the age of 65 who lived in care homes in the City of York were consistently below national and comparator averages (810 per 100,000 aged 65 and over in the City of York in the last quarter of 2016/17 compared to 920 across comparators and 979 nationally). Emergency admissions for people over the age of 65 who lived in care homes was slightly below levels across comparator areas and nationally during the last quarter of 2016/17 and had been frequently below national and comparator averages since the start of 2014/15 (706 per 100,000 population aged over 65 years in the City of York between January to March 2017, compared to 722 in comparator areas and 713 nationally over the same period). This indicated more people were able to be maintained in their usual place of residence, when this was a care home setting.
- Hospital Episode Statistics data showed that, in the last quarter of 2016/17, the percentage of older people who attended A&E as a result of being referred by their GP was below than both comparable areas and the national average (6% in the City of York, compared to 8% in comparator areas and nationally). However, the percentage of those people who were then discharged from A&E without being admitted to hospital was significantly higher (34% in the City of York, compared with 17% nationally). This suggests that, although fewer referrals were made by GPs, less of these needed acute care and could have potentially been managed in the community.
- A local area coordination service had been designed with the City Of York council monies to support people who were vulnerable due to age, frailty, disability or mental health needs. Local area coordinators used an asset based approach to enable people to access and engage in their community. At the time of our review, there were only three

coordinators in post but the plan was to expand this service further. As the service was new, there were no evidence metrics available at the time of our review to demonstrate the effectiveness of this service.

- Some services established with a remit of maintaining people in their usual place of residence had more of a focus on delayed transfers of care rather than admittance avoidance. An example of this was the 'One Team'. This team had recently been established which united the intermediate care and reablement teams to enable people to remain in their usual place of residence. However, the focus at the time of our review for the 'One Team' was on delayed transfers of care rather than community work or admission avoidance. Additionally, the team identified they prioritised delayed transfers of care for reablement rather than maintaining people in their usual place of residence.
- No health checks for people aged over 65 years were undertaken during 2015/16. This service had previously been provided through GPs but had moved over to public health in April 2017. Public health officers were completing the health checks at the time of our review as part of the integrated wellbeing service and were targeting people who had been identified as the most high-risk. The officers then had an ongoing relationship with the person as part of the 'your wellbeing' in house service. At the time of our review, 435 face to face health checks had been completed against a target of 1000 in the first year. Fewer health checks presents a risk as it indicates that people are not being as supported as they could be to prevent or identify ill health that may lead to future hospital admission.
- The ambulatory care unit opened in York Teaching Hospital NHS Foundation Trust in 2016. People managed by the ambulatory care unit could be referred following A&E presentations, directly from GPs or attending for return treatment and checks. Data from the unit suggests 90% of people were discharged with some treatment, which enabled them to remain in their usual place of residence. Our analysis of data for October 2015 to September 2016 showed there were fewer admissions in the City of York for urinary tract infections (UTIs), pneumonitis, decubitus ulcer and other lower respiratory tract conditions compared to national and comparator averages, however there were more admissions for pneumonia and diagnoses associated with accidents and injuries.
- The emergency response service was visiting people in crisis, for example by responding to falls. If they identified additional needs they referred into social services, the urgent care practitioners or primary care services.
- The medicines management team were a very under-resourced team with no specific focus on the frail, older person. There was one part time head of pharmacy employed by the CCG with a further four shared across four CCGs in North Yorkshire. As a result of this, no preventative work was being undertaken in terms of medicines optimisation or admission avoidance.

- There were well established networks for engaging local people in the design, planning, commissioning and evaluation of services. The Health and Wellbeing Board consulted widely when developing the joint health and wellbeing strategy and the ageing well theme. The ageing well forum was responsible for the strategy and led on its implementation. Despite this, there was a lack of a joined-up approach to the voluntary sector where people could navigate the system and access the appropriate support for them.
- There was an annual charge for arranging domiciliary care and support for people who were self-funding, which was £284. A local review of 24 other local authorities' annual administration charges found that the York were at the higher end of the spectrum with most local authorities choosing not to charge. There were 163 self-funders in July 2017.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in the City of York safe?

