North Yorkshire County Council

Agenda

Meeting: Care and Independence Overview & Scrutiny Committee

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

Date: Thursday 21 January at 10.30 am

Recording is allowed at County Council, committee and sub-committee meetings which are open to the public, please give due regard to the Council's protocol on audio/visual recording and photography at public meetings, a copy of which is available to download below. Anyone wishing to record is asked to contact, prior to the start of the meeting, the Officer whose details are at the foot of the first page of the Agenda. We ask that any recording is clearly visible to anyone at the meeting and that it is non-disruptive. http://democracy.northyorks.gov.uk

Business

1. Minutes of the meeting held on 1 October 2015.

(Pages 1 to 6)

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 Monday 18 January 2016, 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.

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**

3. **Joint Health and Wellbeing Strategy -** Report of the Corporate Director – Health & Adult Services

(Pages 7 to 37)

4. **Better Care Fund** – Report of the Corporate Director – Health & Adult Services

(Pages 38 to 45)

5. **Presentation by Dianne Chaplin, Care Quality Commission**

6. **NY Seasonal Winter Health Strategy –** Report of the Corporate Director – Health & Adult Services (Enclosed report submitted to Health and Well-Being Board in November)

(Pages 46 to 68)

7. **Annual Report of the Older Peoples Champion**

(Pages 69 to 72)

8. **North Yorkshire Local Assistance Fund –** Report of the Assistant Director, Policy and Partnerships

(Pages 73 to 77)

9. **Equipment & Telecare 2020 Proposals -** Report of the Corporate Director – Health & Adult Services

(Pages 78 to 82)

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

(Pages 83 to 86)

11. **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
Northallerton

13 January 2016

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
The fire evacuation alarm is a continuous Klaxon. On hearing this you should leave the building by the nearest safe fire exit. From the **Grand Meeting Room** this is the main entrance stairway. If the main stairway is unsafe use either of the staircases at the end of the corridor. Once outside the building please proceed to the fire assembly point outside the main entrance

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	ARNOLD, Val		Conservative	
2	CLARK, Jim		Conservative	
3	ENNIS, John		Conservative	
4	GRANT, Helen	Vice-Chairman	NY Independent	
5	HOULT, Bill		Liberal Democrat	
6	JORDAN, Mike		Conservative	
7	McCARTNEY, John		NY Independent	
8	MARSHALL, Brian		Labour	
9	MOORHOUSE, Heather		Conservative	
10	MULLIGAN, Patrick	Chairman	Conservative	
11	PEARSON, Chris		Conservative	
12	SAVAGE, John		Liberal	
13	SWALES, Tim		Conservative	

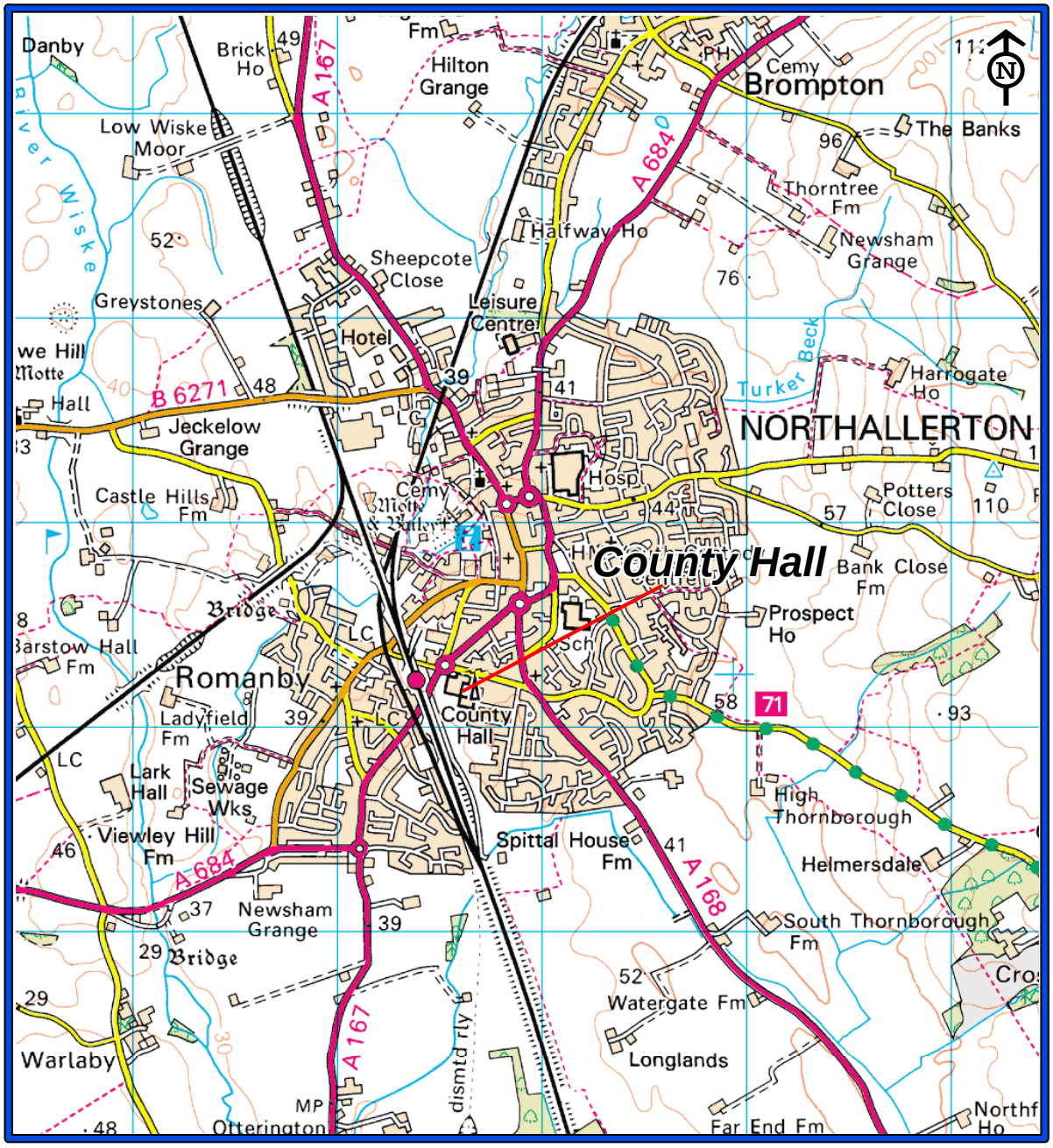
Members other than County Councillors – (2)			
Non Voting			
	Name of Member	*Representative*	*Substitute Member*
1	CARLING, Jon	North Yorkshire and York Forum	
2	SNAPE, Jackie	Disability Action Yorkshire	
3	PADGHAM, Mike	Independent Care Group	

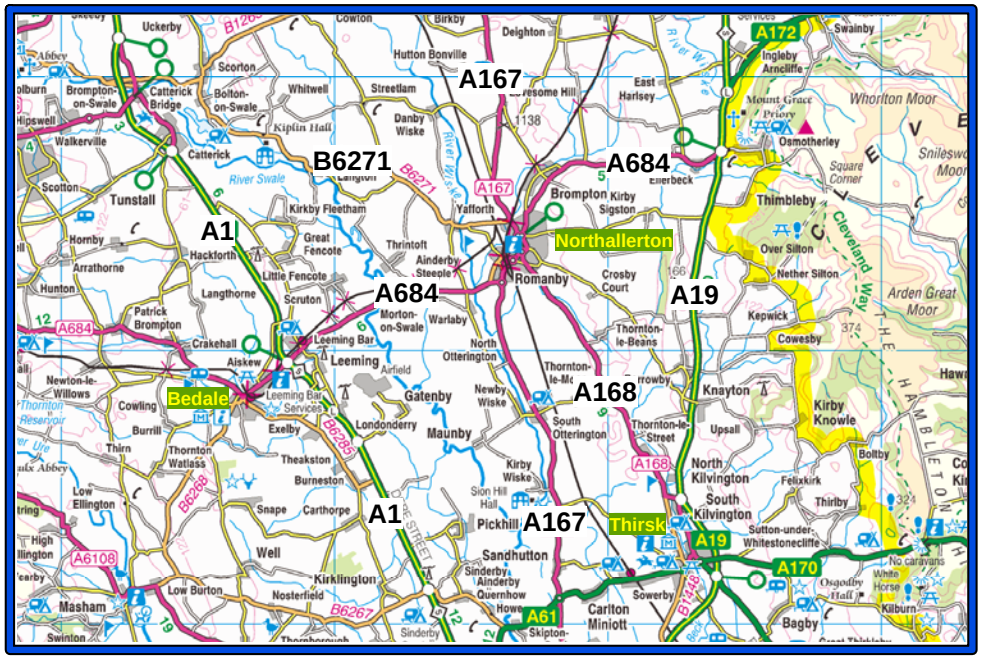
Total Membership – (15)	**Quorum – (4)**

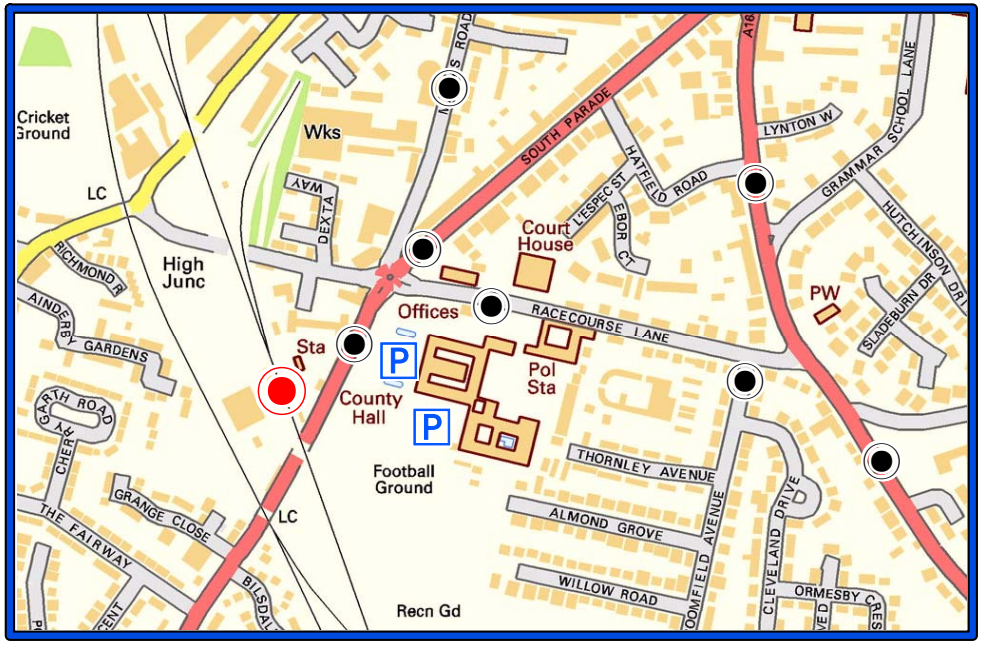
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**0**	**2**	**1**	**1**	**0**	**0**	**13 ***

2. Substitute Members

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







P **Visitor Parking at County Hall**

Northallerton National Rail Station

Bus Stops

County Hall
Northallerton
North Yorkshire
DL7 8AD

Tel : 0845 8 72 73 74

North Yorkshire County Council

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

Minutes of the meeting held on 1 October 2015 at 10.00 am at County Hall, Northallerton.

Present:-

County Councillor Patrick Mulligan in the Chair

County Councillors: John Ennis, Helen Grant, Bill Hoult, John McCartney, Brian Marshall, Shelagh Marshall OBE (as substitute for Jim Clark), Heather Moorhouse, Chris Pearson, John Savage and Tim Swales.

Representatives of the Voluntary Sector: Jon Carling (North Yorkshire and York Forum),
In attendance: County Councillors Clare Wood (Executive Member for Adult Social Care Health Integration). David Chance (Executive Member for Stronger Communities and Public Health)

Officers: Ray Busby (Scrutiny Support Officer, (Policy and Partnerships)), Sheila Hall (Head of Engagement & Governance, Procurement, Partnerships & Quality Assurance (HAS)), Joss Harbron (Head of Provider Services (HAS)), Marie-Ann Jackson Head of Stronger Communities Programme, Policy and Partnerships (CSD), Tony Law (Head of Performance and Intelligence, Resources (HAS)) ,Dr Lincoln Sargeant (Director of Public Health), Cath Simms Head of Targeted Prevention, Care and Support (HAS), Mike Webster (Assistant Director, Contracting, Procurement and Quality Assurance (Health and Adult Services)).

Apologies: County Councillors Val Arnold, Jim Clark and Mike Jordan. Jackie Snape (Disability Action Yorkshire) and Mike Padgham (Independent Care Group).

Copies of all documents considered are in the Minute Book

---

75. Minutes

Resolved –

That the Minutes of the meeting held on 2 July 2015, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

76. 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.

77. Annual Report of the North Yorkshire Safeguarding Adults Board

Considered -

The report of the Corporate Director - Health and Adult Services asking the Committee to receive the Annual Report of the North Yorkshire Safeguarding Adults Board.

Having now decided to retire, Jonathan Phillips, Chairman of the Board, introduced his final Annual Report to the committee.

Jonathan reported that the Board was feeling the benefit of the work over recent years on good governance. Reducing the membership of the Board, for example, had given it a stronger sense of focus. Attendance from representatives of agencies was high. Also, some recent staffing changes had strengthened support to the Board and increased the focus at the second tier level of governance.

Jonathan praised the proactive work of the Designated Adult Safeguarding Managers in relation to abuse of staff.

Jonathan highlighted a number of areas in which scrutiny might take an interest. He expressed the view that in respect of elder abuse, many people, if asked, would not know where to report incidents of potential abuse; most would look to their GP for support and advice. The question was, therefore, whether GPs were sufficiently engaged in safeguarding joint activity as they might be. As care homes and extra care come increasing pressure, this creates an environment where training becomes one area providers possibly look to squeeze and neglect.

Responding to questions, Jonathan agreed that putting the Board on a statutory footing has ensured that agencies are more easily accountable and has clarified responsibilities to ensure participation, in ways that guidance, differentially binding on the partners, was not able to. The coming into force of the Care Act is also significant in that it sets out a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. This gives the board a clear basis in law.

When asked for his thoughts on safeguarding training for councillors, Jonathan agreed that the importance of raising elected member awareness to help keep adults at risk safe does not diminish. Councillor Clare Wood agreed wholeheartedly and said she would discuss options with the Corporate Director for Health and Adult Services.

Resolved -

a) The Annual Report of the Safeguarding Adults Board be noted.

b) The committee agreed that the evidence in its report for 2015/16 suggests the Board is in a healthy state - governance arrangements are sound; work on community prevention and awareness is robust, and strategic links with other partnerships in localities is good.

c) That reports of progress be received.

d) That the committee remains aware of national developments and best practice.

e) That the group spokespersons discuss with the portfolio holder options for members development training on safeguarding.

78. Stronger Communities and Living Well

Considered -

Briefing and joint presentation of the Head of Stronger Communities and North Yorkshire Health and Adult Services on the relationship between the Stronger Communities and Living Well Programmes and outlines the differences and the inter-dependencies between them as they work towards the aim of helping to combat loneliness and isolation by strengthening existing and building new individual and community assets and networks.

Marie–Ann Jackson and Cath Simms gave a presentation and talked through the key elements of the briefing report.

Faced with delivering further significant savings by 2020, the Council recognises that there will be services it has traditionally provided that will no longer be available or will need to be delivered in a different way and in partnership with others - such as libraries transitioning to become community managed. This means a shift from the provision of universal services to targeted prevention and programmes to manage future demand on social care budgets.

Marie–Ann explained that the key characteristic of the delivery of the Stronger Communities Programme, as distinct from the Living Well Service, is it works with communities whereas the focus of the Living Well Service is with individuals.

Stronger Communities has set out to work with local organisations, community groups and other partners from the public and private sectors across North Yorkshire, identifying opportunities to co-produce a range of local support and services aimed at improving the well-being of people of all ages.

Cath Simms advised that as part of its wider prevention programme - Independence with Support When I Need It - the Council has invested in a new Living Well Service which aims to improve the health, well-being and independence of individuals and in doing so prevent, reduce or delay their need for long-term health and social care support.

Whereas the focus for the Stronger Communities programme is to support voluntary and community groups, services and facilities, the Living Well team are working with individuals (and their carers) who are on the cusp of becoming regular users of health and social care services by helping them access local community organisations and supporting them in finding their own solutions to their health and wellbeing goals.

Members discussed local activity in their areas which they believed contributed to the work of the two teams.

