Agenda

Meeting: Care and Independence Overview & Scrutiny Committee

Venue: The Grand Meeting Room, County Hall, Northallerton DL7 8AD (See location plan overleaf)

Date: Thursday 24 April 2014 at 10.30 am

Business

1. **Minutes of the meeting held on 23 January 2014.**

(Pages 1 to 4)

2. **Public Questions or Statements**.

Members of the public may ask questions or make statements at this meeting if they have given notice to Ray Busby Policy & Partnerships *(contact details below)* no later than midday on Wednesday 16 April 2014, three working days before the day of the meeting. Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);
- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

3. **Health & Adult Services Directorate –** Presentation by Richard Webb NYCC Corporate Director – Health & Adult Services.

4. **Integrated Reablement and Intermediate Care Service** – Report of the Corporate Director – Health & Adult Services

(Pages 5 to 15)

5. **Dementia Strategy** – Report of the Corporate Director – Health & Adult Services

(Pages 16 to 20)

Enquiries relating to this agenda please contact Ray Busby **Tel: 01609 532655**
Fax: 01609 780447 or e-mail Ray.busby@northyorks.gov.uk
Website: **www.northyorks.gov.uk**

6. **2020 North Yorkshire** – Presentation by Robert Ling NYCC Technology & Change Manager.

7. **North Yorkshire Draft Alcohol Strategy** – Report of the Director of Public Health for North Yorkshire.

(Pages 21 to 49)

8. **Work Programme** - Report of the Scrutiny Team Leader.

(Pages 50 to 54)

9. **Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances.**

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Nothallerton

14 April 2014

NOTES:

(a) Members are reminded of the need to consider whether they have any interests to declare on any of the items on this agenda and, if so, of the need to explain the reason(s) why they have any interest when making a declaration.

The relevant Corporate Development Officer or the Monitoring Officer will be pleased to advise on interest issues. Ideally their views should be sought as soon as possible and preferably prior to the day of the meeting, so that time is available to explore adequately any issues that might arise.

(b) **Emergency Procedures For Meetings**

Fire
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Persons should not re-enter the building until authorised to do so by the Fire and Rescue Service or the Emergency Co-ordinator.

An intermittent alarm indicates an emergency in nearby building. It is not necessary to evacuate the building but you should be ready for instructions from the Fire Warden.

Accident or Illness
First Aid treatment can be obtained by telephoning Extension 7575.

Care and Independence
Overview and Scrutiny Committee

1. Membership

County Councillors (13)				
	Councillors Name	*Chairman/Vice Chairman*	*Political Party*	*Electoral Division*
1	BURR, Lindsay		Liberal Democrat	
2	CASLING, Liz		Conservative	
3	ENNIS, John		Conservative	
4	GRANT, Helen		NY Independent	
5	JORDAN, Mike		Conservative	
6	McCARTNEY, John	Vice Chairman	NY Independent	
7	MARSDEN, Penny		Conservative	
8	MARSHALL, Brian		Labour	
9	MOORHOUSE, Heather		Conservative	
10	MULLIGAN, Patrick	Chairman	Conservative	
11	PLANT, Joe		Conservative	
12	PEARSON, Chris		Conservative	
13	SAVAGE, John		Liberal	

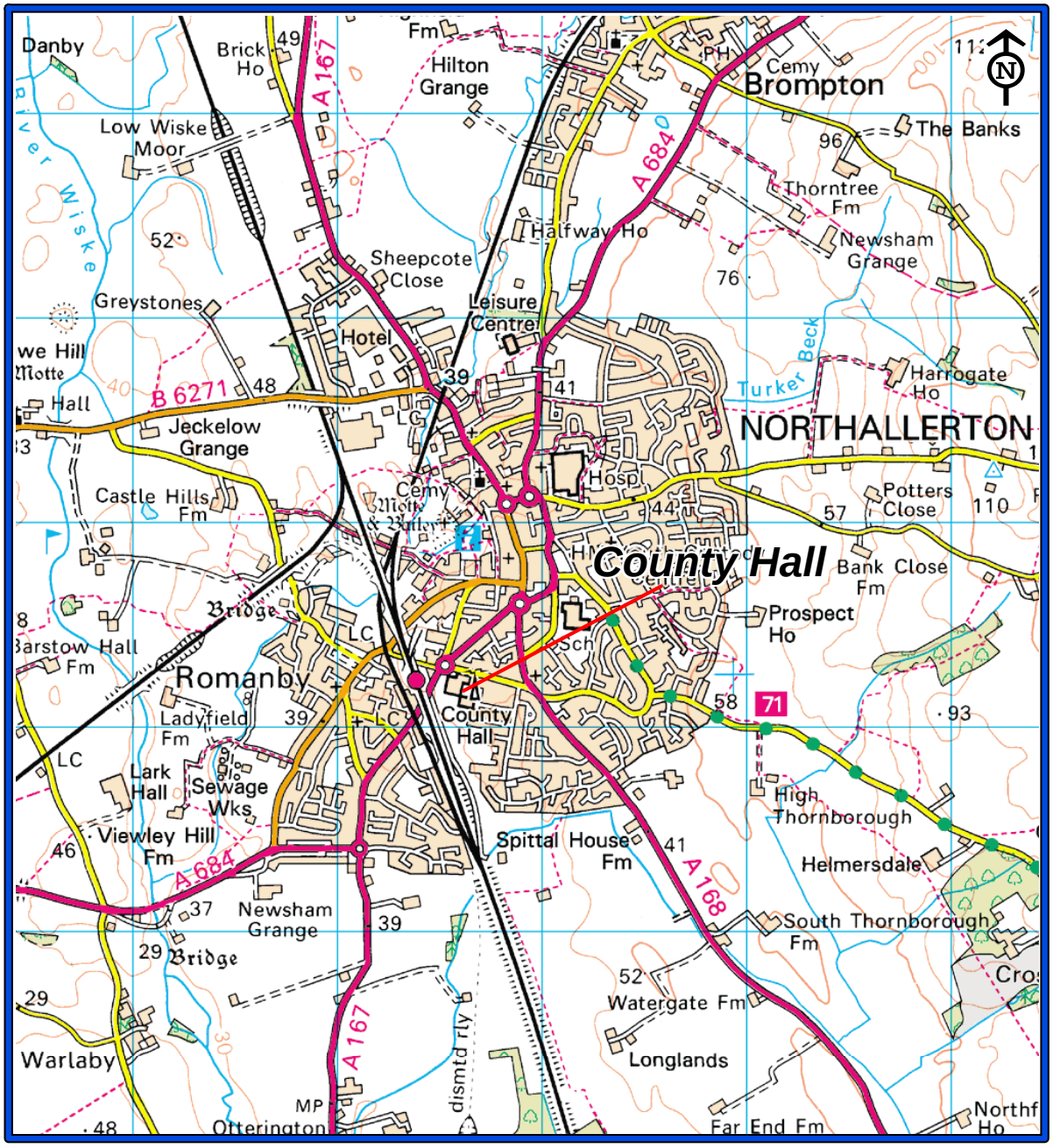
Members other than County Councillors – (2)			
Non Voting			
	Name of Member	*Representative*	*Substitute Member*
1	CARLING, Jon	North Yorkshire and York Forum	
2	SNAPE, Jackie	Disability Action Yorkshire	
3	PADGHAM, Mike	Independent Care Group	

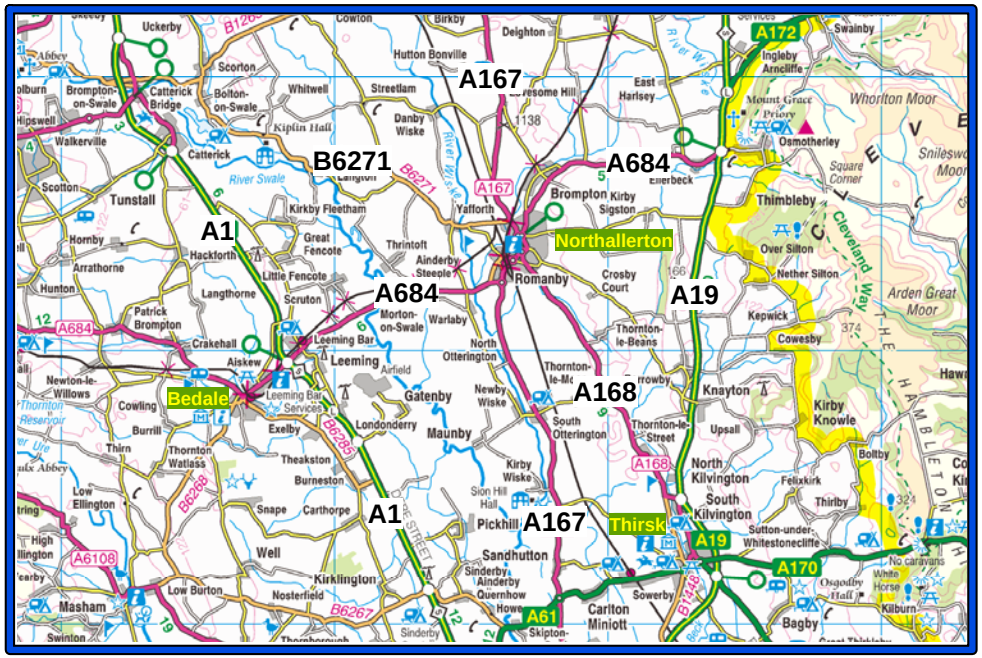
Total Membership – (15)	**Quorum – (4)**

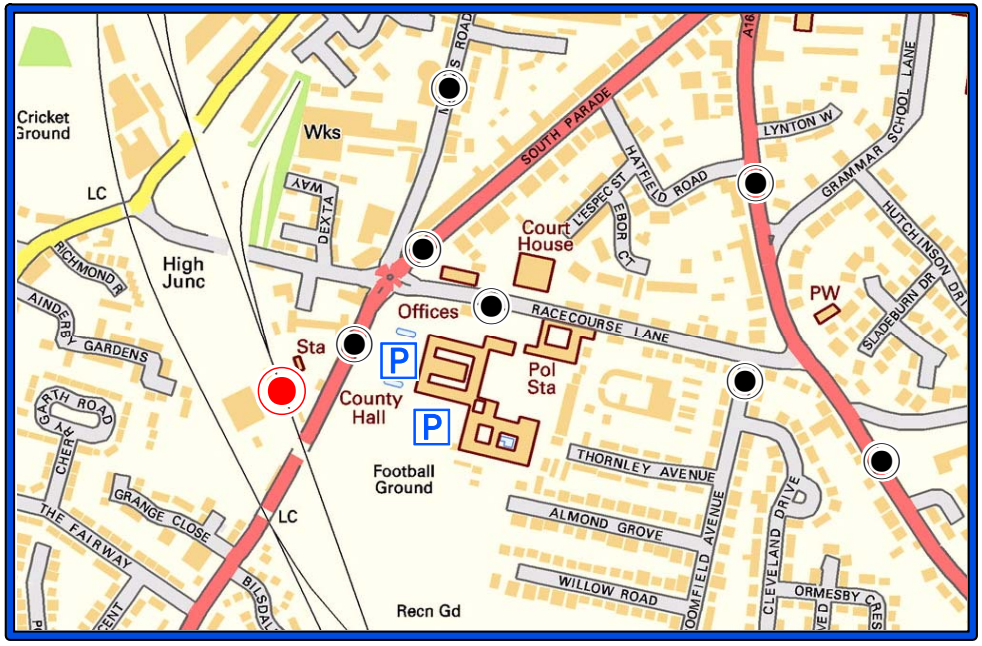
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**1**	**2**	**1**	**1**	**0**	**0**	**13**

2. Substitute Members

Conservative		**Liberal Democrat**	
	Councillors Names		*Councillors Names*
1	MARSHALL, Shelagh	**1**	ENGLISH, Polly
2	CHANCE, David	**2**	GRIFFITHS, Bryn
3	JEFFELS, David	**3**	JONES, Anne
4	BACKHOUSE, Andrew	**4**	
5		**5**	
NY Independent		**Labour**	
	Councillors Names		*Councillors Names*
1	HORTON, Peter	**1**	BILLING, David
2	JEFFERSON, Janet	**2**	
3		**3**	
4		**4**	
5		**5**	
Liberal			
	Councillors Names		
1	CLARK, John		







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North Yorkshire County Council

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

Minutes of the meeting held on 23 January 2014 at 10.30 am at County Hall, Northallerton.

Present:-

County Councillor Patrick Mulligan in the Chair

County Councillors: Lindsay Burr, Liz Casling, John Ennis, Helen Grant, Mike Jordan, David Jeffels as substitute for Penny Marsden, Brian Marshall, Heather Moorhouse, Joe Plant, Chris Pearson and John Savage

Representatives of the Voluntary Sector: Jon Carling (North Yorkshire and York Forum), and Jackie Snape (Disability Action Yorkshire)

Representative of the Independent Sector: Mike Padgham

Officers: Sally Burton (Acting Corporate Director (Health and Adult Services)), Mike Webster (Assistant Director, Contracting, Procurement and Quality Assurance, (Health and Adult Services)), Anne Marie Lubanski (Assistant Director Social Care Operations, (Health and Adult Services)), Ray Busby (Scrutiny Support Officer, (Policy, Performance and Partnerships))

Copies of all documents considered are in the Minute Book

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21. Minutes

Resolved –

That the minutes of the meeting held on 3 October 2013, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

22. Public Questions or Statements

The Committee was advised that no notice had been received of any public questions or statements to be made at the meeting.