The bed occupancy in York Teaching Hospital NHS Foundation Trust was consistently above the optimal 85% level in each quarter of the 2016/17 year, which meant people of the City of York were at increased risk of harm. People living with dementia faced increased lengths of stay due to a lack of availability of nursing and care home beds to accommodate their needs. Mixed feedback was received in relation to the experience of people living with dementia when they required hospital services.

- Residents of the City of York received very similar lengths of hospital stays as people nationally but those people admitted from a care home were able to return to their usual place of residence quicker than people could expect nationally. Hospital Episode Statistics data for between 2014/15 and 2016/17, showed the percentage of admissions that lasted longer than seven days for people aged over 65 years was similar to comparator and national averages (31% for the City of York in the last quarter of 2016/17, compared to 31% and 32% respectively). However, the data for admissions from care homes over the same time period showed that a lower percentage lasted longer than seven days which compared to comparators and national average (33% in the last quarter of 2016/17, compared to 39% and 36% respectively).

- A shortage of available hospital beds meant that people could not be transferred from A&E as quickly as they needed to be. Data showed that bed occupancy at York Teaching Hospital NHS Trust was comparable with the England average throughout much of 2016/17, but consistently above the recommended optimal 85% level. Hospitals with average bed-occupancy levels above 85% deliver reduced quality of care and are likely to face regular bed shortages, periodic bed crises and increased numbers of healthcare associated infections.
- At the dementia involvement focus group, we received negative feedback about the experience of people living with dementia and their carers when someone was admitted to hospital. This included the apparent lack of knowledge and understanding by hospital staff about dementia, delayed transfers of care, mental capacity assessments not always being appropriately undertaken and the inconsistent use of the 'dementia flower' (forget-me-not) in hospital. However, we saw evidence from the trust that they used 'John's campaign' to help encourage the carers of patients living with dementia to become involved in their loved ones care. This included a pledge to involve carers in the care of people living with dementia if they wanted to be involved during any hospital stay.
- Frontline staff identified there was a lack of availability of beds within a community setting for people living with dementia which led to them being admitted to hospital when there was not an identified need for acute care. We were informed there were five emergency respite beds, commissioned by the CCG but these were very difficult to access due to very strict criteria, including the requirement to have a specified level of mobility and cognition. These beds could be accessed via A&E and the community response team but front-line staff felt the number of beds was too few, which led to access being difficult and only worked for a small number of people using services.
- A speciality doctor was employed in A&E on weekdays to help identify frail, older people. This service received positive feedback from staff and people using services. Although we were told by the Trust that there was cover for this post for annual leave and out of office hours from the wider medical team we were provided with no evidence of this and staff told us they were not aware of any such cover. The service also reported to have challenges around links back to primary care for advanced care planning in the community. There was a lack of an elderly frailty framework for supporting and identifying a community response when eligible people had been identified.
- While our analysis showed the rate of A&E attendances of people aged over 65 years from the City of York was consistently below the national average from the beginning of 2014/15 through to the end of 2016/17, analysis from the Department of Health as well CQC's analysis showed that emergency admissions to hospital for older people in the City of York were consistently higher than national and comparator averages (26,056 per 100,000 between March 2016 and February 2017 compared to 24,092 nationally, and 24,099 across comparator areas). This means that, although fewer people aged 65 and over were attending A&E in the

City of York, those who did attend were more likely to require admission to hospital. The total rate of A&E attendance in 2015/16 for people aged over 65 in the City of York was better than the national average (87 per 1000 people, compared to 105 per 1000). However, analysis from the Department of Health showed emergency admissions in the City of York were consistently slightly worse than the England and comparator averages (26,056 per 100,000, compared to 24,092 nationally).