The Committee asked to be kept informed of the progress of a shared outcomes framework which is being developed to measure future performance so that when it reviews the topic again, probably in a year's time, it can properly gauge what has been achieved.

Resolved -

a) That the report be noted.

b) Members recognised the inter-dependency of the two programmes, and were reassured by the evidence presented that they are working together effectively.

c) That at a future mid-cycle briefing, the committee's group spokespersons be advised on the progress on the shared outcomes framework, so that they can take a view whether, and at what point, the committee should review this topic again.

79. 2014 Annual Report of the North Yorkshire Director of Public Health

Considered -

The report of the Director of Public Health for North Yorkshire introducing his annual report.

Resolved -

That the report be noted.

80. Local Account for Adult Social Care and Public Health Services 2014/15

Considered -

The report of the Corporate Director - Health and Adult Services reporting on the contents of the Draft 2014/15 Local Account in respect of the performance of the Adult Social Care and Public Health Services (set out at Appendix 1 to the report) and asking for Members' comments.

Resolved -

a) That the Committee's comments on the Local Account be noted.

b) That the policy of publishing the Local Account as an electronic document only, be continued.

81. Provision of an Integrated, Adult Substance Misuse Service: "North Yorkshire Horizons" - Discussion with Providers - Developing Initiatives Supporting Communities and Lifeline

Considered -

The Report of the Director of Public Health reporting progress within North Yorkshire New Horizons during year one of their contract with NYCC.

Dr Lincoln Sergeant explained that the Council had awarded contracts to DISC (Developing Initiatives Supporting Communities) and Lifeline in May 2014 for the provision of an integrated, adult substance misuse service for North Yorkshire. DISC was awarded the contract for the Treatment Service, and Lifeline was awarded the contract for the Recovery and Mentoring Service

The new service placed an emphasis on peer led recovery, where mutual aid will help individuals recover. Recovery is based on inspiration and motivation from the outset, from 5 key hubs based across the county, as well as local access in rural

areas. The service is focused on helping and supporting people to recover from substance misuse and dependence

The services developed include:

- Supporting 33 GP practices to deliver a drug treatment service, and over 20 pharmacies to deliver a needle exchange service.
- Supervised consumption service from over 30 pharmacies

Ted Haughey (Treatment Service) highlighted a number of achievements:

- 2618 service users have engaged with the service since October 2014.
- The Single Point of Contact service (SPOC) consistently received over 1000 calls per week in the initial months of operation, and it continues to receive in excess of 6,000 calls per month.
- The number of community based 'Meet and Greet' and 'Recovery' groups across North Yorkshire has expanded to over 40. North Yorkshire Horizons inherited only a couple from previous service providers. Groups operate in all localities across North Yorkshire.
- 262 individuals have 'successfully completed treatment' between October 2014 and 30th June 2015 and no longer require support from the North Yorkshire Horizons Treatment Service.

Members agreed that these results and achievements are to be commended, showing as they do that many people are receiving the support they need to turn their lives around.

Resolved -

The committee recognised the initiative's success a year later into the contract, and agreed to talk to the providers on similar lines in another year's time.

82. Strategy for Meeting the Needs of Children, Families and Adults with Autism in North Yorkshire 2015-2020

Considered -

The report of the Corporate Director - Health and Adult Services updating the Committee on progress of the strategy for meeting the needs of children, families and adults with autism in North Yorkshire 2015-2020 to be published in October 2015 and updating the Committee on the Health and Wellbeing Board's decision on whether to publish a brief document specifically for people with autism and the wider public stating the overall ambitions for supporting people with autism in North Yorkshire up to 2020.

Joss Harbron agreed to review how local prevalence figures were presented in the report to give a clearer sense of their relationship to the national context.

Resolved -
That the progress on the strategy for meeting the needs of children, families and adults with autism in North Yorkshire 2015-2020 be noted.

83. Work Programme

Considered -

The report of the Scrutiny Team Leader on the Work Programme.

Resolved -

That the Work Programme be agreed.

The meeting concluded at 12:45pm

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

21 January 2016

Joint Health and Wellbeing Strategy

1.0 Purpose of Report

1.1 This paper briefs Members on the North Yorkshire Joint Health and Wellbeing Strategy (JHWS).

1.2 This issue is of particular significance for the Committee because:

- It affects the whole population of North Yorkshire.
- The Strategy is a shared commitment with partners across the North Yorkshire Health and Wellbeing Board.
- The Strategy has been updated and is consistent with national drivers of improving people's health and wellbeing, integration of health and social care; and enabling people to have greater choice and control of the services they use.

2.0 BACKGROUND

2.1 The North Yorkshire Health and Wellbeing Board is made up of partner organisations from across the county. The Board produced its first Health and Wellbeing Strategy in 2013. This has been updated in order to take into account changing priorities at both national and local level, as well as recognising the need to manage reduced budgets across partner organisations. The updated Strategy (attached) restates partners' commitment to improving health and wellbeing for the whole population, as well as setting out how the Board wishes to continue to improve services.

3.0 KEY POINTS FROM THE STRATEGY

3.1 The JHWS is organised within five themes:

- Connected Communities
- Start Well
- Live Well
- Age Well
- Dying Well

3.2 The Strategy sets out why each of these themes are important and the outcomes the Board wishes to see, supported by some key changes that the public can expect to see by 2020. The themes are not intended to be age specific but are about how we, collectively, consider and deliver the outcomes described.

3.3 To support delivery of the Strategy it is important that the whole system works together to deliver these changes. The Board has set out four things that we need to focus on to ensure there is progress in achieving the outcomes described. These are:

- A new relationship with people using services
- Workforce
- Technology
- Economic prosperity

3.3 The Board understands and recognises that health and wellbeing is about more than health and social care services. Every aspect of public life – education, childcare, housing, employment, the quality of the local environment and the type of community we live in – can affect our health and wellbeing at any point through our lives. The Strategy encourages everyone to be aware of the impact of their actions on health and wellbeing, and to take account of this when planning changes or considering options for themselves, or someone they care for.

4.0 ENGAGEMENT WITH OTHERS

4.1 The draft strategy was consulted on throughout the summer of 2015 and the Board used a number of methods to gain the views of both partners and the public. This included: On-line survey hosted by NYCC on behalf of the Board; publication of the Strategy on partnership websites; attendance at service user and partner forums which provided opportunities to discuss the Strategy; and written feedback from wider stakeholders.

4.2 In addition to the survey questionnaires, the following partners and stakeholder organisations also submitted comments:

- Healthwatch
- Scarborough Borough Council
- Richmondshire District Council
- Harrogate Borough Council
- Transport Planning Office
- NYCC Scrutiny of Health Committee
- County Homelessness Group
- Woodland Trust

4.3 Easy Read and Summary versions of the Strategy were produced to help ensure service users could easily engage and respond throughout the period. The consultation closed on 19 August 2015 with 75 questionnaire responses being received in total, of which 13 were in Easy Read format. The vast majority of respondents were supportive of the strategy and the outcomes set within it. 67 out of the 75 respondent (89%) agreed or strongly agreed with the strategy (question 1 of the survey). The generic survey responses to questions 2-5 were varied and produced a total of 290 comments which ranged from broad agreement with much of the strategy to some specific and individual responses about particular issues. As advised by communications and quality & engagement teams, survey questions were adjusted slightly for the Easy Read version.

4.3 As a result of the responses and comments received during the engagement/consultation period, a number of changes were made to the Strategy.

4.4 In particular, the Dying Well theme was added after feedback from Health Scrutiny which highlighted this as an area which required greater focus. Housing and transport were also issues that were raised as something that the Strategy needed to pay more attention to.

5.0 NEXT STEPS

5.1 The North Yorkshire Health and Wellbeing Board approved the final Strategy at its meeting on 27 November 2015. Partners met in a Board development session on 14 December 2015 to consider how to measure the outcomes set out in the strategy and the way in which the Board will oversee implementation. The Strategy itself is now progressing through NYCC Executive (2 February 2016) and Full Council 17 February 2016) for formal approval in line with the Constitution.

6.0 Conclusions

6.1 The JHWS is a partnership commitment which aims to improve the health and wellbeing with, and for, people of all ages living in North Yorkshire. Specific service/organisation impacts will be identified within relevant implementation plans and overseen by the North Yorkshire Health and Wellbeing Board.

7.0 Recommendations

1. That the Committee receives the Joint Health and Wellbeing Strategy.

Wendy Balmain
Assistant Director, Integration
Health and Adult Services

County Hall
Northallerton

12 January 2015

Health and Wellbeing Board
North Yorkshire

Joint Health and Wellbeing Strategy 2015 - 2020

Signatories to the North Yorkshire Joint Health and Wellbeing Strategy are

Age Concern - representing the voluntary sector

Airedale, Wharfedale and Craven Clinical Commissioning Group

Craven District Council - representing District Council members

Hambleton, Richmondshire and Whitby Clinical Commissioning Group

Harrogate and Rural District Clinical Commissioning Group

healthwatch North Yorkshire

NHS England

North Yorkshire County Council

Ryedale District Council - representing District Council officers

Scarborough and Ryedale Clinical Commissioning Group

Tees, Esk and Wear Valleys NHS Foundation Trust

Vale of York Clinical Commissioning Group

York Teaching Hospital NHS Foundation Trust - representing acute hospital providers

The organisations that are signatories to this strategy have made a commitment to work together to support local systems to achieve continuous health and wellbeing improvements for the population of North Yorkshire.

Contents

Foreword

The North Yorkshire Health and Wellbeing Board is made up of partner organisations from across the county. We understand that there are diverse and complex communities within North Yorkshire and recognise the strong sense of local identity that this brings. We have a history of working together to develop healthier, stronger communities in our county and are well placed to tackle the next stage in partnership not only with each other but, more importantly, with those people who use services and the individuals or groups that provide direct support and care to others.

In 2013 we produced our first health and wellbeing strategy, which took into account what local people and our partners told us they thought our priorities should be. This updated document reflects on the progress we have made so far and outlines what we need to adapt to take into account changing local and national health priorities, as well as managing our reduced budgets. It also takes into account the findings of the latest Joint Strategic Needs Assessment (JSNA), and what local people have told us really matters to them for their long term health and wellbeing.

This updated strategy gives us an opportunity to restate our commitment to improving health and wellbeing as well as setting out how we want to continue to improve services. The five themes of: Connected Communities; Start Well; Live Well; Age Well and Dying Well describe how we intend to maintain the momentum we have built up in delivering our ambition to ensure that people in all communities in North Yorkshire have equal opportunities to live full and active lives from childhood to later years.

County Councillor Clare Wood

Executive Member for Adult Social Care and Health Integration
North Yorkshire County Council

Chairman of North Yorkshire Health and Wellbeing Board

Amanda Bloor

Chief Officer
Harrogate and Rural District Clinical Commissioning Group

Vice Chairman of North Yorkshire Health and Wellbeing Board

Why are we updating the strategy?

We want our strategy to make a difference, rather than being a document on a shelf. That's why we have taken this opportunity to bring it up to date so that people living in North Yorkshire continue to have access to great services which take account of:

- the latest evidence from our Joint Strategic Needs Assessment (JSNA)
- changes in national policy, local ambition and people's expectations
- listening to local people about what's important to them for their long term health and wellbeing and using feedback to shape our services

There are many changes taking place across North Yorkshire all the time that have an impact on our health and wellbeing, and there is always more to do. This document won't describe every change that is taking place, but it has been developed to help us stay focused on achieving those things that are most important for local people. It will help us make a difference by reducing variations in health and care outcomes across the county.

We know that if we do this, we will be making a positive and lasting impact on the health and wellbeing of people and communities in North Yorkshire.

You can see some of the things that people have said recently in the "What people have told us they want from this strategy" sections which appear throughout this document.

Why do we need to change?

- People in North Yorkshire are living longer than ever before. That means we all have the potential to enjoy more years of healthy, active life from childhood right into old age by helping ourselves and our families to live well. But it also means that we may need more help as we get older, to age well and be as healthy and independent as we can be through to the end of our lives.
- Not all the communities in North Yorkshire are as healthy as we'd like them to be. Life expectancy for men living in Scarborough, for example, can vary by as much as 11 years between the richest and poorest areas of the district. We are seeing widening variations in obesity between children living in affluent and deprived neighbourhoods. We want to reduce the gaps as part of our strategy to make North Yorkshire healthier and happier.
- There are more demands on the money available to the health and care system than in the past. This means all organisations need to plan carefully about how to spend the North Yorkshire pound. By doing that together, and using new technology wisely, we believe we can deliver better value for money and do more with the resources we have at our disposal.

The North Yorkshire Joint Strategic Needs Assessment (JSNA) contains more information on the current health and wellbeing of North Yorkshire communities. You can download a copy at www.nypartnerships.org.uk/jsna.

How does this fit into the national picture?

Since 2012 there have also been some big changes in the priorities for health and wellbeing at national level. As the largest county in England, it's not surprising that these are all highly relevant to North Yorkshire.

The most important of these include:

- Working with people throughout their lives to prevent the need for longer term care and making sure people are in control of the choices made about their care and their lives.
- Making sure children's services work together to help every child have the best start in life.
- A new focus on ways in which local health and social care organisations can work together so that people's experience of care is more integrated.
- A new focus on care delivered in or close to people's homes with fewer people being admitted to hospital.

What is this strategy really about?

Working together to make North Yorkshire healthier and happier

This strategy really is important. It is a shared agreement between each partner organisation in the Health and Wellbeing Board with, and for, people of all ages living in North Yorkshire. It is about what we can and want to change.

Those of us who commission health and social care have a legal responsibility to make sure that our commissioning plans are guided by this strategy, and the Health and Wellbeing Board has a responsibility to ensure that this happens.

Health and wellbeing is about more than health and social care services. Every aspect of public life - education, childcare, housing, employment, the quality of the local environment, and the type of community we live in - can affect our health and wellbeing at any point through our lives. We understand this and want to help and encourage everyone to be aware of the impact of their actions on health and wellbeing, and to take account of this strategy when they plan to make changes.

Part of our job is to ensure that we all work well together so that we can achieve the best possible outcomes for local people and communities. We have a responsibility to make sure that our individual plans all face the same way and that when we invest the North Yorkshire pound we invest it wisely.

Understanding the strategy

What we plan to do

To help us concentrate on the most important things for North Yorkshire's health and wellbeing, we have agreed on five key themes to help us organise our work. These themes will sometimes overlap and will be relevant to all age groups.

- Connected communities
- Start well
- Live well
- Age well
- Dying well

We set out why each of our themes is important, what we hope to achieve - 'our outcomes' - and the changes you can expect to see, on pages 8 to 17.

Getting the whole system working better

To really make change happen we want to improve the ways in which the whole health and care system works together in North Yorkshire. We think that a focus on four things which, if we get them right, will help all organisations to achieve better outcomes for local people and communities:

- A new relationship with people using services
- Workforce
- Technology
- Economic prosperity

We explain more about these and why we think they are important on pages 19 to 21.

How we want things to happen

There are some guiding principles that we have adopted which organisations and people who receive services can use as a checklist when we develop new services. This will help build services that are more personal, joined up and equal across North Yorkshire. Our principles are:

- Recognise where things are different
- Tackle issues early
- Joining things up to make life simpler
- Making a positive contribution
- Keep people safe
- Spending our money wisely

We explain more about these and how we will use them in practice on pages 23 to 24.

Outcomes

We want North Yorkshire to be a place where communities flourish, people shape services and have control of their lives

Connected communities

Why is it important?

North Yorkshire people live longer, healthier lives compared to England as a whole, but there are significant variations between districts, communities and population groups.

For example, a girl born in Hambleton today can expect to live for 2.5 years longer than the average for England, but a girl born in Scarborough can expect to live for 0.5 years less. This variation has grown bigger over the last 10 years.

People with severe mental health problems often have poorer physical health too.

Strong local communities have been proved to be effective in supporting people to make healthy choices. They also help people cope with, and recover from, adverse events like illness, economic pressures and even extreme weather.

It prevents individuals feeling lonely and isolated which, in turn, reduces depression and anxiety.

Volunteering has benefits for both the volunteer and for those they help. Voluntary organisations are a vital part of connected communities - they provide things that other parts of the system can't, and their experience of working locally is a valuable resource.

Technology is a key asset for communities, helping to support local business opportunities, providing everyone with better ways of communicating with the outside world, and providing new solutions to self- manage our care.

What have people told us that they want from this strategy?

"To belong to a vibrant, caring community and to have access to health services when I need them."

"To have options and resources available which reduce social isolation. To be able to feel confident attending a medical appointment and understand what's been said, what actions are required and what treatment is needed"

"Recognise the importance that access to woodland and natural green space can have in improving wellbeing"

What changes can you expect to see?