23. Making Difficult Decisions in Adult Social Care: Public Consultation on Eligibility and Charging for Adult Social Care

Considered -

Report of the Corporate Director - Health and Adult Services, informing Members of the results of the public consultation in relation to the County's proposals to raise its eligibility criteria for Adult Social Care to make changes to its charging arrangements for Adult Social Care and its approach to preventative services. Members were also asked to give their views on each of the proposals ahead of decisions being made at Executive on 4 February 2014.

The portfolio holder Cllr Clare Wood believed the consultation process had been rigorous. Detailed analysis of correspondence replies was included so that the Committee could take a view and also help advise her appropriately regarding recommendations to the Executive.

Sally Burton reassured the Committee that the Executive report had yet to be written, but it had been possible to produce a high quality report with evidence of the results of the consultation process, and an account of the emerging thoughts which would determine the final recommendations.

Members agreed that, going forward, it would be important for the prevention strategy to be fully developed to support people through social isolation and loneliness. Adult and Health Services was working closely with CCG colleagues on plans to target services where this would make the most difference. The voluntary and community sector were also involved in developing the community based approach.

Portfolio holder Cllr Don McKenzie said it was pleasing that the results of the consultation process had highlighted the importance of prevention, and these comments were endorsed by Members.

Members agreed that it was important the Committee had not been spared any of the detail about the results of the consultation document, or any of the Directorate's emerging conclusions. During a full debate Members commented:

a) Being told that the Executive report had yet to be written and therefore no recommendations had been arrived at, was helpful and reassuring;

b) Both the report of the consultation and the Directorate's covering report were clear and concise;

c) Officers' unmistakeable commitment to making the consultation process a fair one should be recognised.

The Committee concluded:

1. The consultation process has indeed been carried out in the way it was described to us at our October meeting.
2. The Committee was satisfied that no decisions have been reached prior to any recommendations being made to the Executive.
3. The consultation process was a rigorous one and people had many and appropriate opportunities to contribute and engage with it.
4. The results of the consultation process have been thoroughly and properly assessed and were presented in a transparent and objective way.
5. The rationale of Directorate thinking has been openly documented and the conclusions, as outlined in the covering report, had been properly arrived at.
6. In respect of the proposals within that covering report, the Committee reviewed each of the main conclusions (those formatted in boxes) in turn, i.e., 3.1.16 relating to savings; 3.2.10 relating to disposable income and subsidy; 3.2.14 relating to support by two carers; 3.2.15 relating to charging for services; and 3.3.9 relating to prevention strategy.
7. The intentions in each of these paragraphs was supported bar those highlighted in 3.2.14. Members would want to draw the attention of the Executive to the Committee's discomfort at the possibility of a charge being introduced for two care workers, where this is needed. It seems to the Committee that a relatively small number of people would be bearing a disproportionately high burden. For that reason, should there be financial leeway to exercise discretion in respect of any of the proposals, then such discretion should be exercised here.

8. In relation to paragraph 3.3.9; The Prevention Strategy: the Committee always intended to review service areas integral to a preventative approach – Telecare, Reablement, Support for Carers and so on – but wants to be directly involved in the consultation on the imminent Prevention Strategy. And once introduced, the Committee should play a key role in monitoring the effects and the assessment of its success.
9. More widely, whatever the Executive decision regarding the proposals in the "Making Difficult Decisions" consultation document, the Committee will keep a weather-eye on the effects of Eligibility for Social Care Services and Charging for Community Based Services.

Resolved -

That the consultation report be noted and the Chairman compile a report for the Executive based upon the comments made during the meeting

24. Annual Report on the Older People's Champion

Considered -

The report of County Councillor Shelagh Marshall, North Yorkshire's Older People's Champion, updating Members on the work following from last year's annual report and the work to be focused on for this year.

Members endorsed comments at the meeting that Cllr Sheila Marshall was a first class older people's ambassador for the County Council and thanked her for her tireless work in support of older peoples' interests. Members in particular endorsed her comments in relation to loneliness and isolation. The Chairman added that this issue would always feature in the Committee's work

Resolved -

That the report be noted.

25. Autism Strategy

Considered -

Report of the Corporate Director - Health and Adult Services informing Members of the current status of the strategy and seeking their comments on the document, in particular the priority actions for 2014-15.

Anne Marie Lubanski explained how HAS was working closely with health colleagues on supporting people with Autism. She answered comments from Members regarding the working relationship with Young People, explaining that the two Directorates were working together.

Resolved -

a) The draft interim strategy for meeting with needs of adults with Autism in North Yorkshire 2014~15 in particular the priority actions be received and endorsed.

b) The Committee be advised of the end of the consultation period from decisions reached

26. Work Programme

Considered -

In endorsing the work programme the Committee agreed that the work on the financial abuse review be carried out by a number of Members over the course of the next 2 – 3 months.

The meeting concluded at 12:30pm.

RB

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

REPORT OF THE CORPORATE DIRECTOR – HEALTH AND ADULT SERVICES

24 April 2014

Proposal for a new Health and Social Care Integrated Reablement and Intermediate Care service for North Yorkshire

The START/Re-ablement Service and proposals to develop and integrate with Health Intermediate Care Services in North Yorkshire

1.0 PURPOSE OF REPORT

1.1. To report to the Members of the Overview and Scrutiny Committee regarding the performance of the START/Re-ablement Service and proposals to develop and integrate with health Intermediate Care services in North Yorkshire.

2.0 BACKGROUND

2.1 The START/Re-ablement service was established in 2010 and has been very successful. However changes in the health and social care fields along with a review of the services have indicated that further refinement and development is need.

Health and Social Care integration is a key tenet of the Health and Social Care Act 2012 and is central to the new Care Bill which becomes law in 2014. Integration provides joined up services to the public and improved outcomes whilst delivering financial efficiencies to health and social care organisations.

The proposed new service also forms part of the County Council's agenda on prevention as it equips people with key skills to enable them to stay at home independently for longer.

2.2 The County Council is working in partnership with the 5 Clinical Commissioning Groups (CCGs) to develop new health and social care integrated Reablement and Intermediate Care services for North Yorkshire.

2.3 This report outlines the proposal for a new integrated health and social care Reablement and Intermediate Care service for North Yorkshire.

3.0 CURRENT START SERVICE MODEL

3.1 The START (Short Term Assessment and Reablement Team) service has been operational since September 2010. The service was initially piloted in Selby before being incrementally rolled out around the other areas of the county. START offers a service for up to 6 weeks, and focuses on supporting people to regain skills of daily living, maximising the use of telecare, directly providing a limited range of equipment and signposting to universal services. For some people it may be a very short intervention of only a few days, whilst others may need 6 weeks to optimise their independence, as of February 2014 the average duration of a START episode is 5 weeks. This is developed as part of an outcomes focussed support plan with individual and their family and/or carer.

3.2 The aim of the outcomes focused support plans is to reduce the need for on-going personal care support rather than simply doing tasks on a person's behalf. People who do need an on-going service receive this via a personal budget, Direct Payment or an independent sector service purchased on their behalf.

3.3 The START Service has been successful in positively impacting upon people's lives. **Appendix A** illustrates the improvement to the START service from September 2010 to February 2014. The key headlines are that:-

- Over the period 10829 episodes of START have been delivered to 8564 service users (Graph 1)
- There has been a steady increase to 300 plus episodes per month (Graph 1)
- Around 21% need a further episode (Graph 2)
- 22% do not complete a period of Re-ablement. The reasons for this appear in Graph3. It is relevant that the bulk of these are admissions to hospital
- Currently 70.8% of service users have a nil or reduced on going service. Of these 60.6% receive a nil on going service. (Graph 4 & table)
- Start is well liked by service users with on average 72% of users giving it the highest approval rating of excellent (Graph 5)
- Nationally START has helped to embed a re-abling culture with 85.9% of those discharged from hospital into a reablement service remaining at home 91 days later (Graph 6)

3.4 Although START has been successful there are still inconsistencies in the way it is delivered across North Yorkshire, the proposed integrated reablement and intermediate care service aims to address this inconsistency so that all residents get the same level of service no matter where they live in

the County. The proposed new service will also respond to Central Government policy regarding the integration of health and social care services.

4.0 CURRENT INTERMEDIATE CARE SERVICES IN NORTH YORKSHIRE

4.1 Intermediate care is for people over the age of 18 who have been assessed as being medically stable, do not require hospital care and have short term therapy goals that are achievable within 6 weeks of entering the service. The service is provided on a short term basis either within a service user's home or within a designated residential home. Intermediate Care is targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, or long term residential care.

4.2 Intermediate Care services focus on jointly agreed and implemented pathways for people with long-term conditions. There is operational co-ordination between the range of relevant services and initiatives such as telemedicines/telecare, crisis response, stroke rehabilitation, bed-based intermediate care, home from hospital services and Chronic Obstructive Pulmonary Disease (COPD) services.

5.0 INTEGRATED REABLEMENT AND INTERMEDIATE CARE SERVICE

5.1 The key drivers for this proposal for an integrated Reablement and Intermediate Care service are:

- Central Government policy to integrate health and social care services
- the Better Care Fund
- improving health and social care outcomes for people living in North Yorkshire

5.2 The new service will provide efficient, joined up services for service users and patients and will reduce the need for dependence on long term care, reduce admission into hospital and will facilitate well organised, planned and safe hospital discharge seven days a week. When people develop care and support needs, the first priority should be to restore their independence and confidence. The new integrated Reablement and Intermediate Care service will facilitate the development of effective and realistic outcomes that are focussed on independence and will facilitate support plans that are driven by individual needs, wishes and circumstances. People will be empowered to set goals for themselves that include acquiring new skills, or regaining skills that may have been lost.

5.3 The new integrated Reablement and Intermediate Care service will provide support to people in their own homes to enable them to learn or re-learn skills necessary for daily living. This will be achieved through the use of short term intensive support programmes that:

- Maximise independence, choice and quality of life
- Minimise on-going support required

5.4 Better Care Fund (BCF)

5.4.1 The Better Care Fund (BCF) vision is to create a sustainable integrated health and social care economy for North Yorkshire, drawing together community health, social, primary and voluntary care to deliver a more effective and efficient person centred service. This heralds a new era for integrated Health and Social Care in North Yorkshire. This will provide care and support for people in the most appropriate environment to enable them to be healthy, well and independent through 24/7 integrated services. This will increase community based capacity and capability to prevent avoidable demand on the system and to achieve better outcomes for people.

5.4.2 The project will implement the national conditions for BCF which are:

- Protecting Social Care Services (with a health benefit)
- 7 day services to support discharge from hospital
- Data sharing (via the NHS number)
- Joint assessment and lead accountable officer

5.5 Other areas in the country have integrated reablement and intermediate care services. Think Local Act Personal (TLAP) 'What good looks like' is initiative to support councils (including their elected members) to make the best use of their resources and to promote personalisation in a difficult and challenging context. TLAP's aim is to share ideas about how to get better value for people and taxpayers by pooling evidence about what works.

The proposed new service reflects best practice elsewhere in the country and will have the following functions:

5.5.1 Crisis response

- 24/7 Reactive crisis response service provided via multi-disciplinary teams with a single point of access
- Ongoing access to clinical skills/assessment where indicated
- Good co-ordination across agencies, including GPs and ambulance services, to ensure hospital admissions and emergency care homes admissions are avoided and wherever are safe and feasible.

5.5.2 Hospital Discharge

- Successful team working within hospitals and between acute and community based services
- Well planned and organised early hospital discharge that is safe over 7 day working

- Agreed multi agency protocols which reduce length of stay in hospital and improved outcomes for people being discharged

5.5.3 Integrated Reablement and Intermediate Care

- Reablement continuously developed as the default option for all people being referred for a service
- No decisions taken about long term care and support plan until after period of reablement and intermediate care
- Active therapy to promote and maximise independence
- Focus on recovery approach
- Assistive technology and adaptations and community equipment assessed on entry to service
- Agreed and implemented pathways for people with long term conditions
- Operational co-ordination between range of relevant services and initiatives i.e. stroke rehabilitation, COPD, bed based intermediate care (step up/step down)
- SMART targets for people who access the service
- Extend reablement approach to domiciliary care contracts
- Staff trained, equipped and performance managed in a way that maximises the number of people who are fully reabled to maximise independence in their home setting and require little or no further support

6.0 PERFORMANCE IMPLICATIONS

6.1 The following outcomes will be used to measure the impact of the new integrated reablement and intermediate care service on service users and patients.

The key outcomes of an improved START service will be:

- Reduced permanent admission to residential care
- Remaining out of hospital post hospital discharge
- Improved transfer of care from hospital into community based services
- Improved hospital admission avoidance
- 7 day hospital discharge
- Improved health and wellbeing of patients
- Improved equality of access to high quality care
- Improved patients'/service users' experience of care
- Better utilisation of resources
- Seamless care for patients/service users
- Care is undertaken by the right professionals, at the right time in the right place

7.0 FINANCIAL IMPLICATIONS

7.1 National evidence suggests that by integrating Reablement and Intermediate Care services financial efficiencies are identified that are beneficial to both Local authorities and CCGs whilst improving outcomes for service users and patients.

8.0 LEGAL IMPLICATIONS

8.1 Although integrated Reablement and Intermediate Care services are not a statutory requirement, they reflect intentions the Health and Social Care Act 2012, Better Care Fund plan and the Care Bill 2014.