Are services in the City of York effective?

There was no single shared case record in the City of York, due to several IT systems in operation that were not interconnected. There was an opportunity for system partners to work more collaboratively when a person was in hospital to ensure people were assessed holistically in order to meet their needs. Where a multi-disciplinary team had been co-located in the hospital setting, this was working well and enabled people to move through the system more effectively. However, the multiple and confusing pathways meant staff did not always know who to refer to, particularly out of hours.

- NHS England's Ambulance System Indicators showed that, between May and July 2017, the percentage of 999 calls that had been resolved by providing telephone advice and no ambulance was required was comparable to the national average (9-10% in the City of York, compared to 10% nationally). However, the data showed the proportion of 999 calls who were seen by an ambulance crew but were not taken to A&E were below the national average (31% in the City of York, compared to 38% nationally). This meant there was a potential opportunity for more people to be managed at home without the need for conveyance to hospital.
- There were several IT systems in operation across health and social care in the City of York; these were not interconnected. This meant there was no single shared case record. Some work had been undertaken to give professionals access to other systems but gaps remained. An example of this was that the hospital could only access a summary care record from the GP system, which gave very basic information of that person using services.
- Within case tracking we saw the impact of the lack of sharing of IT systems where we identified a person using services who had a significant medical history, including alcoholism and a do not attempt cardio-pulmonary resuscitation in place. The hospital was unaware of this when the person was admitted following a fall and vomiting.
- There was a lack of collaborative working across the health and social care interface when a person was admitted to hospital. We found that domiciliary care and care home providers were not kept up to date with the person's condition and we saw evidence they were not always involved in discharge planning.
- We heard from people who use services that sometimes when people were admitted to

hospital there was a lack of communication with adult social care providers, which resulted in people continuing to be charged for their care which had caused one person using services “a great deal of distress”.

Are services in the City of York caring?

We saw the voluntary sector were active in supporting people living with dementia while in a hospital setting. There were inconsistencies in how people were engaged with in terms of their future plans.

- There was no single shared case record within the City of York system. This resulted in people having to repeat their story. There was a poor history of shared data and business intelligence.
- Within York Teaching Hospital NHS Foundation Trust there was evidence of strong support from dementia voluntary services to ensure people were kept engaged and active whilst in the hospital setting. We saw evidence of the ‘John’s campaign’ in hospital to encourage carers to be involved with their loved ones.
- From the medical records we reviewed, we found evidence that families and loved ones were kept well informed and were part of decision making about future plans. However, from our discussions with carers, we heard they felt the hospital was operating in an inconsistent way and they felt there was a lack of communication or coordination.

Are services in the City of York responsive?

People who were in crisis were not always able to have their needs met at the right time and place. People were waiting in A&E longer than the national average. There was a lack of evidence of effective discharge planning and examples of where people had been admitted to hospital where they could have potentially been managed within their usual place of residence.

- At York Teaching Hospital NHS Foundation Trust, 86.4% of people were seen within four hours in the A&E department during 2016/17, which was worse than the national average of 89.1% and the national target of 95%. This meant more people were waiting longer in A&E than the national target and national average.
- Hospital admissions for people aged over 65 years that lasted longer than seven days was slightly fewer people in the last quarter of 2016/17 compared to the national average (31% in the City of York, compared to 32% nationally). This was a rise from the previous two quarters (28% in quarter two and 27% in quarter three in the City of York, compared to (31% in quarter two and 30% in quarter three nationally).
- The A&E department commenced front door streaming in July 2016 which triaged ‘walk-in’ people using services to the right place, such as a medical ward, a GP in the urgent care

centre, community pharmacy or social care. We saw evidence this was working responsively and more people were being treated in the most appropriate setting.