By 2020, you can expect to see:

- Vibrant and self-reliant communities in all parts of North Yorkshire, with local people and organisations working together to develop community libraries, community transport services and activities for all age groups.
- Dementia friendly communities where people living with dementia and their families feel supported and confident and a part of their local area.
- Recognition and provision for our military communities, veterans and their families' needs as part of their local health and care services.
- Improvements in technology in rural areas, for businesses and homes, and increased access to technology for children and young people from disadvantaged communities.
- More opportunities for volunteering for people of all ages, and more people taking up these opportunities.
- A stronger link between work programmes across health and social care that make it clearer for people to see how things are connected, for example Stronger Communities, Living Well and local Transformation Board plans.

Outcomes

- Ensuring education is our greatest liberator
- Helping all children enjoy a happy family life
- A healthy start through healthy lifestyles

Start well

Why is it important?

There are over 130,000 children and young people aged 0-19 in North Yorkshire - and this number is growing.

Most North Yorkshire children already get a good start in life, but in a large and diverse county, there are still some who don't experience all the good things we would hope for. This may be for a range of reasons such as rural isolation, poverty, urban deprivation, disability or family breakdown. We need to make sure that these children's needs are spotted early and that they and their families receive the help they need from birth.

It's vital that every child has an excellent education to maximise their life chances - we know that this is a major factor in health and wellbeing throughout life. That includes a positive, safe experience throughout school and college as well as wider educational work to encourage children and young people to make healthy choices about their lifestyle.

Emotional and mental health and wellbeing is important at all ages. We need to support children and young people to be mentally and emotionally healthy. This doesn't just mean the 16,000 or so under-19s who have a recognised mental health disorder. We know that low self-esteem and anxiety can make daily life difficult, and we want to make sure every young person has a source of help when they need it.

What have people told us that they want from this strategy?

"Keeping children and young people safe and ensuring that children and young people are safe from drugs/alcohol and unsafe sex."

What changes can you expect to see?

By 2020, you can expect to see:

- A higher percentage of babies who are breast fed and a higher percentage of children who receive immunisations and vaccinations.
- More children and young people making healthy choices, exercising regularly and eating well.
- A lower percentage of children who are obese or overweight.
- Fewer children and young people taking part in unhealthy, unsafe or risky behaviour - smoking or taking drugs, self-harming, unsafe sex - or becoming the victims of physical, mental or sexual abuse.
- An increase in the level of mental wellbeing amongst children and young people.
- A reduction in the gap in educational attainment between those children who receive free school meals and those who don't.

You can find out more about the work taking place to support children and young people from 'Young and Yorkshire'.
www.northyorks.gov.uk/youngandyorkshire

Outcomes

- People are emotionally resilient and experience good mental health
- Everyone has the opportunity to have a healthy body and a healthy mind
- People are active, involved and can be free from isolation and loneliness

Live well

Why is it important?

North Yorkshire people are healthier, and live longer, than the average for England. But there is still work to do to reduce the number of people affected by conditions that can be prevented or delayed. Heart disease, stroke and cancer account for the greatest proportion of deaths within North Yorkshire. Many of these illnesses can be avoided if everyone is helped to make positive lifestyle choices.

The risk of social isolation and loneliness is greater for people living in rural communities, especially (but not exclusively) amongst older people and those with a disability or long term illness - and people who are socially isolated are more likely to die prematurely.

Being in good employment increases mental and physical health and wellbeing. We need to maximise local opportunities for economic and job development, including apprenticeships and graduate opportunities for the young people who are our future workforce.

The quality of our home is another major factor in health and wellbeing. For example, fuel poverty and cold homes are major contributors to poor winter health. We need to ensure that there is an affordable supply of North Yorkshire homes that have a positive impact on health and wellbeing.

The York, North Yorkshire and East Riding Strategic Housing Partnership has produced a Housing strategy. You can find out more about it at www.nycyerhousing.co.uk

What have people told us that they want from this strategy?

"Good clear communication so we can make healthy choices. Better awareness/training for people who support us about how we can live a happy and healthy life…"

"Having easier access to fitness centres, lowering costs of fitness centres. More information on healthy choices."

What changes can you expect to see?

By 2020, you can expect to see:

- Fewer people saying that they feel socially isolated in their local communities.
- More people receiving personal budgets for their care, to give them choice and control over their lives.
- More people helped to self-manage their own care at home or through local community hubs.
- Fewer hospital admissions and lower premature death rates from heart disease, stroke and cancer, with the biggest improvements in the most deprived areas of the county.
- Improved employment opportunities, including rural areas and particularly for young people and those people who often face most barriers in the labour market - for example people with mental health issues, people with autism and people with disabilities.
- A higher proportion of young people taking up apprenticeships in North Yorkshire.
- Fewer people living in poor quality or inappropriate housing, or living in fuel poverty.
- More people with autism will have access to a diagnostic pathway to support and help improve their health, wellbeing and independence.
- A greater range of options for accessing exercise and fitness services.

Outcomes

- People can make choices to self-manage their care to help them stay independent for longer
- Carers are supported to live their own life

Age well

Why is it important?

North Yorkshire people are living longer these days - more than a year longer, on average, than ten years ago. That means more active older people in good health, but also more people (especially the very old) living with on-going conditions such as arthritis, dementia, heart problems or osteoporosis.

We expect there to be a third more people aged 85 plus by 2021 compared to 2011.

The number of families caring for loved ones continues to rise, with the sharpest rises amongst those providing the highest levels of care. The number of carers over 65 is increasing above any other age group

Care and support for older people takes up the greatest share of resources in the NHS and social care. So it's important to get this right - and if we make services work well together for older people, we can be confident that they can work well together for everyone else, too.

People can feel in control of their lives and are able to make decisions and choices for themselves and be valued as part of a community.

What have people told us that they want from this strategy?

What changes can you expect to see?

By 2020, you can expect to see:

- More health and social care staff working together across local GP surgeries and primary health care centres to support older people in the local community.
- New community hubs offering advice, access and care to people receiving services and those who care for them.
- More carers feeling that they can have a life outside caring.
- Improvements in the way people can choose, buy and fit equipment and Telecare so that they can stay independent for longer.
- A range of options in place that help people to keep their independence for longer. For example, intermediate care and reablement services.
- Fewer older people entering nursing or residential homes for long term care.
- More Extra Care housing available to people across North Yorkshire.
- A greater range of support options for people in their last years of life.
- More people receiving support for themselves and their families at the end of life, with more people dying at home or in the place that they choose.

Outcomes

- Individuals are supported and encouraged to prepare for and plan their last days
- All individuals, their carers and families' experience good end of life care

Dying well

Why is it important?

In North Yorkshire, although most people would prefer to die in their own home, around half die in hospital. The proportion dying at home will increase, but because of a rise in the death rate, the actual numbers dying in hospital will also increase unless we do something to change this.

There has been a substantial shift towards patient choice with people increasingly encouraged to be directly involved in shaping treatment plans for themselves and their relatives.

Death and dying is now beginning to be debated more openly. Nevertheless it still seems to be the case that, in practice, the discussion of death as an inevitable and, in some cases, imminent aspect of life is regarded as morbid and thus avoided.

Hospital cannot offer the individual the same comfort and familiarity that they might find if they were able to die in their own home and in their own bed, surrounded by the people that they love.

Encouraging conversations around quality of life, how and where a person might want to be cared for, as well as financial issues, helps to make sure the wishes of the person dying are followed. If family know about the dying person's wishes it can help them if they ever have to make decisions about care and can help to remove some of the stress at a difficult time.

This could include exploring options such as hospice care which can provide care for the dying and support for the family provided in a person's own home or elsewhere.

What have people told us that they want from this strategy?

"To consider how bereavement support is provided to grieving friends and relatives."

"Dying well is very important for all ages and providing support to friends and relatives should have greater prominence from all organisations"

What changes can you expect to see?

By 2020, you can expect to see:

- A greater range of support options for people in their last years of life.
- More people receiving support for themselves and their families at the end of life.
- More people dying at home or in the place that they choose.
- Greater numbers of trained staff and carers with deeper understanding about the range of issues in end of life care.
- Adoption of new and emerging best practice and principles around end of life care (Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 - www.endoflifecareambitions.org.uk).
- End of life care being planned in an effective and sensitively appropriate way, and for staff to be adequately trained.

Getting the whole system working better

A new relationship with people who use services

We want to develop a new relationship with people who use services and the communities they live in. We recognise that people are part of a community and that we need to build on the strong relationships that are already in place locally to get the best outcomes we can for everyone.

Health and wellbeing services, by their very nature, are often needed most by those in our society that are the most vulnerable and we recognise that we have a statutory duty to help people in this situation. We also understand that people might find themselves in need of help because of a particular set of circumstances and it is important that we organise services in a way that makes it easy to get help whenever it is needed by a person, or their carer.

We want people to have a bigger say over their own care and how they manage their lives, no matter what their health and care needs might be. For people to be able to do this it is important that there is easy access to good information and advice that helps people make informed choices about their care. Getting this right means that, as our needs change, we can look after ourselves and each other for longer and that we can get the right help at the right time from others.

We want to work with people to do things differently and in a more joined up way. We also want to make it easy for people to tell us what they want from services and how we are doing in delivering services.

What have people told us that they want from this strategy?

"I think one of the hardest things for policy makers is to understand the variety of differing complex situations people find themselves in at various stages in their lives, and particularly in later life. So the point in the strategy about developing relationships with service users seems to me to be very important."

"That the professionals communicate effectively with each other, that there are supportive local services, that I am treated as an equal in my care"

As well as having more input into decisions about the sort of care people might receive, we want people to have direct control of the money available to support their care. We are already doing some of this through personal budgets for both health and care, but we expect to see more people using these budgets to self-manage their care.

Workforce

To deliver good health and wellbeing services we need a skilled, motivated and flexible workforce. Health and social care organisations don't always find it easy to recruit and retain staff to work locally - we need to help to change that. We know that nursing staff in care homes and some community hospitals is an area of particular pressure. We are working with organisations who provide care and our education partners to develop the workforce of the future and to attract and retain quality nursing staff so that people can be confident in the care that they receive.

North Yorkshire health and care organisations are working with local people to redesign the health and care system. This includes developing new models of care which will help people access more services in the community that join up health and social care. This will mean staff from different organisations will need to learn new skills so that people using services have a better experience of care.

Some of the ways we can make this happen are through:

- Creating new roles that offer exciting career choices in health and social care.
- More local opportunities for people to develop their skills in health and social care sectors, as well as in education and other children's services.
- More opportunities for people to return to work after a break or after retiring from a full time role.
- Better opportunities for people who have experienced poor mental health to access paid employment.

Technology

Technology is now a fundamental part of every aspect of our lives. The way we access and share information, interact with each other and use services all relies on technology working well and in a way that suits our lives. We want to help organisations to talk to each other more easily so that people can use technology to find out more about health and social care.

We want to help people take responsibility for self-managing their care and technology has a role to play in offering easy ways to access advice and information. There are now many ways to keep in touch and we want to maximise these opportunities for the people who use services.

Technology can be a key asset for communities, helping to support local business opportunities, improving educational experiences across all age groups, providing everyone with better ways of communicating with the outside world, and offering the opportunity to learn from others. We also need to ensure that children are protected from the potential pitfalls of technology especially where this might compromise the personal safety of young people or increase their likelihood of exploitation.

We want to work with partners and the wider community to make sure we are making the best use of the technology that is available to us and our communities.

What have people told us that they want from this strategy?

Economic prosperity

Our successful tourism sector gives us a special sense of the importance of our local communities and heritage. We want to encourage ourselves and our partners to think more creatively about how we can use these assets and the things that are best about North Yorkshire to find new ways in which they can contribute to health and wellbeing.

Creating a supportive environment for businesses is good for the health and wellbeing of the communities around them. For individuals, we know that an increase in income leads to an increase in psychological wellbeing and a decrease in anxiety and depression. For providers, having a vibrant market that offers good opportunities for them to develop their business means that they are more likely to invest in the local area which, in turn, will attract a workforce that delivers high quality care. For communities, ensuring that the local transport plan develops responsive and resilient services, especially in rural localities.

Growing our existing businesses and inspiring enterprise is part of the long term strategy for North Yorkshire. Health and social care organisations are major employers in North Yorkshire and play an important part in the economy, not only in supporting us to stay well, but by offering a wide choice of employment opportunities. This helps local people stay local and it also helps North Yorkshire attract new talent so that we can achieve outstanding quality-improving health and care.

Our principles for making these changes real

We will always use these principles when developing plans, commissioning services and delivering care to check that we are keeping our promises in this strategy.

1) Recognise where things are different…

- So that we respond to differences between local communities
- So that we prioritise the people and place that need things most
- So that we take full advantage of the different assets in urban and rural communities

Every community in North Yorkshire has a different range of resources and assets that can contribute to improving health and wellbeing. Our role is to help support people at every stage in life to use those assets wisely and well, in the way that suits the local community best.

We also need to make sure that we target our improvements on the people and communities that need it most. Although North Yorkshire is relatively prosperous overall, pockets of deprivation exist both in towns and rural areas where improving health and wellbeing can have a really significant effect, and which we need to make priorities for new investment.

2) Tackle issues early…

- By investing more in local services so that we prevent illness in the first place for all age groups
- So that you have more opportunities to access local care and support that can nip problems in the bud

Keeping healthy and well, and tackling ill health in its early stages is much better than trying to deal with things once they have become more serious.

We all know what we should be doing to increase our chances of staying healthy for longer - stopping smoking, cutting down on alcohol, avoiding drugs, keeping our weight down, taking more exercise - but it's much easier to do them when there is a local source of help and support.

3) Joining things up to make life simpler…

- So that you only have to tell your story once
- So that you can trust local services to work together effectively
- So that you get the response that meets your needs, not what's convenient for different organisations
- So that there's less waste caused by duplication

Many of the old organisational barriers that stopped services working together are being broken down. We want to make the most of these opportunities to do things differently - when it makes sense locally. This will mean increased integration between health and social care services as well as between county and district councils or NHS services and the voluntary or independent sectors.

4) Make a positive contribution…

- So that you're inspired and enabled to take responsibility for your health and wellbeing and the decisions about your care are shared between the person and the professional
- So that you have opportunities to support the health and wellbeing of others in your community

These days we hear a lot about the importance of being able to live independently - and having control over our lives is good for our health and wellbeing. You can take responsibility for your own health and wellbeing through lifestyle changes, or by having more control about how you use services - for example by managing your own medication, or having a personal budget to spend on the care you need.

But we also depend on each other to live our lives well. The greatest assets we have in North Yorkshire are the people of North Yorkshire. We want everyone to feel able to make a positive contribution to the health and happiness of your local community - whether that's as an employer, an employee, a volunteer, or just by being a good neighbour.

5) Keep people safe…

- So that you can feel safe and secure in your local community, your school and your family home
- So that you can be confident that you will be treated with dignity and respect
- So that you know we take a 'zero tolerance' approach to any form of abuse

Feeling safe in and around your own home is an important part of your overall sense of wellbeing. We will encourage organisations to make safety a priority when they plan and deliver services, particularly where these relate to children, people with disabilities,, those with dementia, and other vulnerable groups.

We also know that you expect high standards whenever you use public services. Everyone who uses services - and everyone who works in them - has the right to be treated with dignity and without being abused and is responsible for treating other people in the same way.

6) Spend money wisely…

- So that we invest in things you can be confident will deliver good value
- So that we improve the quality of services for the long term
- So that we make the most of the North Yorkshire pound

Value for money is always important, but especially at a time when demands on services are growing and budgets are under pressure. Part of our role is to make sure that what we do spend is spent wisely, on things that we know make a real long term difference.

What do we expect from the Health and Wellbeing Board?

- We will make a difference and to improve health and wellbeing
- We will support each other to tackle problems together
- We will respect local differences
- We will look for ways in which we can work together
- We will stay focused on the strategy
- We will be ready to listen and take hard decisions together when necessary - and stick to them

What do we expect from local communities?

- They will value positive contributions from everyone, whoever they are and at all stages of their life
- They will support people to make healthy choices and live well throughout their lives
- They will speak up about the needs of local people including those who are at risk of being marginalised or in particular need, especially where this relates to children and young people, and other groups who might not ordinarily be able to speak up for themselves

What do we expect from people living in North Yorkshire?

- You will take on more responsibility for your own health and wellbeing
- You will make more healthy choices to improve your health and wellbeing
- You will look out for other people in your community
- You will ask for help when you need it
- You will speak up when things go wrong

How will we measure our success?

We will develop an action plan to include the following elements

Dashboard – key statistical data monitored regularly by the Health and Wellbeing Board.