9.0 EQUALITIES IMPLICATIONS

9.1 A full and comprehensive Equality Impact Assessment is being undertaken with each CCG area.

10.0 CONSULTATION UNDERTAKEN AND RESPONSES

10.1 Public and staff consultation and engagement has been built into the project plan to implement this new service.

11.0 RECOMMENDATIONS

11.1 The Care and Independence Overview Scrutiny Committee is asked to:

i. Note the performance and give comments on the proposal for integrated Reablement and Intermediate Care Services.

Mike Webster
Assistant Director
Procurement, Partnerships & Quality Assurance

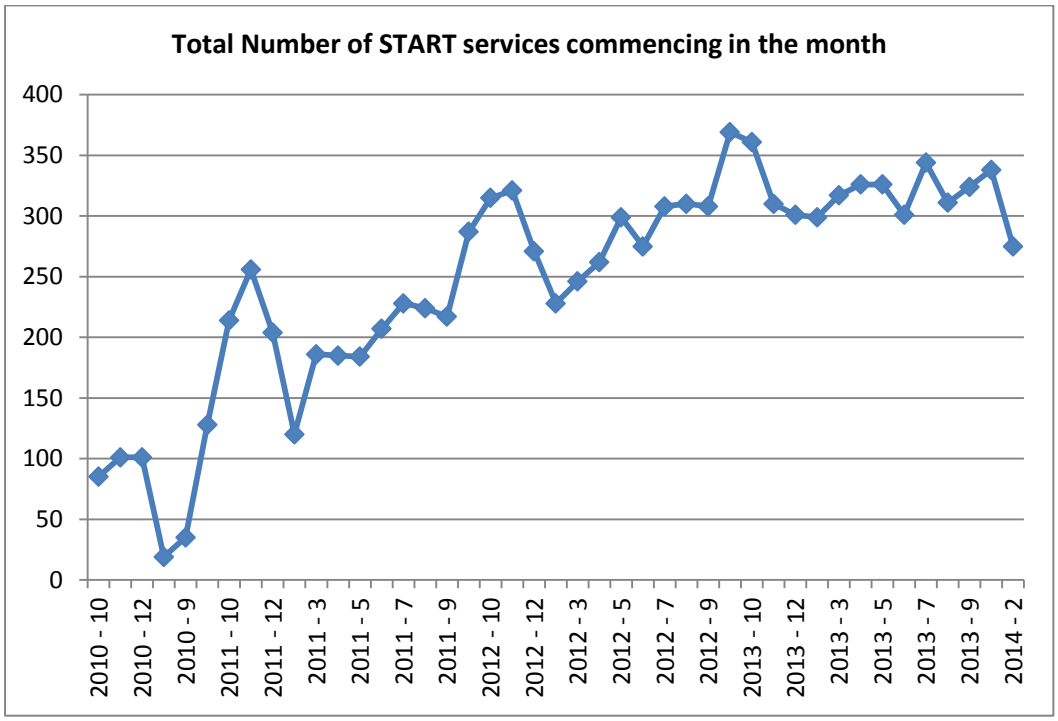
24 April 2014

Appendix A

START Data analysis

Graph 1

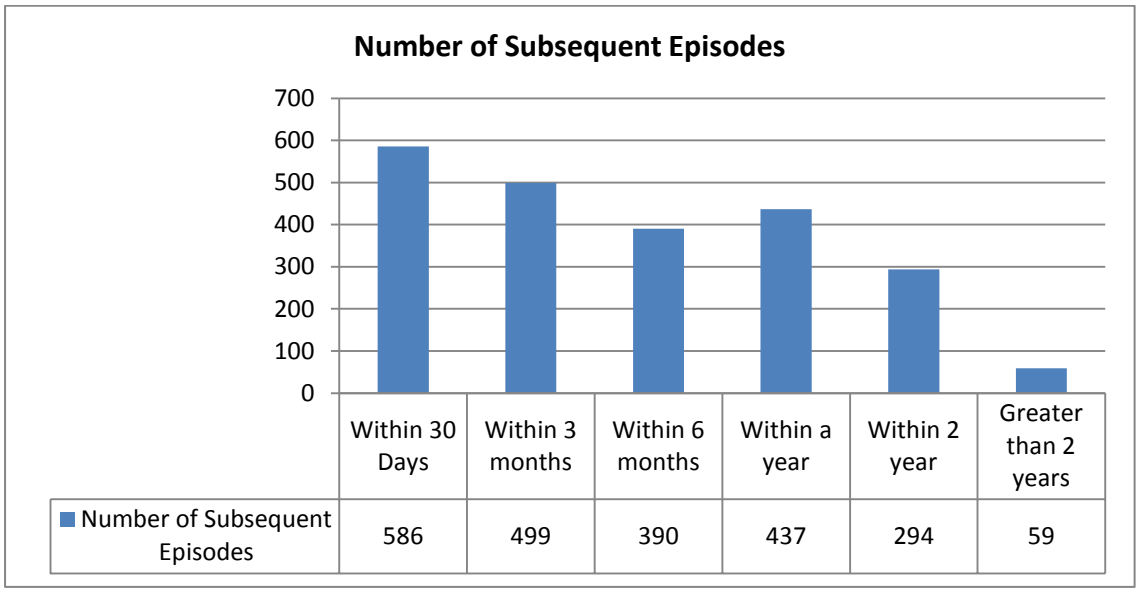
Graph 1 shows the gradual increase in START episodes across all areas from October 2010 to February 2013. Since July 2013 the number of services commencing has been in the main between 300 and 350 per calendar month. The total number of episodes of start is 10829 which represents 8564 service users.



	Episode Type		
	First	Subsequent	Total
Number of Start Episodes	8564	2265	10829
Of which, ceased before planned end date	1918	502	2420

The table above and graph 2 below shows the breakdown of the numbers of start episodes and users. Over the period an average of 22% have ceased before the planned end date (please see graph 3 below for reasons).

Graph 2

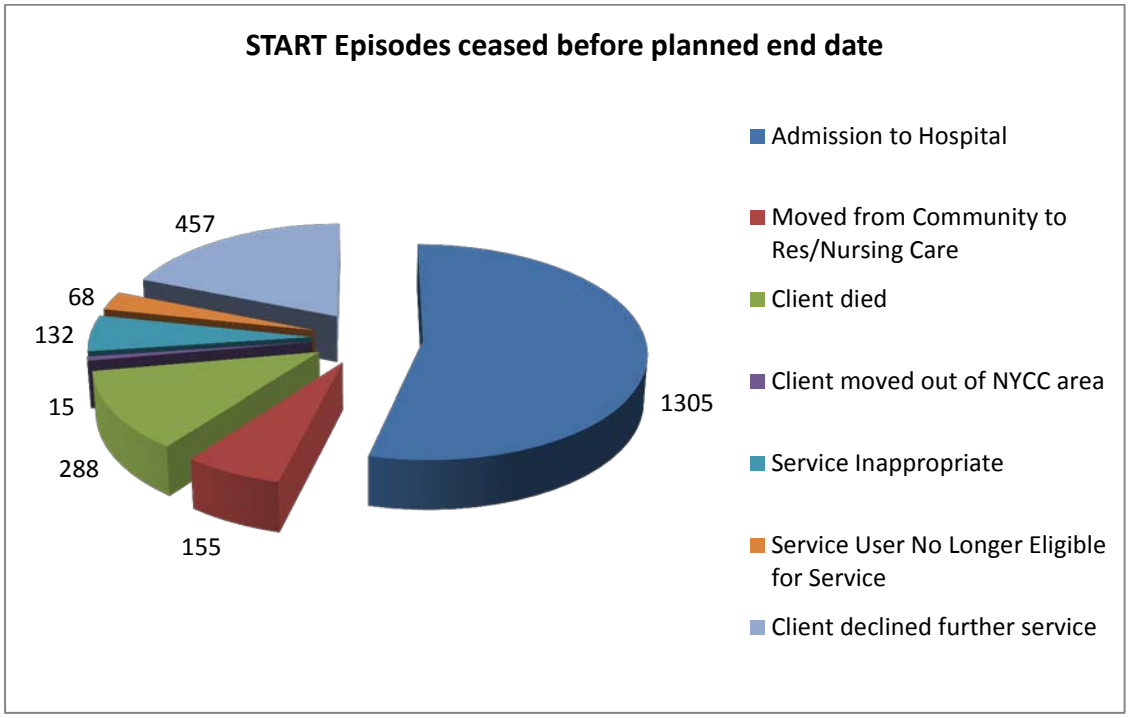


21% of all start episodes are repeated episodes.

A number of users who successfully complete a START episode have subsequent episodes some can be seen as extensions of the initial episodes and take place quite quickly after the first. Some are due to relapse of the original condition and others are new episodes of care.

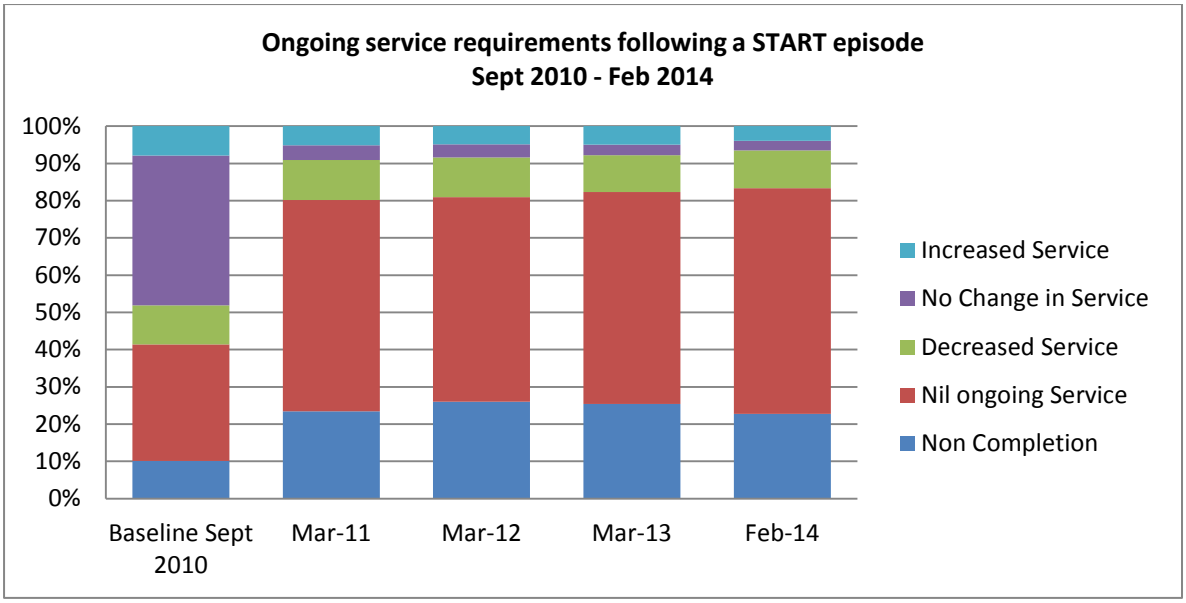
Graph 3

Graph 3 shows the reasons why some START episodes cease before the planned end date. Of the 2420 episodes the bulk are for medical reasons, either admission or readmission to hospital care. This figure could be reduced with greater integration with community health teams. A further 155 are admitted to residential care, again this is a group of clients who through more intense rehabilitation could be kept in the community. Finally there are a group of clients who decline further services, even though START is free for the first 6 weeks of service.



Graph 4

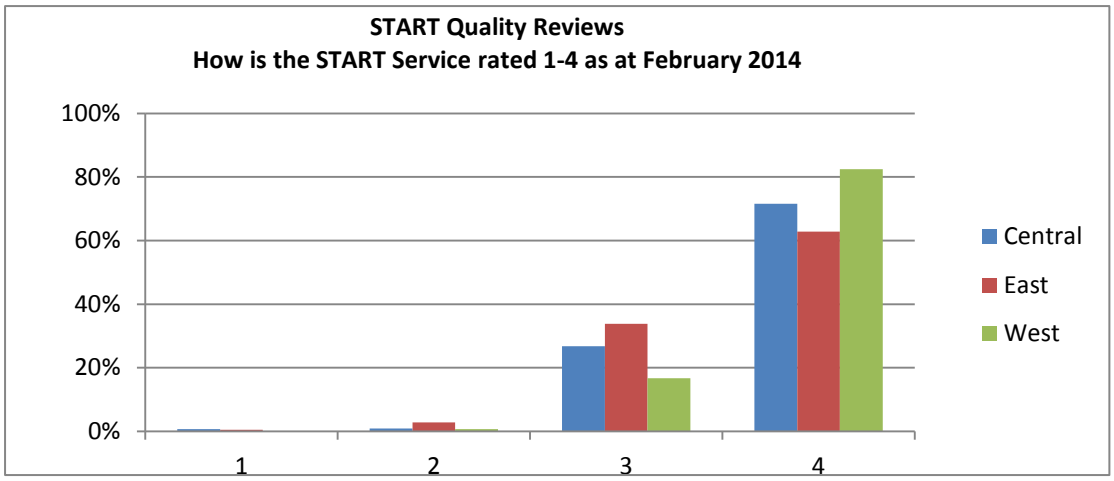
Graph 4 and the associated table plot the progress of START from the initial baseline study in September 2010 to date. The key changes are a significant reduction from no change in services, to a position where services are no longer required (nil on-going service 60.6% Feb 2014) Only 586 (5%) require a subsequent episode with in 30days. The numbers of service users requiring an increase package of care has reduced to 3.9% from 7.9%. However the number of non-completions has risen due to the policy of ensuring all service users have access to START services and not automatically passporting them on to long term services.