- On review of case records at York Teaching Hospital NHS Foundation Trust, we saw evidence of potential admission avoidance had people been identified in the community as “at risk” earlier. Examples of this included deterioration of mobility and a person experiencing difficulties with bereavement. We also heard from frontline staff where they agreed people were admitted inappropriately and admission could have been avoided, given the correct level of support in the community. We heard of one person using services who had been in hospital for over a year who had been admitted with a social issue.
- A lack of evidence of discharge planning was seen in the medical records reviewed, where we saw no expected date of discharge in any medical record. As part of our review, we reviewed 13 sets of records.
- As part of our call for evidence to stakeholders we heard there were concerns around restructuring of adult services and it was felt there was “too much chasing to get support in times of crisis”. One of the suggestions made was to have a qualified member of social care staff dealing with initial enquiries. It was felt this would prevent people from joining a waiting list and instead enable them to access the advice they required in a timely manner.
- Assistive technology was playing a role in responding to people in a time of crisis to prevent their admission to hospital. The social enterprise ‘Be Independent’ was providing an emergency response service to people who had fallen and, if further needs were identified, would refer the person into community services. They also held a contract with the ambulance service whereby the ambulance could redirect non-urgent cases of people who had fallen to them, to be responded to in a more timely way.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in the City of York safe?

Some systems and processes were in place to ensure that safety was not compromised when a person returned to their usual place of residence or alternative setting. The hospital was not at full provision for seven-day services, which could lead to delays in discharge. There was a new system-wide safeguarding policy, which was being rolled out. There was evidence to show the integrated care team had reduced the length of stay for people using their services ensuring they were discharged in a timely manner.

- The hospital was not providing full seven day services. A pathways manager had been recruited by the local authority to focus on improving seven day discharges from hospital. This was being funded by Better Care Fund monies. Analysis undertaken by Department of Health showed that just 17% of people aged 65 and over who were admitted to hospital as an emergency were discharged over the weekend, which was lower than all but one of the City of York's comparator areas. We were told that there were various reasons for this, including lack of senior medical cover at weekends, care home and nursing homes not accepting new discharges due to historical challenges with inappropriate discharges at weekends and a lack of availability of care packages.
- The integrated care team had reduced excess bed days by 33% for people who had been using their services prior to hospital admission between 1 April 2016 to 31 March 2017. The team identified people using services who were at increased risk and facilitated their discharge out of acute care to be supported in a preferred place of residence. A social worker was part of the daily multidisciplinary team meetings.
- Hospital Episode Statistics data showed that in the last two quarters of 2016/17 the percentage of emergency readmissions within 30 days of discharge for people aged over 65 years was above national and comparator averages, but not drastically so (18.9% in the City of York compared to 18.6% nationally and 18.1% across comparators).
- Hospital Episode Statistics data showed that emergency readmissions to hospital from care homes for people aged over 65 in the City of York had fluctuated above and below the national and comparator averages from 2014/15 to 2016/17 and in the last quarter of 2016/17 they were just below national and comparator averages (18% in the City of York compared to 19% across comparator areas and 20% nationally).

- An independent provider was commissioned by the local authority to provide equipment, telecare and assistive technology for the people of the City of York. This provider worked two days per week on the wards at York Teaching Hospital NHS Foundation Trust to proactively support people onto the telecare scheme and offered the first four weeks' service free of charge.
- There was a lack of evidence of any formal frailty pathway in place across the system and no formal audit in relation to how step-down beds were utilised.
- A web-based pharmacy tool that supported discharge from hospital was in place which enabled community pharmacists to identify medicine changes following discharge.
- Within a focus group for services that supported people, we heard concerns expressed in terms of how people were discharged from hospital including the discharge to assess pilot project. An example was given of a person living with severe mobility challenges who was admitted to hospital with a fracture, the discharge to assess assessments were completed approximately two to three weeks after discharge home.
- A priority for the City of York local authority was to improve overall accommodation in the City of York area and close some of the smaller City of York care homes through the older people's accommodation programme. There was a 'moving homes safely protocol' in place and the local authority tried not to move anyone more than once.