Exception reporting – statistical data or information that is escalated to the Health and Wellbeing Board requiring action and review.

Theme discussions – an in depth review of progress against our five themes and enablers to encourage positive challenge and action.

Peer review – an evaluation by a group of Health and Wellbeing Board representatives to improve and enhance performance and share learning.

Letting you know how we're doing

Every quarter…

We hold Board meetings to look at progress on this strategy and to discuss ideas about how we can best improve health and wellbeing in North Yorkshire. Meetings are held in public, and papers are available on the County Council's website **http://democracy.northyorks.gov.uk/committees.aspx?commid=27**

Every year…

We will publish a report on what has been achieved, and what impact it has had on health and wellbeing in North Yorkshire.

We hold a range of events across North Yorkshire to bring people together to talk about what's important to their health and wellbeing. Look out for details in your local newspaper, or check on the website at **http://www.northyorks.gov.uk**

How can you get involved?

Find out more

While this strategy sets out how we will organise our work and some of the biggest changes we expect you to be able to see by 2020, it can't cover all the changes that are planned for your local area.

If you want to find out more, you can contact North Yorkshire HealthWatch, who can signpost you to information about what's being planned for your local area.

Contact them by phone: **01904 621631**

By email: **healthwatchny@nbforum.org.uk**

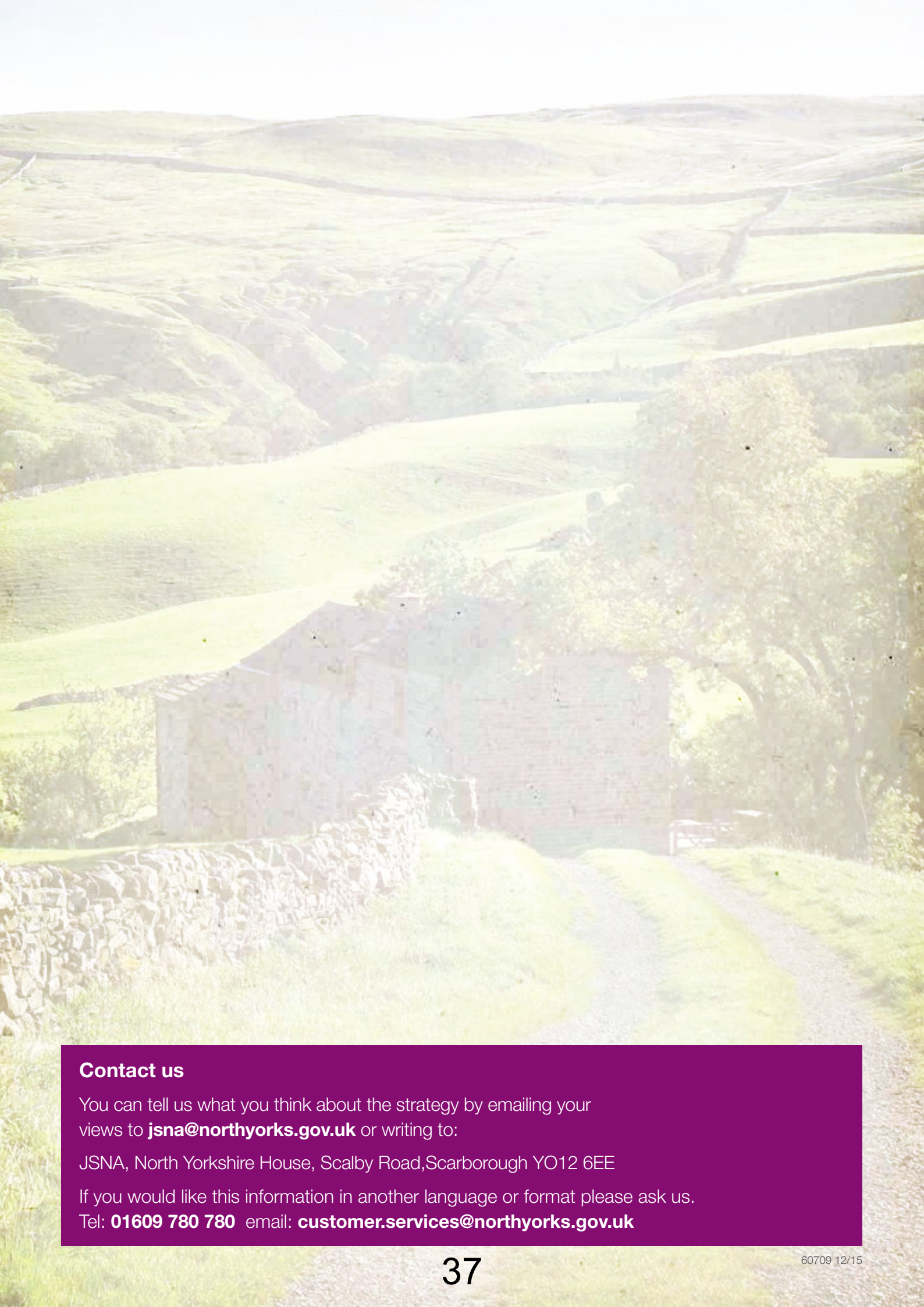
Website: **www.healthwatchnorthyorkshire.co.uk**

Twitter: **@HealthwatchNY**

Help us implement this strategy

We won't always get things right first time and we need and value your help to tell us what's working and what we could do better.

We therefore pledge to continue to talk to you and to listen to see if the strategy is making a difference.



Contact us

You can tell us what you think about the strategy by emailing your views to **jsna@northyorks.gov.uk** or writing to:

JSNA, North Yorkshire House, Scalby Road,Scarborough YO12 6EE

If you would like this information in another language or format please ask us.
Tel: **01609 780 780** email: **customer.services@northyorks.gov.uk**

60709 12/15

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

Better Care Fund

21st January 2016

1.0 Purpose of the report

1.1 This paper seeks to provide assurance to the North Yorkshire County Council Care and Independence Overview and Scrutiny Committee regarding progress implementing the Better Care Fund (BCF). The report provides an overview of performance across the whole plan but is focused on progress implementing new schemes developed to reduce non-elective admissions to hospital.

2.0 Background

2.1 The North Yorkshire BCF was assured through a national process in January 2015. The plan total fund is 46.727m and this is used to support a range of: new and existing health and social care schemes; protection of social care; reduction of non-elective admissions to hospital; with a smaller proportion of the fund supporting implementation of the Care Act and receiving a disabled facilities grant for use by district councils.

2.2 While the BCF plan was developed through 2014 and early 2015 many of the new schemes, value of 10,098m, did not become fully operational until April 2015. This was primarily due to delays recruiting staff and diversion of staff to manage winter pressures in early 2015.

2.3 As the schemes were being developed there were changes to the national metrics. These changes included a performance focus on reducing non-elective admissions to hospital. Throughout 2015/2016 this has been the only metric that has attracted a performance payment.

2.4 All schemes are now fully operational and regular reporting is in place through the Health and Wellbeing Board and to NHS England through quarterly reporting. Local transformation boards have commenced evaluation of new schemes and their success reducing unnecessary admissions to hospital in preparation for 2016 – 2017 NHS and Local Government planning rounds.

3.0 National and North Yorkshire reporting arrangements

3.1 The BCF programme is routinely monitored at a national level through quarterly reports to NHS England based on a Health and Wellbeing Board footprint.

3.2 The attached quarterly report provides an update on progress prepared for the North Yorkshire Health and Wellbeing Board (HWB) in November 2015. The report covers three separate quarterly reporting periods from January 2015 – September 2015.

3.3 The overall performance at a North Yorkshire level shows a slight improvement at 2.8% increase in non-elective admissions compared to 3% at the last reporting period (end June). The annual target for NYHWB is an 8.2% reduction which, given performance year to date, is unlikely to be achieved over the remaining 15/16 quarters.

3.4 There is variation in achieving the non-elective target at local CCG level but this should not be equated with the quality of services available to local populations. It does point to issues with rising demand and further evaluation of how people are enabled to access the right service that meets their health or care need.

4.0 Local Transformation Boards: Progress Evaluating BCF

4.1 The following contributions have been developed by local Transformation Boards at the request of the HWB. They confirm that evaluation of schemes is underway, that different approaches have been taken and that evaluation will continue to be an iterative process to develop a fuller understanding of scheme impact and in particular the correlation with reducing non-elective admissions.

4.2 <u>Vale of York (VoY)</u>

4.2.1 The key VoY schemes that sit within the boundary of North Yorkshire are the Selby Integrated Care Hub, a proportion of the Urgent Care Practitioner scheme and a proportion of the Hospice at Home scheme. The functions of the Mental Health Street Triage scheme have now been mainstreamed into the new mental health contract with Tees, Esk and Wear Valley Foundation Trust. All of the schemes have been monitored and demonstrate an impact on admissions and emergency department attendances, albeit not at the scale planned.

4.2.2 Pressures elsewhere in the system often mask the impact of the specific schemes and further work is being undertaken to understand this. The quality impact of the schemes cannot be understated, particularly the impact of Hospice at Home, and the CCG are committed to continue to fund the schemes in North Yorkshire as long as the financial position allows it.

4.3 Scarborough & Ryedale (SR)

4.3.1 There has been investment in a number of schemes, some of which are local and some of which are pan North Yorkshire or partnership schemes across other CCG areas.

4.3.2 Local schemes include the Ryedale Community Response Team (Malton Hub), Hospice at Home/Care Home Link Nurse Scheme and a number of CCG funded posts supporting the North Yorkshire County Council Living Well programme. In addition Scarborough & Ryedale CCG are contributing to wider schemes, in particular Improving Access to Psychological Therapies (IAPT) and Acute Hospital Psychiatric Liaison Service.

4.3.3 Schemes generally are not demonstrating the targeted reduction in non-elective admissions, with a rise in activity across the CCG area. However, the overall rise is not as high as the non-mitigated rise predicted for this year suggesting that the BCF schemes are having some impact.

4.3.4 Whilst the lack of impact reducing non electives is disappointing, the wider impact (including qualitative) of the schemes should not be underestimated. The IAPT scheme, for example is showing such a significant improvement in access and recovery rates that local GPs are now regularly referring. All of the schemes are able to demonstrate quality improvements, and further work is needed to understand the value of this “quality premium”.

4.3.5 A formal evaluation of the schemes was completed in September 2015, but it was deemed too early to make decisions about continued investment at that stage. There will be further evaluation of the schemes in January 2016 to inform decisions on continued funding and potential commissioning decisions for the 2016/17 BCF.

4.4 Harrogate and Rural District (HaRD)

4.4.1 The HaRD BCF schemes have in the main been implemented since April 2014. The summary below provides an update on the schemes:

- Care Home initiative - in reach team supported by existing Community Geriatrician, increased Community Mental Health Care Home Liaison, GP practices linked to Care Homes. A FAST response team were linked to 4 Care Homes and this has now been expanded to all Care Homes and guidance communicated to GPs to be able to refer. Emergency admissions from Care Homes in 15/16 shows a similar number compared to 14/15. A significant change has been the number of deaths in hospital following an emergency admission from a Care Home showing lower numbers compared to previous two years.

- Mental Health Liaison Service is provided in Harrogate District Foundation Trust over 7 days from 8am to 8pm. In 15/16 emergency admissions for people with a mental health diagnosis has reduced compared to Q1 14/15.

- Community Stroke Team provides specialist stroke rehabilitation supporting patients prior to discharge. A review has shown the average length of stay for stroke patients as 20.8 days, for those patients receiving community support the average is reduced to 15.9 days. Additional FAST response team is to focus on improvement or maintaining patient's independence and enable them to remain in their own home. The additional capacity has provided assessments for an additional 45 new patients per month. Supporting approximately 15 additional patients each month to remain at home and assumed a saving of 75 bed days per month.

- Voluntary Sector Schemes – 5 schemes have been commissioned that support carers, social prescribing, support at Home and Volunteers.

4.4.2 The evaluation of the schemes in October 2015 evidenced full assurance for quality and impact of the schemes. The providers were each asked to provide additional evidence to provide assurance on the success factors including reduction in avoidable admissions and financial evaluation. Scheme evaluation will be completed on a quarterly basis to monitor delivery of services and evidence of investment.

4.5 <u>Airedale, Wharfedale & Craven (AWC)</u>

4.5.1 There are currently 4 BCF commissioned schemes being delivered in the Craven area of North Yorkshire County Council. These schemes include:

- Assisted Technologies Service - Installation of telemedicine into 12 nursing and residential homes across Craven to provide 24/7 clinical support to residents and carers. Installation of 65 iPads into 65 patients' homes across Craven with COPD, Heart Failure and any other complex needs assessed on a case by case basis i.e. end of life, complex comorbidities.

- Care Home Quality Improvement Support Service - The service provides a dedicated support and liaison service to facilitate quality improvement in care delivered across the care homes in Craven.

- Specialist Community Nursing Service - Expansion of existing specialist community services in Craven to support people with long term conditions through comprehensive assessment and care planning.

- Craven Collaborative Care Team Enhancement - Further enhancement of the existing Craven Collaborative Care team to provide a multidisciplinary, multiagency intermediate care services with the aim of preventing avoidable admissions to hospital and long term care. Funding provided to enhance the capacity and capability within the team by 1 WTE Social Care Assessor, 1 WTE Physiotherapist, 1 WTE Advanced Nurse Practitioner (ANP), 0.5 WTE Mental Health Nurse and 4 WTE Community nurses, plus

0.4 WTE link Carers' Resource worker to ensure that the health and social care needs of patients are met in a timely manner.

4.5.2 As well as using data from the AWC Transformation and Integration Group (TIG) dashboard to assess impact across the system in Craven, a local Craven dash board has been developed, covering the 5 Craven practices participating in the 'Better Care Fund' schemes. It details various pertinent activities that would be expected to change as a measure of success of the various schemes.

4.5.3 A separate (qualitative) evaluation framework is being agreed with providers and expected to be completed by mid-December.

4.6 Hambleton, Richmondshire and Whitby (HRW)

4.6.1 The HRW BCF evaluation completed in October 2015 provided assurance that all of the schemes partially meet their evaluation criteria specified through the North Yorkshire submission.

4.6.2 Whilst each individual's schemes impact on non-elective admissions cannot be evidenced directly through quantitative data it can be assumed to be a positive impact and effect on the current position at -3% (September 2015 source MAR). The impact at our main provider is even more significant with a current position of -6% on all emergency admissions and -10% ages 18-64. A recent rise in paediatric activity across the locality is offsetting some of the impacts on adults and older people.

4.6.3 All schemes are delivering increased activity levels and qualitative service improvements strengthening the localities service resilience and the Fit 4 the Future Transformation Programme. Provider feedback includes; improved GP and Partner relations, improved services for Patients and Carers and a real and ongoing commitment to continued service improvement.

4.6.4 All schemes are now fully operational. Mental Health schemes are meeting service targets, Discharge Facilitators are established as change agents to improve discharge processes and a GP Hospitalist model has been implemented and identified as a best practice as part of the Friarage wider transformation proposals. The successes include; reductions in Emergency Admissions with Mental Health Diagnosis, -23% reduction in emergency admissions due to falls, 24 hour support for palliative patients and reduced overnight admissions.

4.6.5 Schemes identified as enabling schemes without specific saving targets are also monitored against their outputs and our service resilience, impacts include a Model of Dementia provision now outlined to inform future commissioning intentions and a District Nursing Service at full capacity and fully engaged in the CCG's Primary Care Workforce transformation project.

4.6.6 The evaluation includes the significant risks of any service reduction at this point of full service delivery and investment and recommends no significant

changes to schemes or existing funding arrangements. Scheme evaluation will remain on-going with a detailed evaluation exercise being completed every quarter to continually monitor delivery of services and prototype developments to justify the investment as a positive contribution and influence to the wider integration agenda.

5.0 Next steps

5.1 Further work needs to be done to understand the value and impact of BCF schemes to prepare for 2016/17.

5.2 This will include a review of BCF guidance due in January 2016 to ensure investment in local schemes continues to be effective in reducing unnecessary hospital admissions and building community health and care service models.

5.3 The BCF has supported building good relationships between health and social care organisations and this will help local planning for 2016/17 as resources continue to be stretched.

6.0 Required from the Committee:

6.1 The Committee note the progress of the North Yorkshire Better Care Fund plan, including that further guidance is due which may require a revision of the plan in 2016/17.

Wendy Balmain
Assistant Director of Integration
Health and Adult Services

12 January 2016

Overall Summary

Whilst our overall target for NEAs has not been achieved, some progress has been demonstrated with reductions against plan in AWC and HRW for the period. We have seen some increases in non elective paediatric admissions which may have offset successes in other areas and there continues to be concerns about data accuracy including coding. The evaluation of schemes is underway with different approaches adopted by local transformation boards. Evaluation will continue to be an iterative process to develop a fuller understanding of scheme impact and in particular the correlation with reducing NEAs. The outcomes of these reviews will inform planning for 2016/17 for which guidance is expected in December 2015.