START	Non Completion	Nil ongoing Service	Decreased Service	No Change in Service	Increased Service
Baseline Sept 2010	10.1%	31.3%	10.5%	40.2%	7.9%
Mar-11	23.4%	56.8%	10.7%	4.0%	5.1%
Mar-12	26.0%	54.9%	10.7%	3.5%	4.9%
Mar-13	25.4%	56.9%	9.9%	2.8%	5.0%
Feb-14	22.7%	60.6%	10.2%	2.6%	3.9%

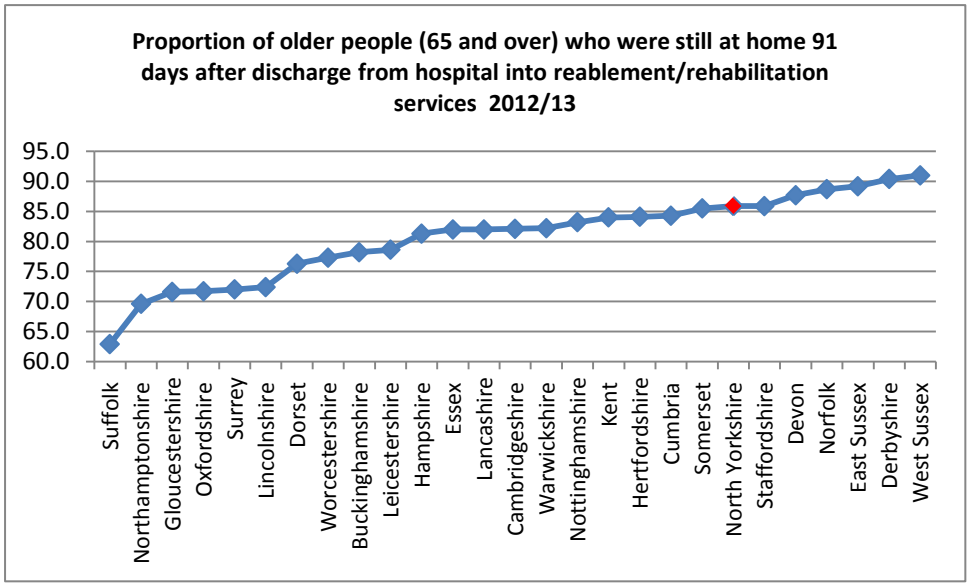
Graph 5

Graph 5 Is taken from the START review given at the end of each episode of START on average 72% of start users giving START the highest approval rating of excellent (4) .



Graph 6

Graph 6 Shows the national impact that the START service has in maintain people at home 91 days after discharge. At 85.9% North Yorkshire is a top quartile performer.



NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

24 APRIL 2014

DEMENTIA STRATEGY

1. PURPOSE OF REPORT

To update members of the Joint North Yorkshire and York (NY&Y) Dementia Strategy 2011-2013, and inform of plans to refresh the strategy and associated action plan. The report also outlines current activity.

2. BACKGROUND

2.1. The Joint North Yorkshire and York (NY&Y) Dementia Strategy 2011-2013 was based on the 17 objectives within the National Dementia Strategy "Living Well with Dementia" (2009). The multi-agency NY&Y Dementia Network (which was facilitated by the former Primary Care Trust - PCT) drove the local strategy/action plan forward; this was an arena for sharing good practice, and some multi-agency subgroups were established to deliver certain actions. Whilst progress has been made over the last 3 years, the pace has been slower due to major restructuring within NHS commissioning. Proposals for the new Dementia Strategy will be presented to the Integrated Commissioning Board.

2.2. Since the publication of the National Dementia Strategy in 2009 we have seen a changing landscape for resource allocation and additional dementia policy/guidance has been published, including for example:

- 'Quality Outcomes for People with Dementia: Building on the Work of the National Dementia Strategy' (DH 2011)
- 'The Prime Minister's Challenge on Dementia – Delivering Major Improvements in Dementia Care and Research by 2015 (2012)
- A nationally mandated CQUIN (2012) aimed to improve awareness and diagnosis of dementia in acute hospital settings.
- NICE Quality Standards and Guidance on Dementia 'Supporting people to live well with dementia' (2013)
- CQC is placing more of a spotlight on the quality of dementia care: 'A Fresh Start for the Regulation and Inspection of Adult Social Care' (2013)

2.3. Within this there is more emphasis on "dementia friendly communities", diagnosis, early intervention, and the quality of post-diagnostic support, combined with effective support for carers. In many ways this fits well with

wider national and local objectives, predicated on a community asset-based approach, enabling people to be more effectively diverted to non-statutory services, avoiding unnecessary/prolonged admissions to acute and intensive services and on supporting people to be independent at home as far as possible. However, this shift in emphasis underlines the need to look again at the dementia strategy with partners, to make it more fit for purpose in guiding the commissioning and development of support/services.

2.4. Linked to the need to respond to the policy challenges and raise the quality of support/options for people with dementia /carers, there are further imperatives related to commissioning, which will result in significant resource implications if left unaddressed. A demographic profile of dementia across the Yorkshire and Humber region commissioned by the Yorkshire and Humber Improvement Partnership showed that for NY&Y the levels of late onset dementia are predicted to rise by almost a third, between 2008 – 2025, from 8,264 to 13,876. Further to this there is evidence nationally that 80% of people in care homes are affected by memory problems/dementia[1], and people with dementia form a large number of unnecessary acute admissions. This highlights why dementia needs to be a priority area of work with partners.

3. MOVING FORWARD

3.1. HAS are actively moving the dementia agenda forward and this portfolio of work has been assigned to a member of staff (Ruth Chamberlain, Commissioning and Change Implementation Officer). This work includes addressing dementia at a strategic level, and supporting HAS' commissioning functions and internal operations to ensure effective support for people with dementia and carers. This is outlined in more detail below.

3.2. **A refreshed dementia strategy**

3.3. It is a priority to refresh the dementia strategy together with key partners. The strategy will be 'high level', and there is an expectation that localities will form action plans, engaging with a wide range of stakeholder to develop these (including people who use services and carers). It is planned for a report to go to the Integrated Commissioning Board (ICB) in June, which will be a joint report with the PCU. The ICB will agree governance issues and the appropriate forum for taking a refreshed strategy forward.

[1] "Low expectations; Attitudes on choice, care and community for people with dementia in care homes" (Alzheimer's Society, February 2013)
http://alzheimers.org.uk/site/scripts/download_info.php?fileID=1628

3.4. **On-going activity**

3.5. HAS is continuing to develop and improve support for people with dementia and carers through a range of activity:

- **Dementia Workforce Development Group** (DWDG) The multi-agency DWDG (originally established through the Dementia Network) has been reconvened and is led by HAS. This will focus on sharing good practice and mapping activity with a view to improving the quality and availability of staff training across agencies.

- **Dementia Champions** – there are 60 dementia champions within HAS. They recently attended a workshop, which focused on clarifying their role/ responsibilities, and included training on telecare for people with dementia. New methods of support to the Champions are being introduced, including a bi-monthly bulletin to promote good practice.

- **Extracare Housing**: the Extracare team will be launching comprehensive dementia guidance that they have produced within the next few weeks (*"Design and Good Practice Guide – Dementia Care and Support in Extra Care Housing"*).

- **Commissioning**:
  - **Providers of domiciliary and residential care; new contract:** the revised contract with providers sets out expectations of providers in relation to standards of care, including people with dementia. To support providers, workforce development guidance on dementia is being produced by HAS, which will include a self-assessment framework that will be used as part of the contract monitoring process.
  - **Dementia Care Navigators** The existing Dementia Care Navigator service has been retendered in six lots (linked to CCG boundaries), in partnership with health. The service specification has been revised to ensure more focus on hard to reach communities and on carer education. It is anticipated that the results of the tendering process will be concluded within the next couple of weeks.

- **Dementia Friendly Communities (DFC):** this is a key element of the Prime Minister's Challenge on Dementia, and will be a new theme within the refreshed dementia strategy. DFC is already emerging in some localities at a 'grass roots' level, and NYCC are taking a strategic view of how these initiatives can best be supported, linking this theme to the Prevention Strategy and to the Community Plan.

- **Dementia Action Alliance (DAA) / Dementia Friends campaign:** HAS is now signed up to the DAA (established by the national Alzheimers Society) as a public commitment to its action on dementia. One element of the DAA is the Dementia Friends Campaign (promoted by the national Alzheimer's Society and Public Health England); a widespread media campaign is about to be launched in May.

- **HAS 'Transformation':** HAS is in the process of transforming the way in which support is delivered, in line with the 2020 programme and the draft Target Operating Model. Work is underway to ensure that as a substantial (and expanding) group of people who require support, the needs of people with dementia are recognised and embedded within this, drawing on evidenced based practice.

4. RESOURCE IMPLICATIONS

4.1. The demand on agencies in delivering many aspects of the strategy is likely to relate more to prioritising time for development work. There may be financial implications related to certain actions but this will be met within existing resources.

5. RECOMMENDATIONS

5.1. Members are asked to note the report. An update report on the progress of the Dementia strategy refresh will be brought back at a later date.

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Date: 14 April 2014
Background documents -Nil

Dementia Support Services Contract Award Briefing

The aim of the Dementia Support Service is to provide a person centred, proactive support and advice service to support those individuals with memory problems who are either suspected of having or with a diagnosis of (predominantly mild to moderate) dementia and their carers. In addition the service will support and sign post individuals to other related services enabling them to better understand their condition, develop self-management skills and access support in their local community to promote their independence, well-being, and give them choice and control.

The current contract with the Alzheimer's Society to provide a Dementia Support Service ends on the 18 May 2014. The old contract has been reviewed and a new specification has been designed which will provide a framework for the Provider to ensure that the best outcomes are being achieved for those needing support and advice and their families and carers.

An unrestricted (open) OJEU compliant procurement process has been undertaken by North Yorkshire County Council and the Clinical Commissioning Groups in North Yorkshire. The aim was to provide a consistent countywide Dementia Support Service which also allows for local service delivery. For those reasons there is a single specification for the service to ensure consistency and the contract was split into the following lots to ensure local service delivery:

- Lot 1 – Hambleton, Richmondshire and Whitby CCG area
- Lot 2 – Airedale, Wharfedale and Craven CCG and South Lakes CCG areas (within North Yorkshire)
- Lot 3 – Harrogate and Rural District CCG area
- Lot 4 – Vale of York CCG area (within North Yorkshire)
- Lot 5 – Vale of York CCG area (outside of North Yorkshire)
- Lot 6 – Scarborough and Ryedale CCG area

The contracts for the six areas will begin on 19 May 2014 and end 31 March 2017 and has the option of a further two years extension. The lots have been jointly funded by North Yorkshire County Council and the Clinical Commissioning Groups in North Yorkshire. The source of funding is as follows:

Lot Number	NYCC Contribution	CCG Contribution	Total Funding
Lot 1	£ 53,000	£14,429	£ 67,429
Lot 2	£ 25,328	£6,460	£ 31,788
Lot 3	£ 59,118	£17,600	£ 76,718
Lot 4	£31,000	£27,825	£ 58,825
Lot 5	£ 0	£40,000	£ 40,000
Lot 6	£44,882	£16,357	£ 61,239

As the costs are fixed, the tender was evaluated on 100% quality. Dementia Forward have been successful in lots 3, 4 and 5 and Making Space have been successful in lots 1, 2 and 6. The current provider, Alzheimer's Society, tendered for all six lots but were unsuccessful. All providers have been notified of the outcome and the award of contract is subject to a mandatory standstill period which finishes on 7 April 2014.

We will be meeting with both providers following the end of the standstill period to ensure that the handover is as smooth as possible and to consider joint publicity options.

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

24 April 2014

North Yorkshire Draft Alcohol Strategy

1.0 Purpose of Report

1.1 This report asks the Committee to:

a. Note the information in the report and Draft Alcohol Strategy

b. To participate in and encourage others to participate in the engagement process.

2.0 Purpose

2.1 This alcohol strategy aims to galvanise partners (statutory and non-statutory organisations, the community and businesses) within North Yorkshire to collectively reduce the harms from alcohol. It sets out the case for action and our 5 year vision. It has been developed to ensure that we continue to build on the on-going work across the county, informed by the latest data and information collected within the Alcohol Health Needs Assessment, using the best evidence of what works where available, and taking into account best value.

3.0 Background

3.1 Alcohol impacts the population. The draft strategy describes the problem and builds the case for action and identifies young people as a significant cohort within the strategy. It outlines what is needed at strategic level to counter the impacts, and describes how we would measure success.

3.2 The Alcohol Strategy Steering Group is a subcommittee of the Substance Misuse Board and is made up from public health, CSPs, licencing, trading standards, police, probation services, police and crime commissioner. It has refreshed the alcohol needs assessment, and agreed this draft strategy based on outcomes from a stakeholder event held in February.

4.0 Proposals

4.1 The strategy steering group has agreed a draft strategy which includes the vision statement:

'Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly'.

4.2 In order to achieve that vision, we have identified three outcome areas:

- Establish responsible and sensible drinking as the norm

- Identify and support those who need help through recovery
- Reduce alcohol-related disorder

4.3 To enable the realisation of those outcomes, we have identified three underpinning themes or values:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Ensuring effectiveness and value for money whilst encouraging innovation

Key Issues

4.4 The draft strategy needs to go for public engagement to check that we have set the correct strategic direction. At the same time, there is an on-going procurement process for a new North Yorkshire wide recovery and mentoring service and a treatment service for adults. An implementation plan for the strategy is being produced but this will be shaped by the final agreed strategy. The implementation plan will need costing out and allocation of resources.