Are services in the City of York effective?

People of the City of York experienced delays in receiving reablement services. There was a reluctance to discharge people over weekends from medical wards, which was predominantly due to a lack of service cover by key system partners.

- Take up to reablement services in the City of York was significantly lower than the national average. Analysis of ASCOF data showed the percentage of older people offered reablement services following discharge from hospital had been significantly lower in the City of York compared to the national average since 2011/12. While in 2015/16 the percentage increased to 2.2% this was still below the national average of 2.9% and comparator average of 3% and data for 2016/17 shows the percentage then dropped again in the City of York to 0.8%, significantly lower than the national average of 2.7% and lower than the comparator average of 2.8%.
- Reablement services were not effective in the City of York with 87.6% of people who received a reablement package through the City of York local authority in 2016/17 still requiring either long term support or further reablement. Our analysis of ASCOF data suggested not only that a significantly low proportion of older people discharged from hospital in the City of York

received reablement, but of those that did, a comparatively low percentage were still at home 91 days after discharge from hospital into the reablement service. Data for 2016/17 showed that only 79.2% of people aged 65 and over discharged from hospital into reablement services were still at home 91 days later, compared to 82.5% nationally and 84.5% across comparator areas.

- Pharmacy, diagnostic and transport services were available during evenings and weekends. Age UK home from hospital operated seven days per week and into the evening.
- There was an apparent reluctance from medical staff to discharge at weekends from the medical wards. This aligns to the Department of Health analysis which showed the percentage of older people admitted as emergencies and were discharged at the weekend was below most of the City of York's comparator areas between March 2016 and February 2017. There was a variety of reasons given as the rationale for this, including no access to reablement at weekends, a lack of seven-day social care working, challenges obtaining new packages of care and lack of senior medical cover.
- There were plans within the hospital to create a discharge hub. This would be a one team approach for continuing healthcare, adult social care discharge liaison and patient flow. This would be one point of referral from the ward. There were plans for this to be operational as soon as possible but this was still in planning phase at the time of our review.

Are services in the City of York caring?

People eligible for CHC funding were identified appropriately in the City of York but a recent review had identified that there was some lack of awareness from health and social care staff into CHC and personal health budgets. There was a lack of awareness into continuing healthcare funding amongst front line staff and it was felt these were not always focused on the person using services.

- Processes in the City of York for identifying people eligible for CHC were effective. Continuing healthcare (CHC) funding was provided by the CCG. The NHS CHC figures for all adults showed that in quarter one of 2017/18 both the referral conversion rate (percentage of newly eligible cases of total referrals completed) and assessment conversion rate (percentage of newly eligible cases of total cases assessed) were much better in the City of York than the England average. Assessment conversion rate for standard NHS CHC in the Vale of York CCG was 88% compared to the national average of 31% while the referral conversion rate was 59% against the national average of 25%.
- From a local Healthwatch York review into CHC issues between 2014/16 it was concluded that some health and social care staff lacked awareness about CHC and personal health budgets and were therefore unable to provide adequate support to people using services, their families and carers. It was also felt that the CHC assessments were not always person centred.

- Within information received from providers it was felt that, due to a poor referral service, stretched resources and the lack of a single point of communication, people frequently remained in hospital beds unnecessarily and could potentially suffer from secondary issues which escalated their needs. It was felt that a single point of communication would enhance the discharge planning process and early referral for appropriate agencies should be actioned.
- The discharge lounge was supported by Age UK, who offered a wheelchair or car service home. This service had received positive feedback. The service also supported the person to settle in at home, ensuring heating was on and the person had basic items, such as bread and milk.
- There was a public reference group helping with the design of the new communications for the changes to the reablement service. The group was helping to develop new information leaflets that were jargon free to improve the experience of people using the service.

Are services in the City of York responsive?