Performance Summary -

This quarter's report on Non-Electives covers periods Q4 14/15 to Q2 15/16. The period saw a rise of non-electives of 406 against a planned reduction of 1,606. See overleaf for a fuller analysis.

	TARGET					ACTUAL PERFORMANCE						
	Q4	Q1	Q2	Q3	Total	Q4 Achieved	Q1 Achieved	Q2 Achieved	Q4+Q1 +Q2 Ahieved	Q4+Q1+ Q2 target	Distance from Target	Perf fund contr
AWC	-31	-12	-56	-72	-171	-95	-4	-59	-158	-99	-59	£188,100
HRW	-227	-90	-413	-530	-1260	121	-71	-100	-50	-730	680	£28,500
HaRD	-279	-108	-500	-642	-1529	-23	118	189	284	-887	1171	0
SR	-149	-56	-268	-345	-820	350	272	226	848	-473	1321	0
VoY	-205	-80	-369	-474	-1128	180	97	150	427	-654	1081	0
	-891	-348	-1606	-2063	-4908	533	412	406	1351	-2845	4196	£216,600

Metric	Year Target	YTD Target	Achieved
Non Elective Admissions *Performance Fund linked	-8.2% (-4,908)	-2,845	+1,351
Delayed Transfers of Care	-647 (-5.5%)		n/a
Admissions to Residential Care	-31 (-4.7%)		n/a
Reablement – Volume	+420 (15.7%)	210	n/a
Reablement – Quality	85.5%	85.5%	87.8%
Injuries due to Falls	-152 (-6.7%)	-104	-43
Patient Experience	72.3% (+0.4%)	n/a	65.2%

Risk and Mitigation

- ❑ BCF will continue into 2016/17 but local budget pressures risk disinvestment in BCF
- ❑ Indications are that the measurement of BCF in coming years will be more diverse
- ❑ Evaluations of schemes is underway but there is an inconsistency in timescales for completion and methodology. All areas will develop on-going measurement of BCF investment as part of the wider integration agenda.
- ❑ CSR implications still be understood alongside NHS planning guidance due to be issued in December.

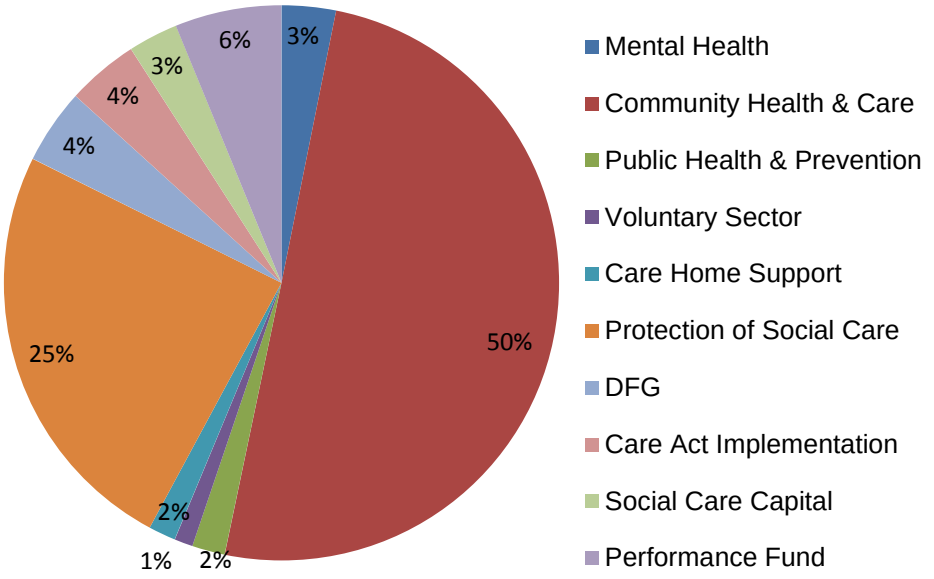


Figure 1: BCF % of spend across sectors in 2015/16

Actions / Next Steps

Action / Activity	Date	Comments
Evaluation of schemes	Nov 2015	Report submitted to HWB
Awaiting 16/17 BCF guidance	Tbc	Expected Dec 2015

Financial Summary

Source	£,000
AWC CCG	2,914
HRW CCG	9,152
HaRD CCG	9,557
SR CCG	7,538
VoY CCG	6,932
NYCC	6,932
DCLG	3,383
Cumbria CCG	319
	46,727

Application £,000	Full Year	Qtr 1 +2 Expected	Q1 + 2 Actual
New Schemes	10,098	5,049	4,662
Existing Community & Reablement & Carers	11,106	5,553	5,545
Protection of Social Care	17,000	8,500	8,500
Care Act	1,932	966	966
DFG / SC Capital	3,383	1,692	1,692
Performance Fund	2,889	1,445	217
Cumbria CCG	319	160	160
	46,727	23,364	21,742

BCF Schemes – Some highlights from local Transformation boards

Airedale, Wharfedale & Craven locality:

- Assisted Technologies Service - Installation of telemedicine into 12 nursing and residential homes across Craven to provide 24/7 clinical support to residents and carers.

Scarborough & Ryedale locality:

- The Improvement in Access to Psychological Therapies (IAPT) scheme, is showing such a significant improvement in access and recovery rates that local GPs are now referring at an un-precedented rate.

Harrogate and Rural Districts locality:

- A significant reduction in the number of deaths in hospital following emergency admission from a Care Home compared to the previous two years; a year on year reductions in emergency admissions for people with a MH diagnosis; a significant reduction in length of stay for stroke victims receiving community support.
- The FAST response team has supported approximately 15 additional patients each month to remain at home with a saving of 75 bed days per month.

Hambleton, Richmond and Whitby locality:

- A 6% reduction in overall emergency admissions and 10% reduction for ages 18-64; a 23% reduction in emergency admissions due to falls; a year on year reduction in Emergency Admissions with Mental Health Diagnosis.
- Provider feedback includes; improved GP and Partner relations, improved services for Patients and Carers.
- 24 hour support for palliative patients and reduced overnight admissions.

Vale of York locality:

- The Selby Integrated Care Hub continues to deliver an improved community offer. There is recognition that further analysis needs to be done to demonstrate the impact and value for money reducing non-electives.
- The CCG continue to work closely with providers to develop more mature risk/share and risk/reward models and this approach is currently being tested with a draft funding model for the Selby Hub for the remainder of 15/16 and beyond.

NEA Activity Q2 Outturn – North Yorkshire

Contributing CCGs	Q4+Q1+Q2 NY Out-Turn	Target Change	Actual Change	Year-on-Year Change
Airedale, Wharfedale and Craven CCG	4,249	-99	-159	-3.6%
Hambleton, Richmondshire and Whitby CCG	10,310	-730	-49	-0.5%
Harrogate and Rural District CCG	12,016	-886	281	2.4%
Scarborough and Ryedale CCG	9,168	-476	848	10.2%
Vale of York CCG	8,286	-654	427	5.4%
			1,348	+13.9%
Cumbria CCG	519		-20.35	-3.8%
Darlington CCG	128		-3.84	-2.9%
Doncaster CCG	59		-1.11	-1.8%
Durham Dales, Easington and Sedgefield CCG	59		-1.25	-2.1%
East Lancashire CCG	38		-0.78	-2.0%
East Riding of Yorkshire CCG	280		-2.50	-0.9%
Hartlepool and Stockton-On-Tees CCG	33		-1.01	-2.9%
Leeds North CCG	355		-5.63	-1.6%
Leeds South and East CCG	100		0.71	0.7%
Wakefield CCG	642		1.60	0.3%
Total	**46,241**	**-2,845**	**1,313**	**+2.8%**

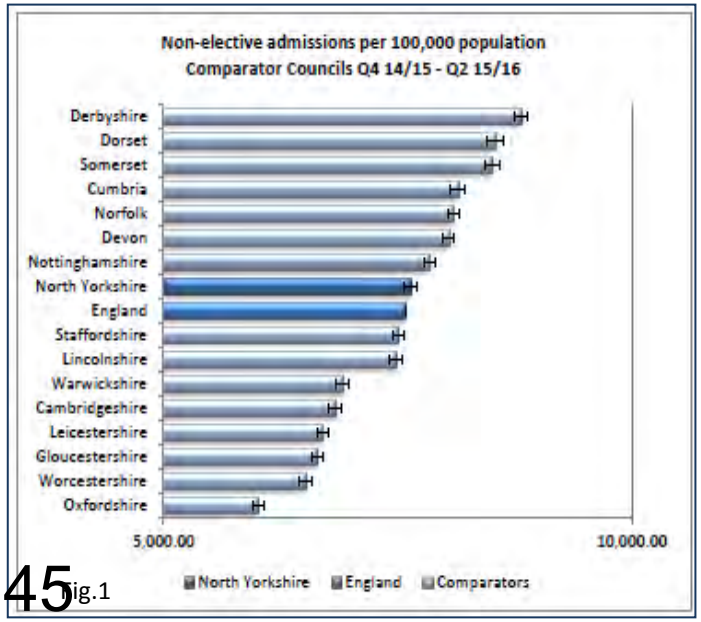


Fig.1

The Number of Non-Elective admissions per 100,000 population in North Yorkshire County Council is 7,640 from Q4 2014-15 to Q2 2015-16, which is slightly above the England Average of 7,584.

NYCC sits 9th out of 16 comparator councils in England, with Oxfordshire County Council performing best, and Derbyshire County Council performing the worst (see figure 1).

Health and Wellbeing Board
North Yorkshire

HEALTH & WELLBEING BOARD

27 November 2015

North Yorkshire Winter Health Strategy 2015-2020

1 Purpose of the Report

1.1 To present the draft North Yorkshire Winter Health Strategy building on the work of the JSNA Winter Health Deep Dive (Feb 2015)

1.2 The Health and Wellbeing Board are asked to endorse the approach and encourage member organisations to contribute to the vision 'to reduce fuel poverty and the adverse effects of cold weather'

1.3 To formally respond to the draft strategy during this 12 week consultation period winterhealthstrategyfeedback@northyorks.gov.uk

2 Background

2.1 The Seasonal Winter Health Strategic Partnership was established at the beginning of 2015 and began developing its strategy based on the JSNA deep dive on Winter Health. A multi-agency partnership event on Winter Health was held on 3rd June 2015 which included partners across North Yorkshire and helped to develop the overarching vision, aims, principles and the four key priorities.

2.2 The final strategy and implementation plan will be presented to confirm Health and Wellbeing Board support in February 2016 before a launch planned on 17th March 2016.

3 Implementation Plan

3.1 A draft implementation plan for the Strategy is being produced with 20 delivery partners and 10 key supporting partners. It will sit alongside the strategy and will identify key actions for each organisation under the four Key Strategic priorities.

3.2 For each of the Strategic priorities an outcomes framework to monitor progress against agreed indicators is being developed as part of developing the implementation plan. The Public Health team are doing work to establish the baseline for these indicators.

3.3 It is proposed that the Strategy Implementation Plan will be monitored by the North Yorkshire Seasonal Winter Health Strategic Partnership, chaired by Assistance Director Policy and Partnerships. This Group will also make recommendations for review of the Strategy should the need arise.

4 Recommendations

4.1 The Health and Wellbeing Board members are asked to consider and support the priorities in the strategy.

4.2 All members receiving the draft strategy are asked to respond to the consultation and commit their organisation as a signatory.

5 Appendices

5.1 Appendix 1 – North Yorkshire Winter Health Strategy

Rachel Richards
Public Health Consultant

Dr Lincoln Sargeant
Director of Public Health for North Yorkshire

11 November 2015

Health and Wellbeing Board
North Yorkshire

North Yorkshire's Winter Health Strategy 2015-20

Working together to reduce fuel poverty and the adverse health effects of cold weather for individuals, families and communities

Seasonal Winter Health Strategy 2015-2020

Foreword

Cold weather can have a significant and predictable impact on people's health. However, for the vast majority of people the real extent of the effects of the cold are not appreciated and few people realise it is largely preventable. The direct effects of winter weather such as icy roads and footpaths with the consequent accidents, slips and trips are well known. Fewer people realise the cold can increase the occurrences of heart attacks, respiratory and influenza related diseases resulting in deaths. In addition to this, there are the indirect effects of the cold including poorer mental health and wellbeing and other risks such as carbon monoxide poisoning from poorly maintained heating and domestic appliances.

Certain groups of people are at greater risk of the direct effects of the cold. For example, those over 75 years and families with children under 5 years. In North Yorkshire during the 2012/13 winter there were 431 excess winter deaths (EWDs). These are the number of excess deaths that occur between December and March each year. For every excess winter death it is estimated there are an additional eight emergency admissions to hospital.

The rate of Excess Winter Deaths across the whole of the UK is three times higher than other colder countries in Northern Europe. Although cold weather is clearly a factor in excess deaths, Scandinavian countries for example do not have the same pattern of excess winter deaths, giving a strong indication that this is a preventable situation. These countries have higher energy efficiency and housing standards and the population reacts differently to cold conditions.

The number of people indirectly affected by the cold in North Yorkshire is less easy to quantify. They may be referred through Health and Adult Social services or Children and Young Peoples Social Services because being too cold has impacted on them in some way. For example, people chose to move out of their rented property before winter because it is too cold, without realising they have become 'intentionally homeless'. Others cannot afford to heat the homes they live in and get into debt. Fuel poverty is a key priority for North Yorkshire's Health and Wellbeing and working together in partnership across the county with various organisations is one of the most effective ways of delivering changes.

We want to work together in partnership with each other, individuals and groups, including the independent and public sector to identify and provide support to reduce the number of vulnerable people in North Yorkshire whose lives are negatively affected by the cold.
We have a strong history of partnership working in North Yorkshire and are well placed with key partners to achieve the priority outcomes we have identified in this strategy. If we target our efforts jointly we can dramatically improve our local response to the increasingly recognised public health and social challenge of being too cold.

Cllr David Chance – Executive Member for Public Health North Yorkshire County Council

Contents

Glossary

CCG – Clinical Commissioning Groups
DECC – Department of Energy and Climate Change
EWD – Excess Winter Deaths
EPU – Emergency Planning Unit
GP – General Medical Practitioner
HWB – Health and Wellbeing Board
JHWS – Joint Health and Wellbeing Strategy
JSNA – Joint Strategic Needs Assessment
LA – Local Authority
NHS – National Health Service
NICE - National Institute for Health and Care Excellence
NYCC – North Yorkshire County Council
NYLRF – North Yorkshire Local Resilience Forum
PCT – Primary Care Trust
PHE – Public Health England
PCT – Randomised Controlled Trial
SWHSP – Seasonal Winter Health Strategic Partnership (North Yorkshire)
SRGs – System Resilience Groups

North Yorkshire Draft Seasonal Winter Health Strategy on a page

"We will improve and maintain health during winter months and prevent avoidable ill-health and Excess Winter Deaths by working together to reduce fuel poverty and the adverse health effects of cold weather for individuals, families and communities in North Yorkshire"

The ***seven strategic objectives*** we will adopt:

1. **EWDs** – *reduce preventable cold-related ill-health and Excess Winter Deaths (EWDs)*
2. **Vulnerable people** –*identify, support and improve the health of the most vulnerable groups*
3. **Services** – *reduce pressure on health and social care services*
4. **Fuel Poverty** – *reduce fuel poverty, the risk of fuel debt and/or disconnection from energy supplies*
5. **Influenza Immunisation** – *increase immunisation uptake rates across the population*
6. **Injury** – *reduce injury resulting from unexpected trips and falls*
7. **Hospital Admissions** – *reduce excess Emergency admissions to hospital*

Our ***four key priorities*** and ***the supporting outcomes:***

(1) General awareness raising: -

- Agree key messages on "Keep Warm, Keep Well, Keep Safe in winter" promoted across agencies in North Yorkshire consistently.
- Coordinate key messages and a single shared information resource.
- Increase awareness of preventable seasonal related ill-health and Excess Winter Deaths to members of the public.
- Increase seasonal influenza immunisation uptake rates.
- Increase awareness among communities and community leaders of ways to strengthen resilience to the impact of seasonal changes and cold weather.
- Increase awareness of impact of cold homes on health among frontline staff and professionals in the independent and public sector.
- Increase understanding of the links between fuel poverty and ill-health by supporting evaluated projects and research.
- Increase awareness among Landlords, Landowners and Homeowners.