4.5 North Yorkshire communication team will provide a media statement and an engagement portal. An online questionnaire will be available to enable people to provide comments and feedback. The engagement will run during April for 4 weeks, commencement date to be finalised.

North Yorkshire alcohol strategy website:
http://www.nypartnerships.org.uk/index.aspx?articleid=28432

Resource Implications

4.6 There are no resource implications other than the costs of public engagement at this stage. However, the implementation plan once developed will require resources which will need to be allocated. Resource allocation will need to align to the prevention strategy to ensure a coordinated approach.

Equalities Implications

4.7 The Public Health Team is leading on the development of an Equalities Impact Assessment with support from Shanna Carrell.

4.8 The Assessment is currently underway and is considered an on-going process.

4.9 To date the key findings indicate that the development of the alcohol strategy needs to seek to address the engagement of specific cohorts, and access. The premise of the proposed draft strategy is to assist harmful and hazardous alcohol users to address their alcohol issues, in line with current national policy. There will be a cohort of individuals who have particularly complex needs and may not have a recovery aspiration.

4.10 Public Health are currently procuring a North Yorkshire wide recovery and mentoring service which will meet the needs of adults with drug and dependent alcohol use.

5.0 Recommendations

5.1 The Care and Independence Overview and Scrutiny Committee is recommended to:

a. Note the information in this report.

b. To participate in and encourage others to participate in the engagement process.

Lincoln Sargeant
Director of Public Health

Report compiled by:	Claire Robinson
Email:	Claire.robinson@northyorks.gov.uk
Date:	4th April 2014
Background Documents:	none
Annex:	North Yorkshire Draft Alcohol Strategy

North Yorkshire Alcohol Strategy

2014-2019

‘Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly’

DRAFTv4

Forward – council
To add later

Forward – PCC
To add later

Executive Summary

Purpose

This alcohol strategy aims to galvanise partners (statutory and non-statutory organisations, the community and businesses) within North Yorkshire to collectively reduce the harms from alcohol. It sets out the case for action and our 5 year vision. It has been developed to ensure that we continue to build on the ongoing work across the county, informed by the latest data and information collected within the Alcohol Health Needs Assessment, using the best evidence of what works where available, and taking into account best value.

Understanding the problem and building the case for action

The impacts from alcohol can be broadly categorised into the health, social and economic effects. In North Yorkshire, although around I in 7 adults abstain from alcohol, around a quarter of all people who drink are estimated to be drinking at harmful or hazardous levels. Alcohol-related hospital admissions are increasing year on year, and nearly 200 people die in North Yorkshire every year as a result of alcohol. It is associated with crime, including domestic violence and sexual crime, and features in antisocial behaviour in particular with over a quarter of incidents associated with alcohol in some areas. It costs society through public services responding to the impacts, as well as on businesses affected by absenteeism and lost productivity. It impacts unfairly on children and families of people who are dependent on alcohol.

Yet drinking responsibly within limits can be safe.

National guidance tells us how we need to tackle this problem by utilising both a population approach with greater awareness to encourage sensible drinking and use of licensing laws – through to evidence-based methods to identify people who are drinking at hazardous or harmful levels and providing the correct level of support. At the moment, we have variable prevention and treatment services across the county.

What do we need to do?

Using the evidence and guidance produced nationally we have set the local strategic direction for dealing with the harms from alcohol within North Yorkshire. We have adopted the vision statement:

'Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly'

In order to achieve that vision, we have identified three outcome areas:

- Establish responsible and sensible drinking as the norm for example through greater awareness in at risk groups; school education; increasing the capacity to prevent irresponsible and unlawful sales; and exploring the feasibility of working with businesses to set a local minimum price for alcohol
- Identify and support those who need help into treatment through recovery for example through establishing clear pathways of support and referral, training professionals who regularly come into contact with people who are affected by alcohol in identification and brief advice; and ensuring specialist treatment services provide support where it is needed most

- Reduce alcohol-related crime and disorder through better application of the licensing laws; working with the North Yorkshire Community Safety Partnership and local partnerships to effectively manage the night time economy

We have also identified three underpinning themes or values to achieve those outcomes:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Ensuring effectiveness and value for money whilst encouraging innovation

We are developing an implementation plan to complement this strategy and will set up the right governance structures to ensure success. We will measure success against a number of outcomes including alcohol related deaths, crime and disorder rates and admissions to alcohol with alcohol related illnesses.

1. Purpose

This alcohol strategy aims to galvanise partners (statutory and non-statutory organisations, the community and businesses) within North Yorkshire to collectively reduce the harms from alcohol. It sets out the case for action and our 5 year vision. It has been developed to ensure that we continue to build on the ongoing work across the county, informed by the latest data and information collected within the Alcohol Health Needs Assessment, using the best evidence of what works where available, and taking into account best value.

This document is intended to provide the strategic overview and priorities surrounding the alcohol challenges for North Yorkshire so that all partners can align their plans to support and deliver the agreed outcomes.

We will develop an action plan to implement the strategy over the next 3 years, working with City of York Council where applicable. Implementation of the action plan will enable a coordinated partnership approach to achieving its outcomes.

2. Understanding the problem and building the case for action

2.1. What harm can alcohol do?

A definition of the different levels of alcohol consumption and their risks is shown in Appendix 1

Health
Alcohol harms health through three mechanisms

- acute intoxicating effects, occurring after a binge
- chronic toxic effects, following prolonged periods of drinking at harmful levels
- propensity for addiction leading to physical and psychological dependency

The immediate intoxicating effects of alcohol - reduced inhibitions, impaired judgement, slurred speech, and nausea/vomiting, for example - are often easily identifiable; however the longer-term health consequences of excessive drinking, despite their serious and potentially deadly nature, may remain undetected. Studies have shown that alcohol is linked to more than 60 different medical conditions including:

- Cancer - alcohol is one of the most well-established causes of cancer. The International Agency for Research into Cancer (IARC; part of the World Health Organisation) has classified alcohol as a Group 1 carcinogen since 1988[1]. A study published in 2011 found that alcohol is responsible for around 4% of UK cancers, about 12,500 cases per year[2]. The proportion of cases down to alcohol was highest for mouth and throat cancers (around 30%), but bowel cancers accounted for the greatest overall number of cases linked to alcohol (around 4,650 cases a year).
- Liver cirrhosis - the final stage of alcoholic liver disease.
- High blood pressure and increased risk of stroke and heart disease
- Mental health issues - there is a link between drinking too much alcohol and a number of mental health problems. Persistent heavy drinking can also be associated with memory loss difficulties.

- Pancreatitis and stomach problems

Social
Alcohol impacts wider than health, it impacts on families and communities

- Children of heavy drinkers are at risk of physical and emotional neglect, abuse, and stress and are more likely to have their own alcohol problems in later life
- Alcohol is associated with truancy
- Alcohol is a factor in up to 50% of cases of domestic violence
- Marriages are twice as likely to end in divorce if one or both partners has an alcohol problem
- Alcohol is associated with antisocial behaviour
- Binge drinking is associated with unsafe and regretted sex
- Homelessness is associated with alcohol dependency

Economic
Data submitted by the Department of Health to the Health Select Committee (Government's alcohol strategy, Third report of session 2012–13) estimates the costs of alcohol misuse as follows:

- NHS in England – £3.5 billion per year (at 2009/10 costs)
- Crime in England – £11 billion per year (at 2010/11 costs)
- Lost productivity in the UK – £7.3 billion per year (at 2009/10 costs)

The submission estimates that the total cost to society is approximately £21 billion per year. (This does not include the impact of alcohol misuse on families and communities.) It is estimated that 8-14 million working days are lost annually due to alcohol-related problems. With regard to safety, up to 25% of workplace accidents and around 60% of fatal accidents at work may be associated with alcohol.

2.2. What are the national drivers?

The **2012 National Alcohol Strategy**[3] states that the problem has developed for a number of reasons: a combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or businesses. It describes how alcohol has become acceptable to use for stress relief, putting many people at real risk of chronic diseases. In addition, it states that cheap alcohol is too readily available and industry needs and commercial advantages have too frequently been prioritised over community concerns. This has led to 'pre-loading' before a night out.
The strategy has developed clear outcomes to 'radically reshape the approach to alcohol and reduce the number of people drinking to excess'. The outcomes expected are:

- a change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others
- a reduction in the amount of alcohol-fuelled violent crime
- a reduction in the number of adults drinking above the NHS guidelines
- a reduction in the number of people "binge drinking"
- a reduction in the number of alcohol-related deaths
- a sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed

The Government did consult on an evidence based minimum price for alcohol of 45p per unit but decided to opt for a far less stringent formula of banning sales of alcohol below the cost duty plus VAT.

The Government's **Drug strategy (2010) 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'**[4] sets out a fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence. The strategy has recovery at its heart and aims to:

- put more responsibility on individuals to seek help and overcome dependency
- place emphasis on providing a more holistic approach by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing
- reduce demand
- take an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
- put power and accountability in the hands of local communities to tackle drugs and the harms they cause

The **Police Reform and Social Responsibility Act 2011**[5] covers a number of areas, some of which are relevant to the alcohol agenda:

- amends and supplements the Licensing Act 2003 with the intention of 'rebalancing' it in favour of local authorities, the police and local communities
- replaces police authorities with directly elected Police and Crime Commissioners, with the aim of improving police accountability

The first North Yorkshire Police and Crime Commissioner was appointed in November 2012. The core functions of Police and Crime Commissioners are to secure the maintenance of an efficient and effective police force within their area and to hold the Chief Constable to account for the delivery of the police and crime plan. As well as their core policing role, commissioners have a remit to cut crime and disorder and have commissioning powers and funding to enable them to do this. They hold a proportion of funding related to community safety/crime reduction. Commissioners are free to pool funding with local partners and have flexibility to decide how to use their resources to deliver against the priorities set out in the Police and Crime Plan.

The **Health and Social Care Act 2012** has meant that from April 2013, upper tier and unitary local authorities have received a ring-fenced public health grant, including funding for alcohol services. Local authorities are supported by Public Health England and are free to design services to meet local needs, working in partnership where this makes sense for them. This can maximise the scope for early interventions and can better meet the needs of specific groups.

It has also meant that Health and Wellbeing Boards have been formed which bring together councils, the NHS and local communities to understand local needs and priorities through the Joint Strategic Needs Assessment (JSNA) and develop a joint Health and Wellbeing Strategy, which sets out how they will work together to meet these needs. The boards promote integration of health and social care services with

health-related services like criminal justice services, education or housing. They help join up services around individuals' needs and improve health and wellbeing outcomes for the local population.

With the new responsibilities for Directors of Public Health (DsPH) under the 2012 changes to the **Licensing Act 2003** DsPH are now considered a responsible authority for the purposes of the Act. This gives them a responsibility to consider responding to licensing applications made to the local authority. However, there is no specific health or public health objective in the Act and responses must be based on the existing licensing objectives set out in the Act.

2.3. What are the local drivers?

The **North Yorkshire Police and Crime Plan**[6] sets out a vision that people in North Yorkshire will: "Be safe; feel safe - protected by the most responsive service in England". A clear deliverable within the plan states that the Police and Crime Commissioner will work in partnership to: "Develop an evidence-based, area wide alcohol strategy working with our partners including health, which leads to improved provision on the ground in local communities and clear, measurable outcomes. The expected outcomes are: reduced levels of anti-social behaviour, violent crime and domestic violence across the force area." The Police and Crime Plan is being refreshed.

The **North Yorkshire Joint Health and Wellbeing strategy**[7] (2012) sets out the priorities of the Health and Wellbeing Board. Alcohol contributes to all the stated priorities:

- Improve the health of everyone
- Ill health prevention
- Healthy and sustainable communities
- People with long-term conditions
- Children and young people
- Emotional health and wellbeing
- People living with deprivation
- Vulnerable groups

It specifically encourages positive lifestyle behaviour changes including a reduction in alcohol consumption.

The **2012 North Yorkshire Joint Strategic Needs Assessment**[8] (JSNA) identified some unmet need with regards to alcohol:

- There needs to be a systematic, coordinated approach to alcohol harm reduction and commissioning of alcohol services involving all partner agencies within an agreed substance misuse strategy.
- Improve the quality of local data on alcohol consumption in North Yorkshire so as not to rely on modelled estimates.
- Improve capacity and access to a Tier 1 programme to provide screening and brief interventions for example in Primary Care or A&E.

- Continue to provide specialist treatment services for dependent drinkers whose health and social issues associated with their alcohol use have become severe whilst improving support for people earlier.
- Include alcohol screening as part of the NHS Health Check programme as indicated in the Government's recently published Alcohol Strategy.
- There is a need to improve the quality of PSHE including drugs and alcohol education lessons to ensure they are relevant and engage pupils in their learning. This should include consulting with pupils on how learning opportunities can best meet their needs.
- In primary schools there is a need to increase the percentage of pupils who do not drink alcohol (49%). There are gaps around support for primary schools at a tier two level. There is a need to put in place targeted interventions for those pupils identified with higher levels of drugs, alcohol or smoking use; including vulnerable groups.
- The Youth Support Service are currently re-tendering for a Young People's Tier 3 services for Risk Taking Behaviour which encompasses evidence based interventions and services around substance misuse (drugs and alcohol) and sexual health for young people.
- A more co-ordinated approach to training is required so that staff are up to date on young people's drug/alcohol use, assessment and referral into treatment services

The updated **2014 North Yorkshire Joint Strategic Intelligence Assessment**[9] highlights how excessive alcohol intake may manifest itself in violent crime, criminal damage, hate crime and antisocial behaviour, particularly within the night time economy as well as increasing vulnerability in respect of child neglect, sexual crime, particularly for young people, and within domestic violence.