People using services were not always receiving the right care in the right place, at the right time. Systems processes and services were in place to support the transition of people to their usual place of residence or alternative setting, but there was insufficient capacity to meet demand. The lack of seven day working meant a significant number of people were not being discharged at weekends.

- We heard from stakeholders across roles that there was scope to improve the timeliness of completing CHC assessments and decision making. However, data for the whole of the Vale of York CCG showed that the number of referrals exceeding 28 days for standard NHS continuing health care (non-fast track) during quarter one of 2017/18 were much better than the national average (2.59 per 50,000 population, compared to 10.27 per 50,000 nationally).
- For the period February to April 2017, the delayed transfers of care for the City of York had been in line with both the England and comparator areas (14 per 100,000 for the City of York, comparator areas and nationally). However, the rate of delayed transfers of care in the City of York had been higher for the majority of 2015 and all of 2016. The rate of delayed transfers of care was showing an improving picture. At July 2017, there was an average of 9.1 delayed days per 100,000 population in the City of York, compared to 13.5 across comparator areas and 13.6 nationally.
- Our analysis shows that, in July 2017, most of the delayed transfers of care in the City of York were attributable to York Teaching Hospital NHS Foundation Trust. Delays from the trust had fluctuated only slightly in the previous year. The other main trust contributing to delays in the City of York was Tees, Esk and Wear Valleys NHS Foundation Trust which managed to

reduce its delays greatly over the year, from a position in July 2016 where it was contributing more to delayed transfers in the City of York than the main acute provider (averaging 10 daily delayed days per day in July 2016).

- The biggest reason for delayed transfers of care in the City of York between February and April 2017 was people awaiting a residential or nursing home placement (7.3 daily delayed days per 100,000 in the City of York, compared to 3.6 nationally and 4.8 in comparator areas). This was in part in relation to a lack of care home provision. The second biggest reason was people waiting for care packages in their own home. However, this was at a lower rate than nationally and in comparator areas (2.8 per 100,000 in the City of York, compared to 3.5 nationally and 3.8 in comparator areas). The third biggest reason was the choice of the person using services, their family or carers (2.9 per 100,000 in the City of York, compared to 2.6 nationally and 2.0 in comparator areas).
- The City of York had some challenges with seven-day working and in particular discharging people over the age of 65 years at the weekend. Data from the Department of Health demonstrated that the City of York was lower than the national average and comparators from October 2015 to September 2016 (17.2% in the City of York, compared to a national average of close to 20% with most of the City of York's comparator areas performing better).
- During our review, frontline staff and senior leaders told us that seven-day working remained a challenge in the City of York. There was a lack of consultant cover in York Teaching Hospital NHS Foundation Trust to facilitate weekend discharge. We heard hospices would not take new referrals over the weekend, therefore if a person was identified as end of life and chose the hospice as their preferred place of death; this was not facilitated during a weekend. Additionally, we heard from providers and senior leaders that care homes, nursing homes and new packages of care were unlikely to accept any new people using their services over a weekend. This was due to historic experiences where people using services had been discharged with no medication or discharge letter, which posed difficulties over a weekend. These concerns had been raised in the system, but no changes had been experienced in practice, making the care homes and nursing homes reluctant to accept new residents at weekends.
- There was a plan in place for a new reablement specification to go live in October 2017 to coincide with the development of the integrated intermediate care service. It was envisaged that this would increase the capacity of the local authority's direct contact hours in reablement by approximately 40%. It was envisaged that the service would promote rehabilitation and recovery, enabling people to attain the optimum level of independence through the provision of both personal care and practical support. The aim of this was for people to be able to achieve their optimal level of independence.
- The 'One Team' had enabled a 14% increase in the number of people using services who

were able to access intermediate care (home and bed based) and had increased the proportion of intermediate care delivered at home from 33% to 50%.