(2) Identifying and supporting the most vulnerable (MV):

-Define the MV groups.
-Create ways to increase identification of the MV.
-Increase routes to reach those MV to the harmful effects of being cold.
-Utilise opportunities to target approaches based on the needs of the MV.
-Maximise current services provided to the MV increasing added value and diversity where needed.
-Increase number of programmes which support the delivery of prevention services in the community and provide consistent coverage when most needed. (e.g. increased uptake of influenza immunisations).
-Increase the range of opportunities for 'support services' to promote resilience in cold weather and community connectedness.
-Increase accessibility for all vulnerable groups to reach the support which most appropriately meets their needs.
-Increase initiatives which support people to reduce unnecessary fuel consumption and reduce fuel poverty.
-Develope opportunities to involve service users.

(3) Shared responsibility and making every contact count:

-Increase awareness across North Yorkshire among professionals and others (independent and public sector) to feel confident in giving advice and signposting service users, as well as neighbours, friends and family members.
-Increase training and awareness for staff working with vulnerable groups about the link between household temperature and effects on health and wellbeing so that it positively impacts on practice and improves services.
-Increase ability to refer individuals to appropriate services to improve their health and wellbeing in winter.

(4) Partnership commitment:

-Align priorities to achieve better health and wellbeing for the population of North Yorkshire especially in winter months.
-Create policies and plans which take into account the impact of winter / cold weather as part of the year-round planning and decision-making.
-Increase consideration of impact of winter on health across all sectors (including utilities, housing, service providers etc)
-Create stronger partnerships taking action in response to significant issues e.g. poor quality housing and fuel poverty.

Executive Summary

What is the context for this Strategy?
North Yorkshire County Council became responsible for population health outcomes under the terms of the Health and Social Care Act 2012 and has a duty to ensure plans are in place to protect the health of their populations including preparation for cold weather, snow and ice. There is a shared agreement between each partner organisation in the North Yorkshire Health and Wellbeing Board to work together to deliver change, reducing the impact of seasonal ill-health and ultimately reducing excess winter deaths (EWDs).

There is a North Yorkshire Health and Wellbeing Strategy 2013-2018 (2015 update) which has been developed jointly by partners across North Yorkshire and this work links into those priorities. This strategy also has links to:-

- the York North Yorkshire and East Riding Housing Strategy 2015 – 2021.
- The North Yorkshire Local Resilience Forum
- Local District Cold Weather Plans and CCG System Resilience Groups

What is the Purpose of the Strategy?
The North Yorkshire Health and Wellbeing Board is made up of partner organisations from across the County who understand the importance of working together across diverse and complex rural communities within North Yorkshire. This Strategy is about working together across the agencies to tackle the effects of the cold on people in North Yorkshire. We want our strategy to galvanise partners, statutory and non-statutory organisations, businesses and communities within North Yorkshire to work co-operatively to reduce the harms from the cold and help lift people out of fuel poverty. It is built on the latest data collected within the North Yorkshire Partnership Joint Strategic Winter Health Needs Assessment (JSNA), and uses the best evidence of what works where available, taking account best value (NICE Guideline NG6). See ***page 9*** for list of organisations involved.

How does this fit into the National Picture?
Since 2012 there have been a number of key strategic drivers nationally, including:-

- the governments Fuel Poverty Strategy Cutting the Cost of Keeping Warm (DECC, March 2015) which followed changes in legislation (December 2014) to increase the number of homes with Band C energy ratings by 2020;
- the full appraisal on “Excess Winter Deaths and morbidity; the health risks associated with Cold Homes” (NICE guidelines NG6, March 2015).
- “Protecting health and reducing harm from cold weather – local partnerships survey report” from Public Health England in November 2014 reporting on how agencies need to work together to achieve change

- the Public Health Outcomes Framework (2013) with specific indicators to reduce excess winter deaths (EWDs) and address fuel poverty;
- the NHS Five Year Forward View (October 2014) putting higher priority on prevention of ill-health and working in partnership with patients and communities
- the Cold Weather Plan for England 2014 (October 2014) report on protecting health and reducing the harm from cold weather from Public Health England.
- the NHS Outcomes Framework (2014-15) and the Adult Social Care (2014-15) include tackling health outcomes by improving the wider determinants of ill health and preventing avoidable early deaths which can be positively influenced by tackling cold, damp homes and fuel poverty.
- the Health and Social Care Act (2012) include duties for local authorities to ensure plans are in place to protect the health of their population including preparation for cold weather, snow and ice.

What about the North Yorkshire local Strategic Direction?
The NHS 5 year forward view plan and Social Care Strategies outlined the need for 'prevention' to reduce the number of people unnecessarily accessing services. In addition, local Housing Strategies and Transport Plans being developed in partnership with districts, businesses and communities across North Yorkshire all contribute to

- prevent people needing services and ensuring people are in control of the choices they make about their health and wellbeing
- ensure partners work together so that complex issues that affect health and wellbeing, like fuel poverty and cold homes, can be improved effectively
- focus on increasing people's awareness of the impact of choices they make on their health and wellbeing

How does this Strategy fit with Community Resilience in North Yorkshire?
The North Yorkshire Local Resilience Forum (NYLRF) is a multi-agency body set up to discharge the statutory obligations and duty of care required of identified agencies under the Civil Contingencies Act (2004). This key work consists of assessing risk in North Yorkshire and coordinating all agencies in their efforts to plan and mitigate potential impacts, such as snow and flooding, on our communities. This work is coordinated by the NYCC Emergency Planning Unit (EPU).

NYLRF is made up of key agencies (Police, Fire and Rescue, Ambulance and Health Agencies, Local Authorities) and other supporting agencies (Utility companies, Highways England, Network Rail etc.) with a shared responsibility for identifying vulnerability and supporting the resilience of local communities.

A key component in this work is the early sharing of information with colleagues and partner agencies to provide a coordinated well-informed response to major or critical

incidents and any emergency situation. This may include increased activity in emergency care due to seasonal pressures (e.g. increased hospital admissions due to winter illness such as influenza). Community engagement, communication and promotion of resilience at all levels is fundamental to the work of NYLRF and an established robust multi-agency structure is in place across North Yorkshire to deliver relevant messages to the public.
NYLRF fully support the strategic objectives of the North Yorkshire Winter Health Strategy.

What are System Resilience Groups (SRGs)?
System Resilience Groups (SRGs) link to the NHS Clinical Commissioning Groups (CCGs) with 5 SRGs covering the population of North Yorkshire. The SRGs membership includes the operational leads of the health and social care services.

They are responsible for:-

- Effective delivery of bespoke urgent care in their geographical area.
- Planning additional winter capacity for urgent and emergency care.

The SRGs report to NHS England and provide assurance and feedback to the NYLRF. SRGs make predictions about activity levels for NHS services during the year (e.g. elective care, emergency care, diagnostics) and report to NHS England nationally as well as to the NYLRF. This all year planning activity includes winter months. Work is also coordinated through the regional Urgent and Emergency Care network to support the delivery of the urgent and emergency care strategy.

Partnership working

A Shared Commitment to Improving Winter Health
In order to improve the outcomes for people relating to cold weather, and reduce the number of excess winter deaths and unnecessary admissions to health and social care we need to work in partnership across a number of agencies. There are many complex and interacting factors influencing the winter health outcomes. For example, the environment, housing conditions; income levels; vaccination status; age and general health and wellbeing.

These challenges mean that across North Yorkshire we need to be able to:-
- lead changes in a coordinated way
- communicate messages consistently and clearly
- build on and not duplicate the work of other agencies
- know the impact we are having on the health outcomes for people

To do this the North Yorkshire Health and Wellbeing Board delivery group established **A North Yorkshire Seasonal Winter Health Strategic Partnership** to develop and drive this strategy on behalf of the partners within North Yorkshire.

The North Yorkshire Seasonal Winter Health Strategic Partnership

The North Yorkshire Seasonal Winter Health Strategic Partnership (SWHSP) is a multiagency partnership leading and developing this strategy on behalf of North Yorkshire and linking to existing partnerships such as the Health and Wellbeing Board, Local Resilience Forum, Voluntary Sector and Housing Partnerships. Part of this work means finding the evidence; identifying and mapping where there are gaps in evidence and / or services and establishing new links where needed to achieve the overall vision. The North Yorkshire Seasonal Winter Health Strategic Partnership (SWHSP) meets quarterly and reports to the Delivery Board of the North Yorkshire Health and Wellbeing Board.

The Partnership's *Strategic Vision* *is:-*

" to improve and maintain health during winter months and prevent avoidable ill-health and Excess Winter Deaths by reducing the adverse impact of indoor and outdoor winter conditions on the populations health and wellbeing".

The Partnerships 7 Strategic Objectives are to:-

- Reduce preventable cold-related ill-health and Excess Winter Death (EWD) rates.
- Improve Health and Wellbeing among vulnerable groups.
- Reduce pressure on health and social care services.
- Reduce fuel poverty, the risk of fuel debt and/or being disconnected from energy supplies.
- Increase Influenza Immunisation Uptake Rates.
- Reduce injury resulting from accidents, trips and falls.
- Reduce excess Emergency admissions to hospital.

The SWHSP will develop an all year round strategic and systems-wide approach to achieve the above strategic goal and objectives in North Yorkshire through partnership and collaboration. This includes effective evidence based planning and coordinated working to implement a wide range of interventions that address the multiple problems of the most vulnerable in order to achieve measurable improvements in the objectives.

The first task of the partnership was to produce this jointly agreed Draft Seasonal Winter Health Strategy 2015-2020 and subsequently an implementation plan that reflects the evidence and includes the recommendations of NICE guidelines, the Fuel Poverty Strategy and elements of the Cold Weather Plan so that these align with other strategic and operational plans (see references at end of this document).

List of organisations involved in North Yorkshires Seasonal Winter Health Partnership

Who is involved?

- System Resilience Groups
- Clinical Commissioning Groups
- Local Health Resilience /Partnership groups
- Winter Weather groups – District Councils, including housing representation
- Capacity Planning Groups
- Mental Health Foundation Trust
- Harrogate and District NHS Foundation Trust;
- North Yorkshire County Council Adult Social Care;
- York NHS Trust;
- the Voluntary Sector elected through the VCSE Strategy Group North Yorkshire
- Yorkshire Ambulance Service NHS Trust.
- Healthwatch North Yorkshire;
- Children Young People Services

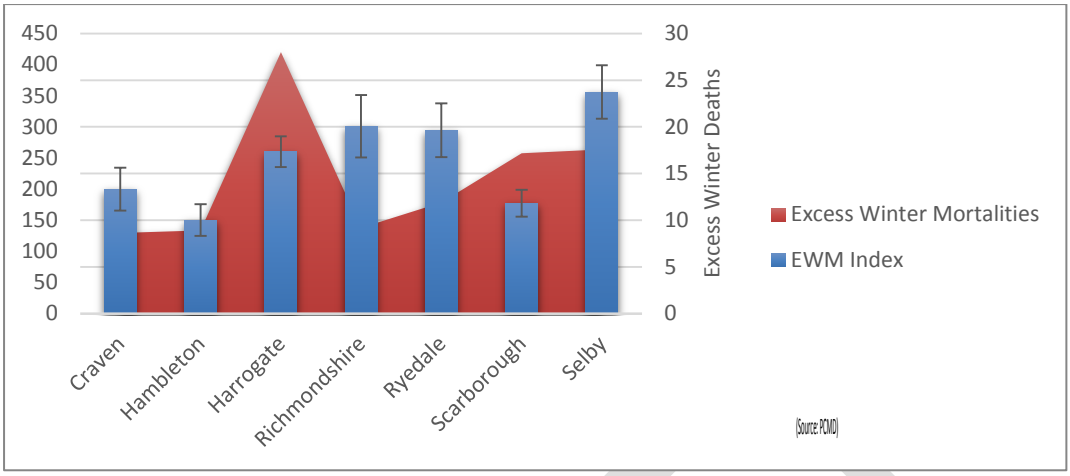
How big is the problem in North Yorkshire?

Every year in North Yorkshire there are hundreds of Excess Winter Deaths (EWDs). These deaths are calculated by comparing the number of deaths that occurred during the December to March winter period with the average number of deaths occurring in the preceding August to November and the following April to July.

- There are an estimated 431 Excess Winter Deaths each year in North Yorkshire (ONS 2012/13)
- The majority of winter deaths occur in people aged 75 and over
- For every Excess Winter Death it is estimated there are an additional 8 emergency admissions i.e. approx. 3,448 avoidable NHS hospital admissions

The following Figure 1 shows both excess winter mortality and the EWM Index by District. It demonstrates the large variation across North Yorkshire. Mortalities are relatively rare events and do not provide enough data in a single year to draw conclusions between districts in North Yorkshire geographies. The 5 year snapshot comparison between the districts shows Selby with the highest EWM Index and Craven with the lowest. Harrogate, with the highest population, has the largest number of excess winter mortalities.

Figure 1 North Yorkshire EWM Index and Excess Winter Deaths by District, 2009-2014 (EWM = winter deaths – average non-winter deaths)



Tackling winter health issues, particularly fuel poverty, cold damp homes and increasing the take-up of flu vaccinations, can make a significant contribution to reducing winter pressures on health and social care services and improve the health and wellbeing of the population.

Understanding the problem and building the case for action

Across North Yorkshire there is a growing older population, many of whom are living in rural areas with fixed incomes. This older demographic is important to consider, together with the quality of the housing stock in North Yorkshire which is also older and less energy efficient.

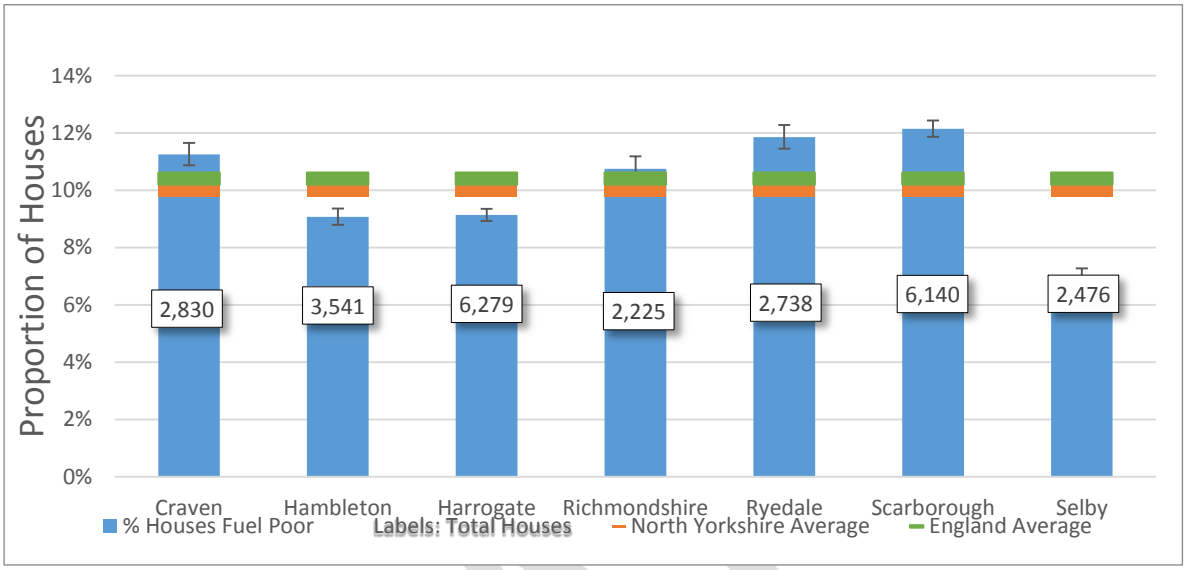
The impact of cold weather on health is estimated to cost the NHS £1.5bn a year[1] and over 18,000 people died prematurely last winter[2]. The excess cost of winter emergency admissions in the former North Yorkshire and York PCT area in 2010/11 was £3.7m. Excess emergency admissions to hospital from respiratory conditions alone in the same period cost £2.4m.

Fuel poverty is a potential causal factor of increased morbidity and mortality from winter weather. Figures 2 and 3 show the distribution of fuel poverty in households across North Yorkshire. The new (2013) definition of fuel poverty in England is measured on a low income, high costs basis. A household is considered to be in fuel poverty if:

- they have required fuel costs that are above average (the national median level) and
- were they to spend that amount they would be left with a residual income below the official poverty line.

Fuel poverty can be a useful indicator for areas where households struggle to heat their homes, but it does not necessarily describe the temperature of a household. Households with higher fuel poverty may have well heated homes, and conversely, a low fuel poverty household may have a poorly heated home.