2.4. What is the picture in North Yorkshire?

The North Yorkshire Alcohol Health Needs Assessment[10] was updated at the end of 2013. The key points identified from it and the Joint Strategic Intelligence Assessment are:

Risk of alcohol related harm

- Modelled estimates of alcohol consumption show between 7-8% of the North Yorkshire population who drink are classified as higher risk drinkers; 20-22% are classified as increasing risk drinkers; 71-74% are classified as lower risk drinkers.
- Nationally around 4% of 16-64 year olds are classed as dependent
- Modelled binge drinking rates are between 23.2% and 28.1% with the highest estimated rates in Richmondshire. These are all higher than the England rate.
- Modelled rates of abstainers as a percentage within the total population aged 16 years and over are between 12.8% to 14.8%
- Nationally, hazardous drinking rates are highest in the 45-64 year old age band, followed by the 25-44, 16-24 and 65+ age bands respectively.
- Nationally, the proportion of men who drink hazardously is approximately 1.5 times higher than females, although the gap is less pronounced in the younger age bands.

- Drinking in pregnancy can increase the risk of miscarriage and Foetal Alcohol Spectrum Disorders. National data indicates that 5% of pregnant women drank alcohol on two or more days prior to interview compared with 20% (women aged 16-49 years) who were not pregnant or unsure

Health outcomes

- The alcohol specific death rates for men in North Yorkshire are just under twice the rates of those of women. There is a difference when comparing rates to England. Male rates are approximately a third less than England; however the rate in women is similar to England. The highest rates for both men and women are in Scarborough. North Yorkshire is following the England trend of a steady increase in the rate for those dying from alcohol specific conditions in men, and a flattening of the rate after a slight increase for women.
- Alcohol specific death rates for both men and women follow a gradient of inequality with those from more deprived backgrounds more likely to have a higher death rate.
- Alcohol related admissions to hospital have continued to rise in line with national figures, with rates in women being about half those for men. Most districts are less than the England average but Craven has a statistically significant higher rate than England for female admissions.
- Locally, the hospital admission rate due to alcohol-specific conditions amongst under-18 year olds is in line with the national average. The rate has steadily fallen over the last few years.
- The cost of ambulance attendances in North Yorkshire and York where alcohol was involved was nearly a quarter of a million pounds in just one quarter of this year.

Crime and antisocial behaviour

- Alcohol related crime is not significantly high compared to other areas of England. There has been a marked fall in crime attributable to alcohol in England and North Yorkshire over the last 5 years. Scarborough has the highest rates of alcohol attributed crime (about double that of Ryedale)
- Rates of alcohol related anti-social behaviour vary between districts. Between April and August 2013 the proportion of antisocial behaviour linked to alcohol ranged from 13% in Ryedale to 27% in Scarborough.
- 18 to 29% of police recorded antisocial behaviour is linked to alcohol and has a significant impact on peoples sense of wellbeing across North Yorkshire
- Between April and August 2013, the proportion of crime linked to alcohol varied from 9% in Ryedale to 16% in Richmondshire and Scarborough.
- Custody data shows that across North Yorkshire Police, between 30% and 40% of all arrestees are drunk or have consumed alcohol.
- Between April and August 2013, the proportion of violent and sexual crime linked to alcohol in each Command ranged from 26% in Hambleton to 40% in Richmondshire and Scarborough.
- On average 9% of fatal road collisions in York and North Yorkshire involve alcohol
- There are on average over 38 fatal collisions and 380 serious collisions in North Yorkshire per year involving alcohol (2008-12)

- There have been an average 46 complaints of underage sales per year for the last 3 years in North Yorkshire
- It is estimated that the total cost to detain Alcohol Related Detainees in North Yorkshire Police Custody between 1st June 2013 to 1st September 2013 is £158,400.

Vulnerable Groups

- In 2012 8% of children in Year 6, and 32% of children in Years 8 and 10 in North Yorkshire said they had an alcoholic drink in the last 7 days (both lower than a previous survey in 2010)
- National estimates are that 30% of children live with a binge drinker, 22% live with a hazardous drinker and 6% live with a dependent drinker
- We have a large military presence in North Yorkshire with nearly 15,000 serving personnel. The Kings Cohort study[11] showed that alcohol misuse in the Army runs at a level twice that for the same group in the general population levelling out to that of the general population by age 35. Rates were higher in those returning from deployment.
- Street drinking has been identified as a particular problem for some districts

2.5. What does the evidence say we should be doing?

The National Institute for Health and Clinical Excellence (NICE) has produced five key evidence guidelines that relate to alcohol:

- Alcohol Use Disorders: Preventing harmful drinking (Public Health Guidance 24) (2010)[12]
- Alcohol Dependence and harmful alcohol use Clinical Guideline 115 (2011)[13]
- Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications. Clinical Guideline 100 (2010) [14]
- School-based interventions on alcohol (Public Health Guidance 7) (2007)[15]
- Behaviour change: individual approaches (Public Health Guidance 49)(2014)[16]

NICE describe two approaches.

- Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed. They can help those who are not in regular contact with the relevant services; and those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking. They can also help prevent people from drinking harmful or hazardous amounts in the first place.
- Individual-level interventions can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage.

Prevention and education

NICE say that locally, licensing should:

- Be based on local data and, if necessary, limit the number of new licensed premises in a given area.

- Work in partnership to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others.
- Undertake test purchases to ensure compliance with the law on under-age sales.
- Ensure sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases.

NICE suggested that national policy should:

- Consider introducing a minimum price per unit.
- Consider revising legislation on licensing.
- Consider a review of the current advertising codes to ensure children and young people's exposure to alcohol advertising is as low as possible.
- Assess the potential costs and benefits of a complete alcohol advertising ban to protect children and young people from exposure to alcohol marketing.

NICE also highlights the use of school based interventions to reduce alcohol:

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance.
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account (based, for example, on individual, social and environmental factors). It should aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink. Education programmes should:
- increase knowledge of the potential damage alcohol use can cause – physically, mentally and socially (including the legal consequences)
- provide the opportunity to explore attitudes to – and perceptions of – alcohol use
- help develop decision-making, assertiveness, coping and verbal/non-verbal skills
- help develop self-esteem
- increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption.

Early identification and harm minimisation

NICE advises the provision of screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers). Where screening everyone is not feasible the following applies. NHS professionals should focus on people:

- with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders);
- with relevant mental health problems (such as anxiety, depression or other mood disorders);
- who have been assaulted;
- at risk of self-harm;
- who regularly experience accidents or minor traumas;
- who regularly attend GUM clinics or repeatedly seek emergency contraception.

Non-NHS professionals should focus on people:

- at risk of self-harm;
- involved in crime or other antisocial behaviour;
- who have been assaulted;
- at risk of domestic abuse;
- whose children are involved with child safeguarding agencies;
- with drug problems.

In young people aged 16-17 yrs, the use of screening tools is validated. NICE advise a focus on key groups that may be at an increased risk of alcohol-related harm. These include those:

- who have had an accident or a minor injury
- who regularly attend genito-urinary medicine (GUM) clinics or repeatedly seek emergency contraception
- involved in crime or other antisocial behaviour
- who truant on a regular basis
- at risk of self-harm
- who are looked-after children
- involved with child safeguarding agencies.

For adults who have not responded to brief structured advice on alcohol, offer an extended brief intervention (up to 4 sessions of 20-30 minutes each). Staff should be trained to provide alcohol screening and structured brief advice.

The cost effectiveness reviews and economic modelling for the Alcohol Use Disorders: Preventing harmful drinking NICE guideline suggests that screening plus brief intervention at the next GP consultation, the next registration with a new GP or the next A & E visit would be cost effective when compared to doing nothing.

Referral to specialist treatment should be made if one or more of the following has occurred. They:

- show signs of moderate or severe alcohol dependence;
- have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem;
- show signs of severe alcohol-related impairment or have a related co-morbid condition.

Treatment & rehabilitation

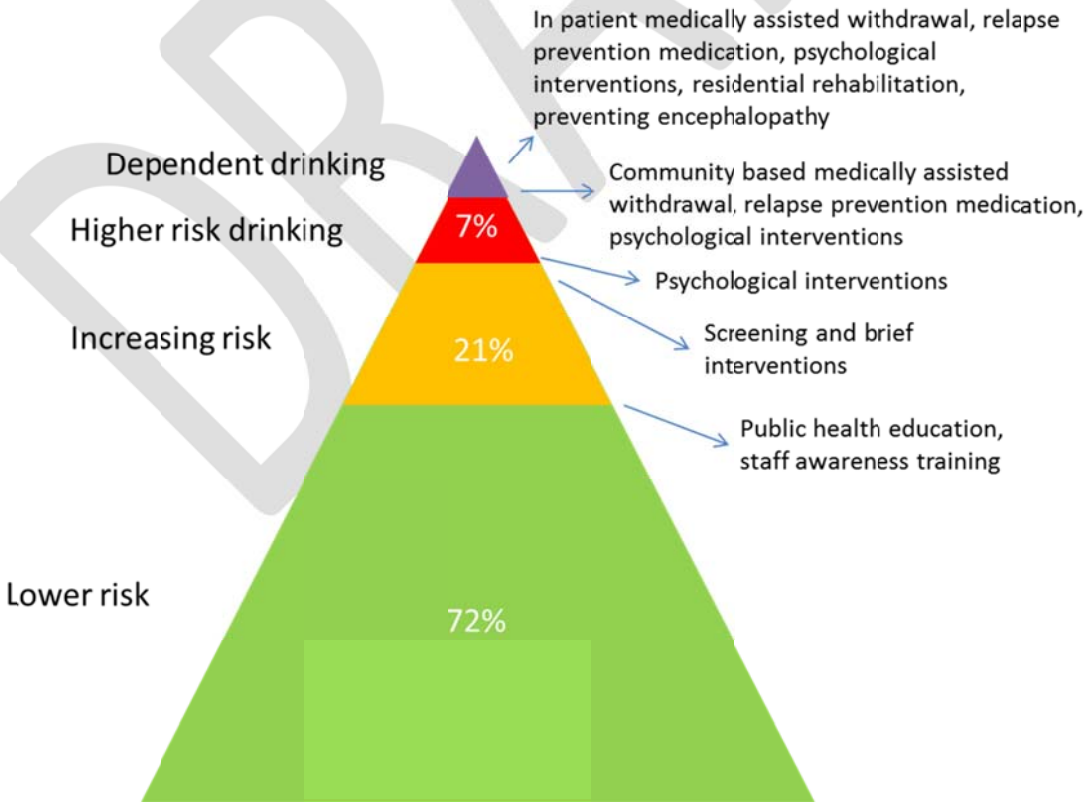
- For all people seeking help for alcohol misuse:
    - give information on the value and availability of community support networks and self-help groups;
    - help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend.
    - Provide a psychological intervention focused specifically on alcohol-related cognitions, behaviour, problems and social networks.
    - Offer behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment.

- For high levels of consumption offer outpatient-based community assisted withdrawal programmes.
- For very high levels of consumption and/or additional complications consider inpatient or residential assisted withdrawal.
- After successful assisted withdrawal offer a community programme which consists of an appropriate drug regime and psychological interventions.
- Encourage families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.

As well as the NICE evidence, the Alcohol Matrix[17] produced by Drug and Alcohol Findings summarises the treatment of alcohol-related problems among adults organised by specific interventions through how their impacts are affected by staff, management, and the nature of the organisation, and whole local area treatment systems. The different types of treatment interventions depending on levels of risk are summarised below.

Alcohol treatment has been shown to be highly cost effective. Comparing the use of resources six months before the start of the UKATT treatment to the six months prior to the one year follow-up interview, the suggestion is that, for every £1 spent in treatment, the public sector saves £5 (UKATT Research Team[18]).

Figure 1: Levels of intervention for different types of alcohol risk (% relates to estimated proportion of risk levels in North Yorkshire)



The Department of Health produced Signs for Improvement [19]which sets out commissioning interventions to reduce the harm caused by alcohol in local communities. It identifies seven High Impact Changes that are calculated to be the most effective and practical actions used extensively across the NHS and local government:

- Work in partnership
- Develop activities to control the impact of alcohol misuse in the community
- Influence change through advocacy
- Improve the effectiveness and capacity of specialist treatment - Ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the area.
- Appoint Alcohol Health Worker(s) - Commission an adequate number of Alcohol Health Workers or Alcohol Liaison Nurses to work across the acute hospitals.
- Identification and Brief Advice – Provide more help to encourage people to drink less, through Primary Care and A/E
- Amplify national social marketing priorities - Commission local social marketing activity which builds on the evidence, strategy and tools provided by the national social marketing programme. Ensure this promotes the local available service response.

The national framework for the commissioning of adult treatment for alcohol misusers categorises the interventions above into four tiers:

Tier 1	Generic services which work with a wide range of clients. As a minimum they should be able to screen and refer individuals to local specialist services.
Tier 2	Specialist but low threshold services which are easy to access.
Tier 3	Services provided solely for drug and alcohol misusers in structured programmes of care.
Tier 4	Structured services which are aimed at individuals with a high level of presenting need, including inpatient drug and alcohol detoxification and residential rehabilitation units.