- Frontline staff and senior leaders identified there was a lack of residential and nursing home placements in the City of York for people living with dementia and who displayed behaviours that challenged. This meant people living with dementia could experience longer hospital stays whilst a placement was sought.
- The joint protocol for the transfer of care was implemented across the system in May 2016. It identified that steps would be taken regularly to measure the impact of the protocol and measure its impact and effectiveness, including estimated date of discharge, use of letters, complaints, allocation of social worker and MDT assessment. However, no audits had been completed at the time of our review, therefore no assurance had been gained as to the protocol's effectiveness.

Maturity of the system

What is the maturity of the system to secure improvement for the people of the City of York?

- Governance arrangements in the City of York remained largely with individual organisations with limited sharing of performance information across the system. There was limited evidence of shared and agreed performance metrics to inform or support system performance.
- The STP was not perceived as relevant to the City of York. The Health and Wellbeing Board had only recently refocused and as a result individual organisations were working to their own vision and strategies without any meaningful wider system alignment.
- The role of the Health and Wellbeing Board, until very recently, had been underdeveloped and a lack of integrated outcome measures meant monitoring of performance was siloed and in accordance with organisational performance measures.
- Historically relationships within the system had been challenging but these were improving. System leaders demonstrated a growing commitment to working together in a collaborative way.
- The local authority had commissioned a report, with the involvement of external partners, and the recommendations made had been used to stabilise and shape the adult social care market. This included planned investment in community based services, affordable housing and social prescribing to support local people remaining in their own homes. However, this was at a draft stage and had not yet been implemented to assess the impact.

- Market pressures remained a significant challenge for the City of York and the extent to which system leaders worked collaboratively to address them was limited. Initiatives in this area of provision were very much led by the local authority.
- While the BCF had facilitated some integrated working between health and social care, budgets remained very separate. There were still legacy cultural issues particularly in relation to finance and associated risk sharing. Leaders had much to do to encourage trust and support in this regard.
- Developing the capacity and capability of the health and care workforce was recognised as a key challenge for the system posing a potential risk to the future delivery of plans. However, there was no collaborative system-wide workforce strategy.
- There was a local workforce strategy board led by the local authority which had variable attendance from partners. However, there was no system wide workforce strategy or vision. There was limited evidence to show the impact of this strategy at the time of our review in addressing workforce challenges.
- Information governance arrangements were at the early stages of integration. Health and social care used different records systems that often led to confusion and duplication of effort. There was a shared use of NHS numbers although more work was required to fully implement this.
- Although there was a positive approach to prevention in primary medical services and good support at home from the voluntary sector, there was limited evidence of multi-disciplinary team working for effective outcomes. In addition, the lack of clearly defined pathways and a single point of contact meant that people using services did not always experience care and support in the right place at the right time by the right people. As a result, people's experiences varied considerably.

Areas for improvement

We suggest the following areas of focus for the system to secure improvement

- Work should continue at pace to develop strong relationships across the system to address the lack of collaboration and trust between system leaders.

- Work is required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions and for specifying accountabilities and shared governance arrangements, to prevent duplication.
- There needs to be a system-wide response to effectively managing the social care market and domiciliary care capacity.
- An effective system of integrated assessment and reviews of the needs of people using services should be introduced.
- The system should prioritise work towards improved performance against the high impact change model.
- Work should be undertaken to share learning and experience between staff at the interface of health and social care so there is shared trust and so understanding and historical cultural barriers are broken down.
- The full implementation of seven day working should be reviewed across the system to ensure the people of York are able to return to their usual place of residence at the earliest opportunity.
- There needs to be a greater emphasis on moving towards joint commissioning across the system.
- A review of IT interconnectivity should be completed to ensure appropriate data sharing and a more joined up approach across health and social care services.
- Work should be undertaken to communicate more effectively with people who use services, their families and carers to ensure their voice is heard across the health and social care system.
- The system should build in clear evaluation of systems to demonstrate the impact on people and the system overall.
- Medicine optimisation should be fully embedded in the system.
- Continuing healthcare arrangements should be more robust and person centred.