Figure 2 - 2012 Fuel Poverty by District (source: DECC)



The extent of fuel poverty and cold homes are both major contributors to poor winter health. Fuel poverty is caused by three main factors:

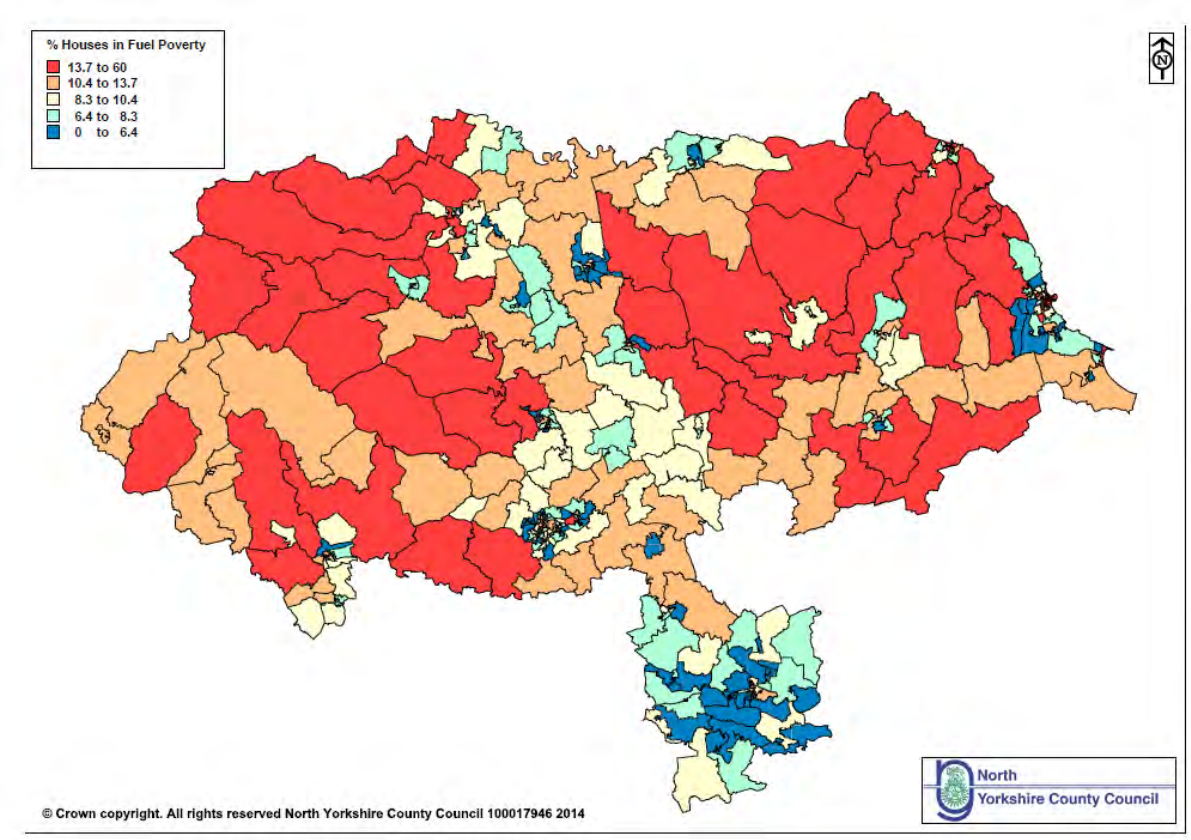
- inefficient homes,
- high energy costs and
- low incomes.

Improving the energy efficiency of housing has been shown to reduce health and social care costs and improve health and wellbeing.

In North Yorkshire, fuel poverty stands at 10%, that is **26,229 households**. Figure 3 shows the percentage of households in North Yorkshire in fuel poverty. Fuel poverty is more likely to occur in rural areas like North Yorkshire because housing tends to be older and more difficult to make energy efficient. Many homes have solid walls so are more difficult to insulate and a large proportion of homes are off the mains gas network, meaning higher costs for heating fuels. More generally in rural areas, there is a lower take up of benefits and energy advice and grants.

Figure 3 North Yorkshire Residents, % of Houses in Fuel Poverty 2010-2012, Low Income High Cost

(Source DECC)



Mortality and Morbidity

The impacts of fuel poverty and cold damp homes on health and wellbeing are felt most notably by vulnerable households, in particular older people, those living with chronic illness or disability and children.

Whilst fuel poverty and cold homes are factors in EWDs the scale of morbidity should not be underestimated. According to the Marmot Review Team, 'There is a strong relationship between cold temperatures and cardio-vascular and respiratory diseases, children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems than children living in warm homes, mental health is negatively affected by fuel poverty and cold housing for any age group…'*The Health Impacts of Cold Homes and Fuel Poverty*'[1].

[1] See http://www.foe.co.uk/sites/default/files/downloads/cold_homes_health.pdf (2011)

The 'Hills Fuel Poverty Review' found that, "Thirty-four per cent of fuel poor households contain someone with a disability or long-term illness, 20% have a child aged 5 or under, and 10 per cent a person aged 75 or over.[2]

Cost to health of fuel poverty and cold damp homes

The Government has been working on a methodology to estimate and monetise change in Quality of Life Years (QALY) that result from improving energy efficiency of homes and the resultant financial value of the health savings per measure installed. For example below:-

Intervention	QALY saved per measure installed	Value of health saving per measure installed (£-Net Present Value)
Cavity Wall Insulation	0.049	£969
Solid Wall Insulation	0.036	£742
Replacement boiler	0.009	£224
Central Heating	0.012	£303

In addition, potential areas for cost savings locally include:

- Reduced GP consultations, out-of-hours calls, attendances at walk-in centres, district nurse visits and drug prescriptions.
- Reduced emergency department visits.
- Reduced inpatient admissions.
- Reduced social care service costs.

Recent research begins to quantify the Social Cost of cold homes (ref Journal of Public Health 21 Aug 2014 pp251-7) and NICE have undertaken work demonstrating some potential cost savings see NICE costing statement http://www.nice.org.uk/guidance/ng6/resources/costing-statement-6811741

[2] Fuel Poverty Advisory Group (for England) - 11th Annual Report 2012-13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266350/fpag_11th_annual_report.pdf

Objective Details

Strategic Vision and Priorities

In order to deliver against the strategic vision and the 7 Strategic Objectives the following four key strategic priorities have been identified, based on the evidence in the NICE guidelines and the Fuel Poverty Strategy.

Four Key Strategic Priorities

1. **General awareness raising**
2. **Identifying and supporting the most vulnerable people**
3. **Shared responsibility and making every contact count**
4. **Partnership commitment**

1 - General awareness raising

This strategy recognises the need for a single source on information with clear and consistent messages that increases awareness among professionals and members of the public that this is a priority in the prevention of ill-health effects of winter. A North Yorkshire- wide awareness raising approach under the heading “Keep Well, Keep Warm, Keep Safe” in winter is being developed.

Outcomes

- Coordination of key messages and a single shared information resource
- Increased awareness of preventable seasonal related ill-health and Excess Winter Deaths to members of the public.
- Increased seasonal influenza immunisation uptake rates
- Increased awareness among communities and community leaders of ways to strengthen resilience to the impact of seasonal changes and cold weather.
- Increased awareness of impact of cold homes on health among frontline staff and professionals in the independent and public sector.
- Increased understanding of the links between fuel poverty and ill-health by supporting evaluated projects and research.
- Agreed key messages on “Keep Warm Keep Well Keep Safe in winter” promoted across North Yorkshire consistently as part of a multi-agency, partnership campaign

- Increased awareness among Landlords, Landowners and Homeowners.

2 – Identifying and supporting the most vulnerable

This strategy recognises that there are a wide range of people who are vulnerable to the cold, particularly in rural areas of North Yorkshire. Those most vulnerable to the cold need support to prevent ill-health, hospital admissions, social care interventions and excess winter deaths. For example, people living with a chronic medical condition such as heart disease, a disability, older people and families with children and young people. Sometimes, personal circumstances such as being socially isolated and unable to afford to keep warm, is enough to make someone vulnerable potentially leading to harm which could be avoided e.g. slips, trips and falls. This strategy will ensure that we recognise the needs of and provide support for the most vulnerable including the factors above and those on low incomes, by providing preventative approaches through early interventions and targeted awareness raising.

Outcomes

- Defined the most vulnerable groups in North Yorkshire
- Created ways to increase identification of the most vulnerable in North Yorkshire
- Increased routes to reach those most vulnerable to the harmful effects of being cold
- Utilised opportunities to target approaches based on the needs of the most vulnerable.
- Maximised current services provided to the most vulnerable increasing added value and diversity where needed.
- Increased number of programmes which support the delivery of prevention services in the community and provide consistent coverage when most needed. (e.g. increased uptake of influenza immunisations)
- Increased the range of opportunities for ‘support services’ to promote resilience in cold weather and community connectedness.
- Increased accessibility for all vulnerable groups to reach the support which most appropriately meets their needs.
- Increased initiatives which support people to reduce unnecessary fuel consumption and reduce fuel poverty.

- Developed opportunities to involve service users in the evaluation / design of interventions.

3 – Shared responsibility and making every contact count

This strategy recognises that everyone can be affected by cold weather (all ages, male and female) directly or indirectly. We are all responsible, whether we are parents, employees, neighbours and friends, for reducing preventable, cold-related ill-health and Excess Winter Deaths, especially if we live and /or work with those who are most vulnerable to the effects of the cold. This strategy encourages us all to take a shared responsibility across all services for all citizens and use the concept of 'making every contact count' to protect everyone from the adverse effects of cold weather.

Outcomes

- Increased awareness across North Yorkshire among professionals and others (independent and public sector) to feel confident in giving advice and signposting service users, as well as neighbours, friends and family members.

- Increased training and awareness for staff working with vulnerable groups about the link between household temperature and effects on health and wellbeing so that it positively impacts on practice and improves services.

- Increased ability to refer individuals to appropriate services to improve their health and wellbeing in winter.

4 – Partnership commitment

This strategy recognises the need to continue to work in partnership across many sectors including health, voluntary sector, councils and other agencies to deliver Joint Commissioning and effective and coordinated services.

Outcomes

- Aligned priorities to achieve better health and wellbeing for the population of North Yorkshire especially in winter months.

- Created policies and plans which take into account the impact of winter / cold weather as part of the year-round planning and decision-making.

- Increased consideration of impact of winter on health across all sectors (including utilities, housing, service providers etc)

- Created stronger partnerships taking action in response to significant issues e.g. poor quality housing and fuel poverty.

Partnership Communication

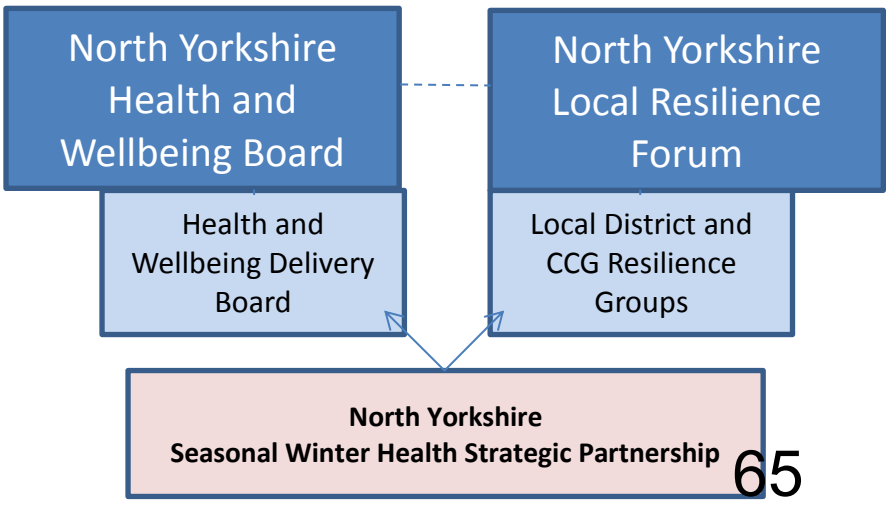
There is acknowledgment that plenty of good work is already being undertaken in localities across North Yorkshire by various agencies and we want to find ways to build on this and focus on addressing areas where more needs to be done and where there is the greatest impact locally. By working closely with partner agencies at the right scale and volume, we can ensure local action is well integrated, communicated, evaluated and effective.

Through signing up to this strategy the partnership is committed to communicating effectively not only with other agencies but also with members of the community. This includes:

- Delivering coordinated awareness raising with all members of the community
- Delivering targeted training to identified partner agencies
- Facilitating coordinated communication within and between partner agencies
- Promoting a consistent approach and key messages on seasonal winter health across all partner organisations in North Yorkshire.

Leadership and Governance

This overarching Strategy was commissioned and approved by the North Yorkshire Health and Wellbeing Board. Leadership at a "system" level will continue to be owned by this Board. However, some aspects of its delivery will rest with partner organisations. For example the responsibility for devising, delivering and monitoring the detailed actions that flow from healthcare service delivery in winter and relating to system capacity and resilience will be overseen by the Local Resilience Forum and the existing reporting arrangements to NHS England who will in turn be linking to the North Yorkshire Health and Wellbeing Board.



Measuring the Impact

The Seasonal Winter Health Strategic Partnership aims to prevent the adverse effects of winter on the population. Since winter health is a complex area due to the breadth of factors affecting the outcomes, attempts have been made to rationalise these and measure the complex winter health performance frameworks under three outcome domains - Population; Person: Community i.e. so that:-

1. **Population**
   The population does not suffer adverse health effects as a result of Seasonal Climatic Change

2. **Person**
   Across the county there is consistent affordable warmth

3. **Community**
   Communities have active networks to address Seasonal Climatic Change issues

Grouped under each of these 3 outcomes domains are a series of indictors relating the domain, the indicators are population level. Below the population indicator level the activity of the projects/schemes that are running across the county is captured demonstrating what is in progress to improve health and wellbeing.

Through ongoing discussion with partners, indicators will be developed around housing quality and the activity in voluntary sector groups, as the strategy and action plan sub-groups progress their work. Task and finish groups established will develop specific measures around the schemes of work, ultimately demonstrating progress against the population measures and therefore the overarching outcomes.
The intention is to engage all the partnerships involved in activities linked to this strategy to ensure that there are measurable outcomes linked to the SWHSPs 7 strategic objectives (***page 8***). For example, measureable impacts across North Yorkshire include:-

- Reducing preventable cold-related ill-health and Excess Winter Deaths (EWD)
- Improving Health and Wellbeing among vulnerable groups.
- Reducing pressure on health and social care services.
- Reducing fuel poverty, the risk of fuel debt and/or being disconnected from energy supplies.
- Increasing Influenza Immunisation Uptake Rates.
- Reducing injury resulting from accidents, trips and falls.
- Reducing excess Emergency admissions to hospital.

Equality Statement

This strategy recognises that winter cold weather can affect people regardless of age; ethnicity; religion or belief; disability; sexual orientation; gender. An equality impact assessment is being undertaken to inform the development of the plan and determine the impact on various groups and take appropriate action.

The North Yorkshire Seasonal Winter Health Strategic Partnership recognises that winter health issues, particularly fuel poverty, cold damp homes and poor take-up of flu vaccinations, can make a significant contribution to winter pressures on health and social care services.

Whilst older people and young children are predominantly the most at risk, it is important to note that there are other vulnerable groups such as the homeless and those in poor quality cold housing.

Products developed under this strategy and its implementation plan will be systematically reviewed using an Equality and Diversity Impact assessment to ensure they meet the needs of users and that mitigations and proactive action is in place to ensure no one within the identified protected characteristic groups are disadvantaged.

For comments on this draft strategy and feedback please email:-

Winterhealthstrategyfeedback@northyorks.gov.uk

Links to other Strategies, Related Documents and Guidance

HM Government "Cutting the cost of Keeping warm" A fuel poverty strategy for England URN 15D/062 (March 2015)

NICE National Institute of Health and Care Excellence Guideline "Excess winter deaths and morbidity and the health risks associated with cold homes" (5 March 2015)

Public Health England "Protecting health and reducing harm from cold weather – local partnerships survey report" (November 2014)

North Yorkshire Local Resilience Forum Multi-agency response arrangements (?Ref doc needed)

References

[1] NEA November 2014 http://www.nea.org.uk/Resources/NEA/Action%20for%20Warm%20Homes/documents/Letter%20to%20Prime%20Minister.pdf

[2] ONS November 2014 http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2013-14--provisional--and-2012-13--final-/index.html

NORTH YORKSHIRE COUNTY COUNCIL

Care and Independence Scrutiny Committee

21st January 2016

Annual Report of the Older People's Champion

1. **Introduction**

This is my sixteenth Annual Report, and for the second year, I am reporting on how my national work is enabling me to support the priorities in North Yorkshire County Council's Health and Well Being Strategy. Vulnerable Groups are the Council's priority and within that Group lies The Campaign to End Loneliness. In particular I am working with the Living Well teams whose role it is to work within the Community identifying those who may be lonely and asking those people what they would like to do to encourage social inclusion.