Reducing offending and Night Time Economy

A recent Ministry of Justice review[20] of reducing reoffending provides an overview of key evidence relating to reducing the reoffending of adult offenders. It concludes that overall, there is currently insufficient evidence to determine the impact on reoffending of alcohol treatment for offenders, although treatment in some settings do show promise. There is, however, good evidence that alcohol-related interventions can help reduce hazardous drinking more generally.

A useful summary of the types of interventions to help reduce disorder in the Night Time Economy[21] groups the interventions into six areas:

- Pricing
- Licensing
    - Outlet density and mix
    - Monitoring and enforcement
    - Licensing hours

- Premises design and operations
  - Glassware management within premises
  - Manager and staff training
  - Accreditation and awards
  - Environment within the premises (covering capacity, layout, seating, games, food, and general atmosphere)
- Public realm design
  - CCTV
  - Street lighting
  - Active frontages
  - Public toilet provision
  - Glassware management outside premises
  - General layout
- Service interventions
  - Transport (covering buses, taxis and parking)
  - Policing (covering targeted policing, street policing, third party policing, transport policing, anti-social behaviour/drink banning orders and alcohol arrest referral schemes)
  - Health care
  - Noise and light pollution
  - Public education campaigns
- Community mobilisation (eg third party policy, and ensuring residents are aware of licensing restrictions to report breaches)

2.6. What's currently happening to reduce harm from alcohol in North Yorkshire

Prevention
Reducing alcohol features in the Children and Young Persons plan with universal education provided on drug and alcohol. Some specialist providers of treatment to young people provide targeted prevention. Some providers of treatment services across the districts offer some prevention advice but this is not consistent.

There are several national campaigns to raise awareness of alcohol issues (eg know your limits, drinkaware, change4life) and a local campaign (reduce my risk) from the North East produced by Balance, shown in the Tyne Tees area which covers parts of North Yorkshire.

Reducing crime and antisocial behaviour
Each district has a Community Safety Partnership (CSP) and part of their remit is to tackle alcohol related crime and disorder. Interventions fall into four main categories:

- Responsible drinking
- Responsible retailing
- Enforcement
- Environment

There are many actions being taken but reduced funding is always a threat, and there are different priorities across the county. A new Community Safety Partnership model is proposed to start from April 2014. It amalgamates all the CSPs into one North Yorkshire CSP with delivery at North Yorkshire and local district level.

Identifying people at risk
There is a nationally commissioned Directly Enhanced Service (DES) in primary care which provides specific funding for GPs to deliver Identification and Brief Advice (IBA) to newly registered patients. Figures from October 2010 to September 2011 show that across North Yorkshire 12,282 newly registered patients were screened for alcohol misuse.

Yorkshire Ambulance Service have developed a pathway across Yorkshire for identifying and referring people with alcohol related harm to treatment services but this has short term funding only.

Treatment Services
Currently treatment services at the different tiers are provided by a variety of providers in each district and funded by various funding streams which may or may not be recurrent. They mainly cover Tiers 2 – 4. Access to services is not equitable across the county and is described in detail in the Alcohol Health Needs Assessment.

North Yorkshire public health is currently going through a procurement process for adult substance misuse services including alcohol across North Yorkshire. The new service is expected to be operational by October 2014 and will have a strong focus on helping drug and alcohol misusers to recover from dependence and will replace most existing drug and alcohol treatment provision commissioned by the council. Treatment provision delivered by GPs (shared care) in their practices under the local authority primary care contract and pharmacy-based supervised consumption and needle exchange services will continue to be commissioned separately. The new service will be for Recovery and Mentoring; and Treatment Services with care provided at Tiers 2-4. There is more scope to strengthen Tiers 1 and 2.

For children and young people there is a Risky behaviours Team which provides specialist support for alcohol and substance misuse. The Healthy Child Programme is due to be recommissioned in 2015.

The Department of Health is piloting mental health nurses and other mental health professionals to work with police stations and courts so that people with mental health conditions and substance misuse problems get the right treatment as quickly as possible with the aim to help reduce re-offending. Liaison and Diversion services should ensure that individuals can access appropriate interventions, in order to reduce health inequalities, improve physical and mental health, tackle offending behaviours including substance misuse, reduce crime and re-offending and increase the efficiency and effectiveness of the criminal justice system. This will be rolled out nationally by 2017.

2.7. Modelling the scale of the unmet need
Using the latest numbers of people screened through the GP new patient Directly Enhanced service means that around 2.5% of the adult population are being screened by that route per year. Using the NICE Alcohol Commissioning and Benchmarking tool[22], that should result in approximately 1843 people who have hazardous drinking patterns receiving brief interventions per year. However, the tool

estimates that there are 120,000 people who have harmful or hazardous drinking patterns in North Yorkshire, meaning only 1.6% are potentially receiving brief advice through that route per year.

With the addition of NHS Health checks (all 40-74 year olds without existing cardiovascular disease screened every 5 years), that number of people receiving brief advice can be increased to 4746 per year at the current NHS Health Check uptake rate of 50% of invitations. That still means only 4% of harmful or hazardous drinkers taking up advice per year. It is not clear what the ideal rate of alcohol screening should be but these numbers demonstrate the need to scale up screening and identification.

There were 1042 service users engaged with treatment services due to alcohol in 2012/13. Nationally it is estimated that only 10% of people who may be eligible are engaged with services. If we assume (using the NICE Alcohol Commissioning and Benchmarking tool) that 2.6% of the adult population are dependent drinkers, then there would be a potential 12850 people in North Yorkshire who are dependent (ie around 8% are engaged). It is recommended in the Signs for Improvement guidance that at least 15% of dependent drinkers need to be engaged with treatment services which would mean a realistic target would be 1928 people engaging with treatment services ie a gap of around 900 – or nearly doubling current service provision.

2.8. What people have told us

Stakeholder event

A stakeholder event was held on 17th February 2014. 75 delegates attended the event to discuss the vision, outcomes and priorities for action. A full report from the event has been published[23].

Key themes identified from the event that the vision and outcomes should include were:

- Working together – the notion that to really make a difference, we all need to be taking responsibility
- To reduce the many different harms from alcohol
- To recognise that some groups or communities are affected more than others. Protecting children was a recurrent theme
- A culture shift is needed to denormalise risky drinking behaviour.
- That there are some ways of working or values that we should collectively adhere to – for example to reduce inequalities, and ensure whatever we do is effective and cost effective, and encourage innovation

Actions needed to meet the vision and outcomes were placed on flipcharts with two axes – impact and feasibility. Key themes of actions that emerged were:

- Awareness raising of the harms from alcohol in the population, through technology, social media, libraries, schools, further education and universities
- Awareness raising of the harms, use of identification tools and brief interventions, and support available with professionals regularly coming into contact with people who drink at hazardous or harmful levels in different settings (eg police, GP, probation, community pharmacies, youth justice system, ambulance and A/E)

- Clear pathways for treatment once harmful or hazardous drinking is identified using a directory of local resources and a single point of access
- Effective use of police and local authority powers (eg section 27, exclusion zones, licensing conditions)
- Influencing local increases in cost of alcohol, reduced strength of alcohol and reduced cost of soft drinks

Big Issues from the Joint Strategic Needs Assessment (JSNA)
As part of the process to develop the JSNA in 2012, local residents were asked to identify the big issues affecting health and wellbeing locally. Typical issues around alcohol were its links with crime, anti-social behaviour, domestic violence and impact on people's health.

Comments received about alcohol were around the following themes:

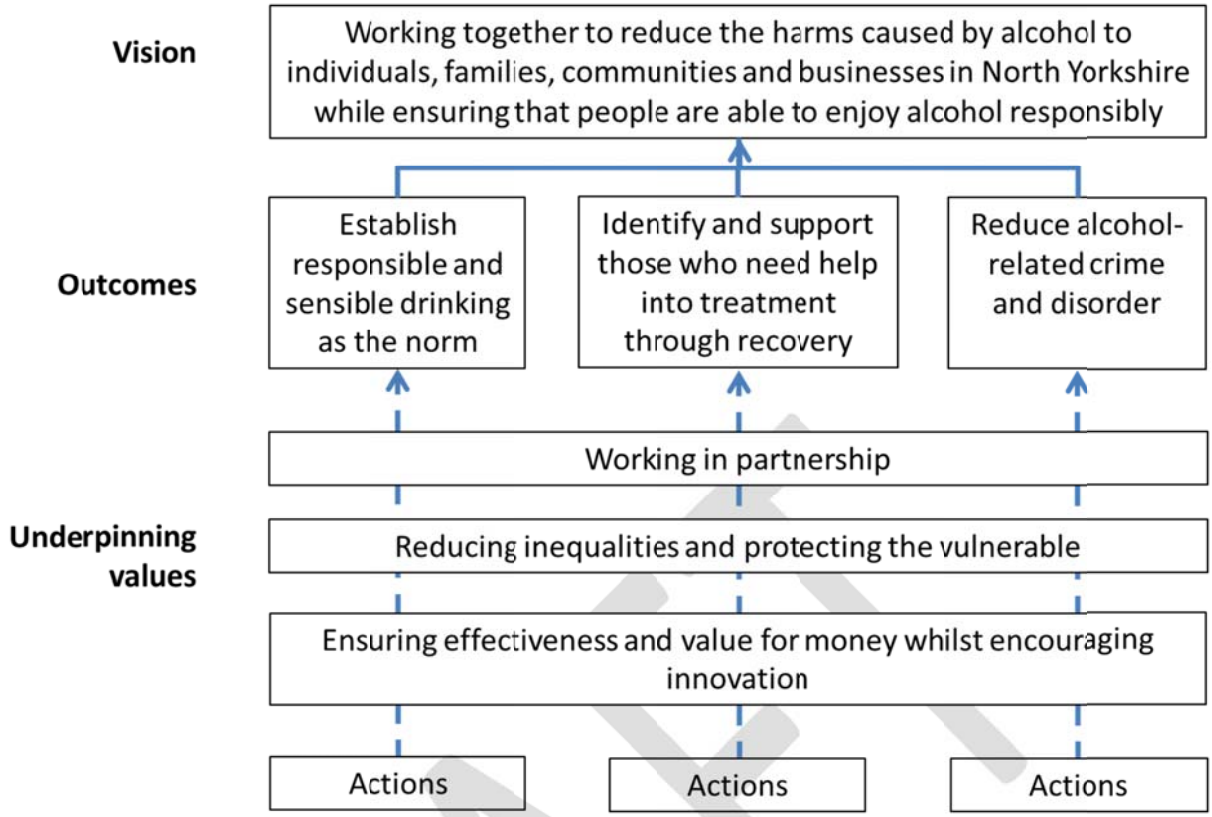
- For both crime and anti-social behaviour, alcohol is seen as the key causation factor. It can also lead to other issues e.g. 'risky' sexual activities.
- Chronic health problems due to excessive alcohol consumption - Inability of A&E and other acute services to meet the demands of this type of patient.
- Harm caused by drugs and alcohol i.e. crime, particularly theft and violent offences.
- Reduced funding for preventative work linked to drugs and alcohol.
- Alcohol linked to violent behaviour including domestic abuse.
- Excess drinking across all age groups, including underage drinking.

3. What do we need to do?

3.1. Our Vision

Working with our stakeholders, we have developed a shared vision:

> *'Working together to reduce the harms caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly'*



3.2. Outcome areas

In order to achieve that vision, we have identified three outcome areas:

- Establish responsible and sensible drinking as the norm
- Identify and support those who need help into treatment through recovery
- Reduce alcohol-related crime and disorder

These areas will be used to develop the action plan

3.2.1. Establish responsible and sensible drinking as the norm

For too many, harmful or hazardous drinking has become normal. We need to shift that culture so that low risk drinking becomes the norm. This is so right across a person's life course, starting with pregnancy and foetal development, to influencing aspirations in childhood through to teenage years, to young adulthood and leaving home, to the stresses of work and middle age and then retirement and risk of isolation in old age. Education and awareness raising is part of the solution, but this needs to be targeted as different people respond differently to how information is given. Availability of alcohol also impacts on what society sees as the norm.

We will:

- support schools to deliver consistent and high quality personal, social, health and economic (PSHE) education around alcohol (and other risky behaviours)

- increase awareness of the harms of alcohol, support available, identification tools, and benefits of sensible drinking across the whole population but specifically with:
    - parents and children (through the recommissioning of the Healthy Child Programme)
    - women of child bearing age and young mothers
    - further education establishments including colleges and universities
    - middle aged males
    - other population groups as needs are identified
- increase the capacity to prevent under-age sales (including proxy sales), sales to those who are intoxicated, non-compliance with any other alcohol licence condition, irresponsible drinks promotions and illegal imports of alcohol and ensure sanctions are fully applied to businesses that break the law
- work with businesses to encourage sensible drinking and explore the feasibility of local minimum pricing of alcohol
- ensure that there is a systematic process to include 'health' as part of the consideration on licensing applications and renewals

3.2.2. Identify and support those who need help into treatment through recovery

There is clear evidence that some people are more at risk of dependent and harmful drinking than others, that we are not identifying them consistently, and services are not offered at the scale needed for the size of the problem. We therefore need a systematic process to ensure that people in the general population, as well as those who are more at risk are identified early, effective advice and support is given, and that there are clear pathways to treatment that has the magnitude to cope with the demand.

We will:

- Develop a clear pathway that specialists and non-specialists can use from identification to support and referral, depending on the level of risk identified, alongside a directory of local resources available. This needs to link to the community navigator model being developed across the county with single point of access.
- Develop the awareness, skills and capacity of professionals (eg police custody, ambulance, emergency departments, primary care, probation) who come regularly into contact with people who are suffering the consequences of alcohol* to identify harmful and hazardous alcohol use, offer brief advice, and refer to specialist treatment appropriately
- Support the development of specialist services in settings where professionals come regularly into contact with people who are suffering the consequences

* including people with relevant physical conditions; relevant mental health problems; who have been assaulted; at risk of self-harm; who regularly experience accidents or minor traumas; who regularly attend GUM clinics or repeatedly seek emergency contraception; involved in crime or other antisocial behaviour; at risk of domestic abuse; whose children are involved with child safeguarding agencies; with drug problems

of alcohol* and an increased need is identified (eg A/E, custody, probation, street drinking)
- Increase awareness and the use of simple identification tools and effective advice and signposting in the wider public health workforce (eg housing agencies, social care, community pharmacies)
- Ensure that specialist services have the capacity to deal with the expected need
- Increase the uptake and ensure the effectiveness of the GP led NHS Health Checks for the population aged 40-74 years in identifying people who are at risk of harm from alcohol, and providing appropriate support
- Pilot and evaluate innovative programmes like police Alcohol Referral Schemes and street triage
- Ensure antenatal screening, support and interventions are effective
- Work with Public Health England in the local implementation of the Liaison and Diversion programme

3.2.3. Reduce alcohol-related crime and disorder

Alcohol is linked to crime and disorder and draws a disproportionality large resource from the police and impacts on public services like A/E and the Ambulance services, the community and businesses.

We will:
- Explore the feasibility of increasing local availability and reducing pricing of non-alcoholic drinks in licensed premises
- Using local health, crime and related trauma data, map the extent of alcohol-related problems locally before developing or reviewing a licensing policy
- use licensing powers effectively to limit availability of alcohol where the density of licensed premises causes disorder including increasing community awareness of licensing reviews
- work with the North Yorkshire Community Partnership and Safer York to ensure a coordinated response to reduce disorder
- support local partnerships to effectively manage their night time economy to minimise harm from alcohol
- work with 95 Alive Partnership to reduce the impact of alcohol on road safety

Alcohol treatment and recovery services in some settings may also impact on crime and disorder

3.3. Underpinning Values

To enable the realisation of those outcomes, we have identified three underpinning themes or values:
- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Ensuring effectiveness and value for money whilst encouraging innovation

3.3.1. Working in partnership

Central to this strategy is the call to action for all partners who play a part in reducing harm from alcohol. Only by working together will the outcomes be achieved. There are a number of actions working together that will facilitate better outcomes:

- Data and intelligence sharing between organisations
- Pooling of resources to meet the need coherently rather than duplicating effort
- Working with the drinks industry and licensed trade to effect positive changes
- Ensuring cross cutting action across other strategic areas

Working in partnership is a question that needs to be asked in the development of all our actions – can we do this better if we work together on this, and if so, how do we enable this to happen?

3.3.2. Reducing inequalities and protecting the vulnerable

We know that there are inequalities within North Yorkshire with some districts having double the rate of alcohol related deaths than the England average, and some having higher antisocial disorder rates than others. Males are more likely to die from alcohol related disorders, but the female rate appears higher than expected when comparing to the England rates.

We also know that there are some groups that are more vulnerable to alcohol use than others are. For example, children and young people who live with people who are dependent drinkers may have safeguarding issues; military personnel are at higher risk of harmful drinking and may not wish to access military health services; people with mental health disorders have a higher risk of alcohol use

In all actions, we need to ask – is this helping reduce inequalities, and are there particular groups we need to target? Some actions will be universal, but some actions will need to be more focused either geographically or to a particular group.

3.3.3. Ensuring effectiveness and value for money whilst encouraging innovation

Some actions have clear evidence that they are effective, and save money down the line. However, not all actions have the same level of evidence. Therefore, we need to ensure that we continually evaluate whether actions are achieving their stated aims, and if not, change it, or invest in something else which shows promise.

In these times of austerity, we need to ensure that investments achieve value for money, as well as achieving better outcomes.

Where there is potential for innovation, this should be encouraged, with clear measures of success criteria and timeframes, and not being afraid to say something has not worked.

4. How will we measure success?

4.1. Governance

The alcohol strategy steering group is accountable to the North Yorkshire Substance Misuse Board. Once the action plan has been developed, this group will review its membership and evolve into an Alcohol Strategy Implementation Group. The Alcohol Strategy Implementation Group should be accountable to the North Yorkshire Substance Misuse Board but will report into the North Yorkshire Community Safety Partnership and Children's Trust Board.

The action plan will use project management systems to ensure delivery. Process measures will be used to ensure that actions are being implemented in a timely way.

4.2. Outcome indicators

Over the 5 years of this strategy, we need to demonstrate that the actions are impacting on the desired outcomes. We are developing some outcome indicators linked to the vision and each of the outcome areas which will be monitored regularly. Some outcomes (eg alcohol related deaths) have a delay in them, in that it takes time for actions to affect death rates, and death rates for a particular year are normally released approximately two years later once all the data has been collated and validated. We therefore need a mix of real-time outcomes or proxy measures as well as more long term outcome measures.

Outcomes	**Indicators***
Overarching	• Alcohol related deaths • Crime and disorder • Community outcomes measure (perceptions)
Establish responsible and sensible drinking as the norm	• Local prevalence of alcohol consumption (not currently available) • Alcohol consumption in children (Y6, Y8 and Y10) • Number of underage sales • Alcohol related visits to Emergency Departments
Identify and support those who need help into treatment through recovery	• Number of people who have been screened effectively • Number of people who are in effective treatment • Alcohol related admissions to hospital
Reduce alcohol-related crime and disorder	• Violent crime related to alcohol • Hate crime related to alcohol • Criminal damage related to alcohol • Antisocial behaviour related to alcohol • Sexual crime related to alcohol • Domestic violence related to alcohol • Alcohol related road traffic accidents

*these need further development

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Appendix 1: Definitions

The Department of Health defines alcohol misuse into three categories:

Hazardous drinking (also known as increasing risk) - these people are drinking above recognised sensible levels but not yet experiencing harm. Increasing risk limits are defined by the Department of Health as drinking more than 3-4 units a day for men and more than 2-3 units a day for women on a regular basis.

Harmful drinking (also known as higher risk drinking) - this group are drinking above recommended levels for sensible drinking and experiencing physical and/or mental harm. Higher risk drinking is classified as the regular consumption of more than 8 units a day for a man (more than 50 units a week) or more than 6 units per day for a woman (more than 35 units a week). Individuals categorised as higher risk drinkers are not dependent on alcohol.

Dependent drinkers - this group are drinking above recommended levels, experiencing an increased drive to use alcohol and feel it is difficult to function without alcohol. Dependent drinking can be sub-divided into two categories; moderate dependence and severe dependence, traditionally known as chronic alcoholism.

In addition **binge drinking** is defined as drinking at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women). Binge drinking usually refers to people drinking a lot of alcohol in a short space of time or drinking to get drunk.

Lower risk drinking is defined as men drinking no more than 3-4 units a day and women drinking no more than 2-3 units a day on a regular basis.

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

24 APRIL 2014

WORK PROGRAMME REPORT

1.0 Purpose of Report

1.1. The Committee has agreed the attached work programme.

1.2. The report gives Members the opportunity to be updated on work programme items and review the shape of the work ahead.

2.0 Background

2.1 The scope of this Committee is defined as:

> ***'The needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector.'***

3.0 Mid-Cycle Briefing

3.1 At their last Mid-Cycle Briefing Group Spokespersons heard that the prevention strategy, which the Committee recognised was a fundamental part of the 'Making Difficult Decisions' consultation process, is still work in progress. It was appreciated that the new Director, Richard Webb, would want to be comfortable with its approach; therefore it was agreed that he be invited to discuss with the Committee his view of the prevention strategy as part of a broader presentation on the challenges faced by Social Care – especially in North Yorkshire.

3.2 The Executive has agreed a rolling programme of in-depth analysis of performance in key areas, directorates taking it in turn to update on a chosen service area by key activity, impact on budget, key HR implications, where relevant, and brief commentary to set the context.

3.3 At their last Mid-Cycle Briefing Group Spokespersons continued this analysis of the figures relating to residential and nursing care and the performance of the Directorate generally in promoting people's independence. You will recall that it had been agreed that Group Spokespersons would look at performance data relating to items coming up to your meeting. The START report on your agenda includes performance data as recommended by the Group Spokespersons.

3.4 At the next Mid-Cycle Briefing Group's Spokespersons have asked for performance data information with regard to people with long term

conditions so that advice can be given on how best to approach this topic at your July meeting.

4.0 Public Health Reports

4.1 Your Group Spokespersons have agreed that a series of Public Health reports will be considered, starting with the Alcohol Strategy, followed at your next meeting by Mental Health Strategy and Smoking Cessation.

5.0 Financial Abuse Review

5.1 So far, County Councillors Helen Grant, John McCartney, John Savage and Patrick Mulligan have been involved in the Financial Abuse Review. Three meetings with interested groups and individuals have been held, namely: two Faith Debt Advice organisations operating in the Hambleton and Northallerton area, a Citizens Advice Bureaux in Hambleton / Richmond and with the Manager of Hambleton Advocacy.

5.2 Themes emerging from these early discussions are:

- Lack of knowledge of abuse and what it is
- Lack of awareness due to frailty, fluctuating capacity, mental health and other health issues
- Lack of understanding of Powers of Attorney. This can mean those named on the documents misuse these powers
- Use of Powers of Attorney inappropriate for personal gain
- Concerns over withdrawal of support which could be provided by family members, close friends, neighbours of carers.
- Concerns about the consequences for the person(s)
- Concerns over isolation and loneliness
- Concerns over family disputes
- Level of acceptance due to the relationship with the perpetrator
- In terms of debt advice when working with clients it can be seen that some form of financial exploitation may be an underlying factor
- The quality of referral to advice agencies from other organisations is crucial
- On many occasions when financial exploitation is an issue the perpetrator is often someone close
- The services for victims is not always joined up
- The importance of financial literacy in schools

- In a high number of cases where exploitation is apparent, Mental Health issues are clearly a factor
- Staff and volunteers are coming across a number of occasions where financial abuse is clearly in evidence. But it is not always obvious as abuse. There is continuing work with the County Council on awareness raising for staff and volunteers.

5.3 In terms of Safeguarding, a positive impact can only occur if the Safeguarding process is conducted with the interest of the vulnerable person at the heart of the process.

5.4 Strategic issues so far raised include:

- Investment in prevention strategies is critical
- Raising awareness in vulnerable communities
- Joint working to promote holistic support
- Lack of choice of services in isolated communities
- Consistency of approach from responsible NYCC staff
- The impact of funding cuts on vulnerable adults which has the potential to further isolate people and increases their vulnerability

5.5 Further meetings are planned with interested groups so that the review report can be made available to the North Yorkshire Safeguarding Board in June.

6.0 Recommendations

6.1 The Committee is recommended to consider the attached work programme and determine whether any further amendments should be made at this stage.

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14 April 2014

Background Documents: None

Appendix 1

Care and Independence Overview and Scrutiny Committee – Work Programme Schedule 2014/15

Scope

The needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector

Meeting dates

Scheduled Mid Cycle Lead Members of Committee	Thurs, 15 May at 10:30am	Thurs, 4 September at 10:30am	Thurs, 4 December at 10:30am	Tues, 24 March 2015 at 10:30am
Scheduled Committee Meetings *Agenda briefings to be held at 9.30am prior to Committee meeting. Attended by Lead Members of Committee*	Thurs, 3 July at 10:30am	Thurs, 2 October at 10:30am	Thurs, 22 January 2015 at 10:30am	Thurs, 23 April 2015 at 10:30am

In-depth Scrutiny Review

Meeting	SUBJECT	AIMS/TERMS OF REFERENCE	ACTION/BY WHOM
Thursday, 24 April 2014 at 10.30am	Homecare Services - Short Term Assessment and Re-ablement Team	Assessment of effectiveness – Review of Performance	Report from HAS
	Prevention Strategy	Position following adoption of consultation report	Report from HAS
	Dementia	Update on activity against National Objectives	Report from HAS
	Alcohol Strategy	Public Health	Report from HAS

Care and Independence Overview and Scrutiny Committee – Work Programme Schedule 2014/15			
Overview Reports			
MEETING	**SUBJECT**	**AIMS/TERMS OF REFERENCE**	**ACTION/BY WHOM**
Thursday 23 July 2014 at 10.30am	Integrated Joint Commissioning		Report from HAS
	Integrated support for people with Long Term Conditions	Support for people in the community	Report from HAS
	Carers Issues	*Possible informal discussion with Carers Forum representatives*	
	Extra Care (possibly – timing dependent on Executive forward work plan)	Progress/Situation report on procurement (possible location visit of extra care premises at some point)	Report from HAS
	Personalisation	Evaluation/Self-directed Support/ Review of Direct Payments	Report from HAS
	Mental Health Strategy	Public Health	Report from HAS
	Smoking Cessation	Public Health	Report from HAS
Thursday, 2 September 2014 at 10:30am	Out of County Placements/Complex Needs	Update	Report from HAS
	Safeguarding Issue	to be determined. *(possibly specialist work to safeguard vulnerable people?)*	
	Developing the local market - services to support personalisation		Report from HAS
	Integrated Community Equipment/Centres for Independent Living/User led organisations		Report from HAS

Please note that this is a working document, therefore topics and timeframes might need to be amended over the course of the year.