2. Supporting you to live well your way

As part of its wider prevention programme, North Yorkshire County Council has invested in a new Living Well team. Living Well Coordinators are working with individuals (and their carers) who are on the cusp of becoming regular users of health and social care services by helping them access their local community and supporting them to find their own solutions to their health and wellbeing goals. The role will help to reduce loneliness and isolation and help to prevent or resolve issues for people before they become a crisis.

As well as working with many teams within the Council (such as Public Health and Stronger Communities), the living well team is working in partnership with NHS Clinical Commissioning Groups, District Councils and voluntary, community and social enterprise organisations (VCSE).

They support the work of the Stronger Communities team to identify gaps, needs and community assets, providing information for the community directory. They are visible in their local area as extra eyes and ears; developing networks and links with other important services, such as Community Support Officers, GPs, Pharmacies, and community leaders.

Living Well Coordinators spend time with individuals on a one-to-one basis to Identify what is important to them, what potential networks of support they have and what their priorities are. They work with individuals to achieve the outcomes that are important to them, for example helping them make simple changes to their lifestyle and their home environment and helping them to maintain or improve their wellbeing and independence.

As well as supporting people to maximise their own health, wellbeing and independence, Living Well Coordinators are developing an excellent knowledge of local

services and initiatives and where necessary they will support people to access those services.

This might range from access to home adaptations, such as a grab rail to prevent someone having a fall in their own home, support to access a local friendship club to stop someone feeling isolated, to providing advice on healthy living and sign posting to lifestyle services.

The Living Well Team supports adults who are currently not eligible for on-going social care support. They may be

- Individuals who are lonely and/or socially isolated
- Individuals who have had a recent loss of a support network; including bereavement
- Individuals who have had a loss of confidence due to a recent change/event
- Individuals requiring face to face information, advice and guidance

This may be older people or people with physical, learning disabilities, sensory impairment or mental health needs.

3. Workshops on loneliness

Future Years, The Yorkshire and Humber Forum on Ageing (which I chair) applied to Awards for All to put on eight workshops to raise awareness of loneliness, what may cause it, ways to identify those in the community who may be 'at risk' and how to reconnect older people to their community. I reported last year that The Former Older People's Partnership Board had commissioned York University to look at the Forums throughout North Yorkshire whose main aims were to promote social inclusion amongst older people. From this a database was developed with the contact details for anyone to access. Added to this database were the social activities which North Yorkshire's carers and other older people could access.

Future Years organised two of the eight workshops in North Yorkshire, at Scarborough and Harrogate, for carers, older people and professionals to attend. At both workshops, officers from North Yorkshire attended including the two Living Well officers for Harrogate and Craven. The workshops have been very well received.

4. The Campaign to end Loneliness

The Campaign is now into the third year of its intermediate strategy. During last year the plans to recruit ambassadors was developed and people recruited. The Ambassadors will help to raise awareness across the whole country in a similar way to the work I have done to raise awareness. I have been asked to help with that training as I am considered to be an ambassador myself.

I was invited to take part with 15 others to develop ideas for the next strategy 2017 – 2021. You will recall that I chair the Age Action Alliance Isolation and Loneliness Working Group which meets quarterly. In last year's report I spoke about the project I was leading in Hampshire in partnership with Hampshire County Council, Boots Plc

and Age Concern, Hampshire to develop ways to identify those in the community who may be at risk to their health of the effects of loneliness.

The outcome of this work 'Making Connections' was published on the AAA website and more recently I wrote an article for the quarterly journal "Working with Older People'. This was published at the beginning of December. Janet Crampton, a former officer of NYCC worked with me to write the report of the project and the published article.

I have been working with officers from HAS and the North Yorkshire Fire and Rescue Service (FRS) over the last year to improve the way that we identify older people at risk of fire who live alone or are isolated. The initial plans for delivery of this were delayed pending the establishment of the Living Well Service, but I am hopeful that new arrangements will begin in the spring. The FRS across the whole of England has been very active in the community doing fire checks in older people's homes. FRS across Yorkshire has joined hospitals to work with them when patients are being discharged by carrying out a home safety check before discharge.

The Village Agents in the Settle area have referred many older people to the FRS to carry out home safety checks.

5. Transport in North Yorkshire

I can honestly say I have never been so busy as a councillor. Transport is a key service to preventing a feeling of isolation and the effects of loneliness amongst older people, yet more cuts to our funding for transport mean there will be no County provided Public or Community bus services north and east of Grassington. I have organised 3 public meetings in Upper Wharfedale, 101 came to the first meeting in Kettlewell Village Hall to hear Richard Owens reporting on the County's financial position and suggesting that volunteers may wish to set up a volunteer car scheme. Villagers were adamant that a Volunteer car scheme was completely inappropriate for them. If one wakes up ill, an appointment to see the GP must be made before 8.00am How can you make an appointment if you don't know whether you can get someone to take you to the surgery. No one volunteered to drive anything, car or community bus at that meeting.

I discussed the position with a business consultant in Langstrothdale, he recruited two retired business/finance people who between them developed a business plan to run a timetabled community bus service. This was then reported to a second public meeting when 60 attended and at the end of that meeting 30 people volunteered, (sixteen to drive). This small group put in a bid to North Yorkshire to run a timetabled community bus service. The bid was accepted and a third meeting called to report on 'what happens next'. Following that another 6 people volunteered. I cannot speak highly enough of the Passenger Transport Services who have given huge support and met local people when asked to do so. DCLG has asked me to write them a report on how we have achieved this in Upper Wharfedale, when indications were that no one wanted to volunteer for anything.

6. Concessionary Bus passes research

At a national level, I identified a gap in research on concessionary bus passes. No one had analysed the social value to older people of the use of bus passes. I took my justification for this research to UKAFA (UK Advisory Forum on Ageing) and was offered support from Age UK, U3A, ACRE, and the Chairs of the 9 Regional Forums on Ageing through the use of their databases to circulate a survey monkey. Financial support came from Future Years and Hull University. There had been research on the economic value of the use of a concessionary bus pass by the Green Journey Lobby Group and a report published by Age UK through the reporting of case studies. The report was published on October 1st – Older People's Day. Again this report was published on the Age Action Alliance (AAA) website and in the weekly bulletin and the Future Years website. I reported to the AAA Transport Working Group just before Xmas where I learned that NYCC was to be given £150,000 for Community Transport in the year 2016/17.

7. December meeting of the AAA Isolation and Loneliness

The Cabinet Office (CO) hosted the last meeting of that working group. David Knott (senior civil servant at the CO) attended and spoke about the aims of the Social Action Team. 4 members of that team attended and we heard about some of the successful projects which have been funded by the CO. That office is very keen to collaborate with the Isolation & Loneliness Working Group and plan more work. One member of the Working Group has offered to develop a new project and another, who leads the 'Community Network' website, has offered to meet me for a discussion on how we might extend this work amongst older people and within NY's Stronger Communities work.

Report by: County Councillor Shelagh Marshall OBE
North Yorkshire's Older People's Champion

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

21st January 2016

North Yorkshire Local Assistance Fund

1 Purpose of report

1.1 The purpose of this report is to update the Committee on the North Yorkshire Local Assistance Fund (NYLAF).

2 Background

2.1 The NYLAF provides emergency support for vulnerable people aged 16 or over to move into or remain in the community, and to help families under exceptional pressure to stay together. Awards are made in kind, in the form of goods or services. Items requested must be essential and critical to the needs of the applicant or those of their family. Available items include essential items of household furniture and equipment, beds and bedding, food vouchers, clothing vouchers, utility top-up vouchers, utility reconnection charges and essential home repairs.

2.2 For further information about the Local Assistance Fund, including eligibility criteria, which vulnerable groups are supported and how often and what people can apply for please visit our webpage at: http://www.northyorks.gov.uk/article/25908/Local-assistance-fund

2.3 At the last update to the Committee on 2 October 2014, as part of a wider stakeholder engagement, Members were invited to comment on the future of the NYLAF ahead of a decision to be made by the Executive in February 2015.

2.4 Three options were presented to the Committee: to maintain the funding at its 2014/15 level; to reduce the funding by approximately 25% to bring it in line with the sum identified by Government in the December 2014 local government settlement; or to abolish the Fund entirely. Members of the Committee agreed that continuing the NYLAF at its 2014/15 level was the most appropriate and recommended the Executive supported this option.

2.5 The Executive on 3 February 2015 considered all the evidence provided and recognised the valued contribution the NYLAF made to vulnerable individuals and families across the County but in light of challenging financial circumstances and a reduction in many other services it was decided to

proceed with a 25% reduction in funding to bring it in line with the sum identified by Government in the December 2014 local government settlement. The Executive report and minutes for the meeting can be found here: http://democracy.northyorks.gov.uk/committees.aspx?commid=18

3 Re-procurement and contract award

3.1 With the future of the NYLAF secured County Council Officers could re-procure the service for a contract start date of 1 October 2015.

3.2 The Council received eight bids, up from five in 2012. One failed to meet mandatory thresholds for service and was subsequently disapplied.

3.3 Contracts were scored a maximum of 70% for quality and 30% for competitive pricing. Quality asked a range of questions about the company structure; implementation of the service; agreements with suppliers and best value; competency and impartial operation of the service on an on-going basis, and added social value that could be brought to North Yorkshire.

3.4 The standard of the tenders was very high, the evaluation panel, which assessed all of the tenders, were particularly impressed with Connect Assist, a social enterprise based in South Wales. As well as receiving the top score for quality, Connect Assist also offered the most competitive tender price showing a drive to reduce administration costs to ensure the Fund can help as many people as possible.

3.5 Since the contract start date NYCC have been very impressed with the standard and professional nature of the service Connect Assist has provided, building on the already good reputation of the NYLAF. New features have been added to the operation of the service to assist agencies making applications and to further speed up the time it takes between receiving an application and the award reaching the applicant. This was reflected in positive comments about Connect Assist from partner agencies, charities and NYCC colleagues at the NYLAF stakeholder workshop on 22 October 2015.

4 Awards made

4.1 As each local authority was given the discretion to mould its welfare assistance scheme in a way that was deemed appropriate for local communities, every authority has done something slightly different. The strength of the North Yorkshire scheme lies in someone getting some support from a specialist agency for an underlying issue and with it, potentially, some assistance from the NYLAF.

4.2 Frequent engagement with stakeholders, as well as experience from the first two years of the Fund has meant for steady improvements, implemented throughout the year and also incorporated into the procurement process and

contract. This includes, but is not limited to - expanding the number of authorised agencies, increasing the range of items that can be applied for, adding more information about wider sources of support and ensuring that the contractor is open between Christmas and New Year.

4.3 The partnership with the Rainbow Centre to provide emergency food parcels for residents in Scarborough has continued for the financial year 2015/16 due to the demand that was seen as well as the efficiency and cost effectiveness with which the Rainbow Centre operate. The Rainbow Centre have issued 2,141 food parcels to individuals, couples and families on behalf of the NYLAF since August 2013.

4.4 **The breakdown of applications received by District:**

District	Year 1 1 April 2013 – 31 March 2014	Year 2 1 April 2014 – 31 March 2015	Year 3* 1 April 2015 – 30 November 2015
Harrogate	427 (13.3%)	612 (11.5%)	350 (13.5%)
Scarborough	1,472 (45.8%)	2,938 (55.3%)	1,333 (51.3%)
Selby	361 (11.2%)	592 (11.1%)	283 (10.9%)
Richmondshire	206 (6.4%)	278 (5.2%)	151 (5.8%)
Craven	175 (5.5%)	227 (4.3%)	103 (4.0%)
Hambleton	313 (9.7%)	336 (6.3%)	163 (6.3%)
Ryedale	257 (8.0%)	333 (6.3%)	214 (8.2%)
Total	**3,211**	**5,312**	**2,597**
Unsuccessful applications	60 (1.9%)	121 (2.4%)	92 (3.5%)

*Available data to date

These proportions have been consistent since the scheme began and broadly reflect the levels of demand seen under the DWP's Social Fund. Clearly, population plays a key part in driving this demand, as Scarborough and Harrogate represent the largest population settlements in North Yorkshire, followed by Selby. In terms of the particularly high volumes stemming from Scarborough district, there is similarly a strong link between issues such as levels of deprivation, unemployment and benefits take-up in this part of the county and the high demand for emergency NYLAF support.

The 2015 Index of Multiple Deprivation (IMD) identifies 23 Lower Super Output Areas (LSOAs) within North Yorkshire which are amongst the 20% most deprived in England. 17 of these LSOAs are in Scarborough district alone. Scarborough also has the highest headline unemployment rate in North Yorkshire at 5.1% (as at end of June 2015). NYLAF figures suggest that applications under the two highest volume NYLAF categories – families under pressure and homelessness – are highest within Scarborough district.

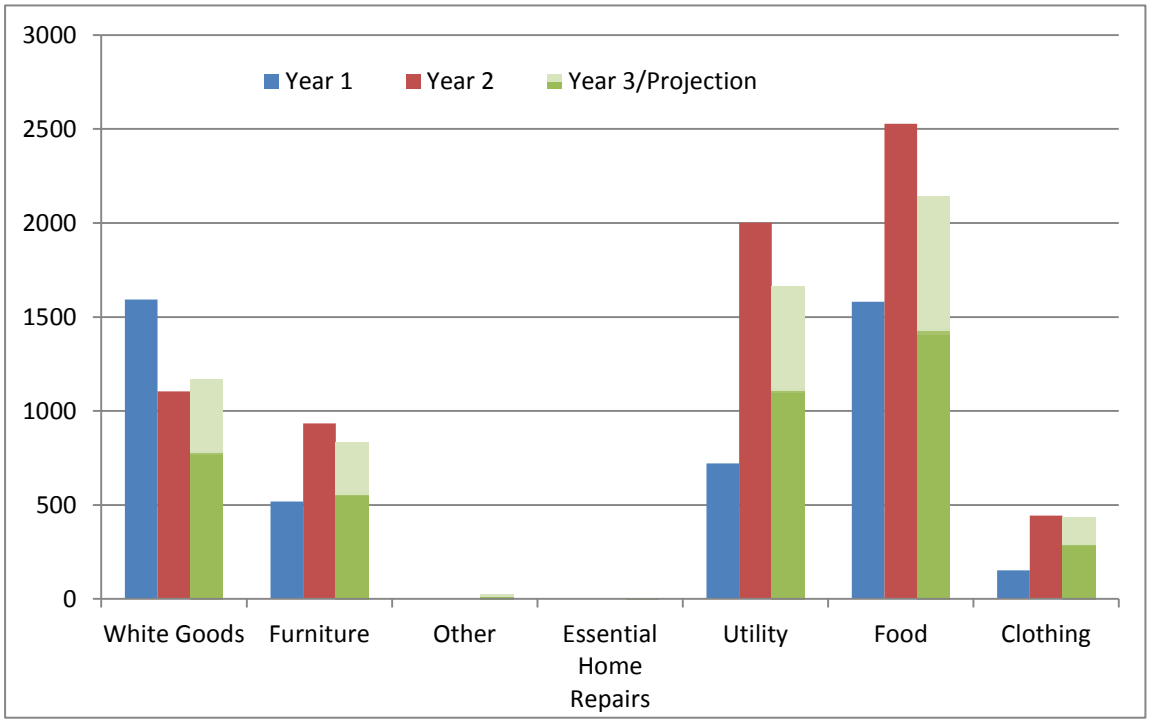
4.5 **The breakdown of applications awarded by vulnerable groups:**

Vulnerable group+	Year 1 1 April 2013 – 31 March 2014	Year 2 1 April 2014 – 31 March 2015	Year 3* 1 April 2015 – 30 November 2015
Homeless/risk of homelessness	371 (14.9%)	852 (20.3%)	541 (30.0%)
Learning disability	46 (1.8%)	54 (1.3%)	15 (0.8%)
Released from prison/supervised on a community order	67 (2.7%)	105 (2.5%)	65 (3.6%)
Drug/alcohol dependency	82 (3.3%)	124 (3.0%)	39 (2.2%)
Family under exceptional pressure	1,229 (49.2%)	2,034 (48.5%)	776 (43.0%)
Mental health problem	308 (12.3%)	455 (10.9%)	180 (10.0%)
Victim of domestic abuse	102 (4.1%)	220 (5.2%)	90 (5.0%)
Physical disability	250 (10.0%)	265 (6.3%)	73 (4.0%)
Carer	42 (1.7%)	83 (2.0%)	27 (1.5%)

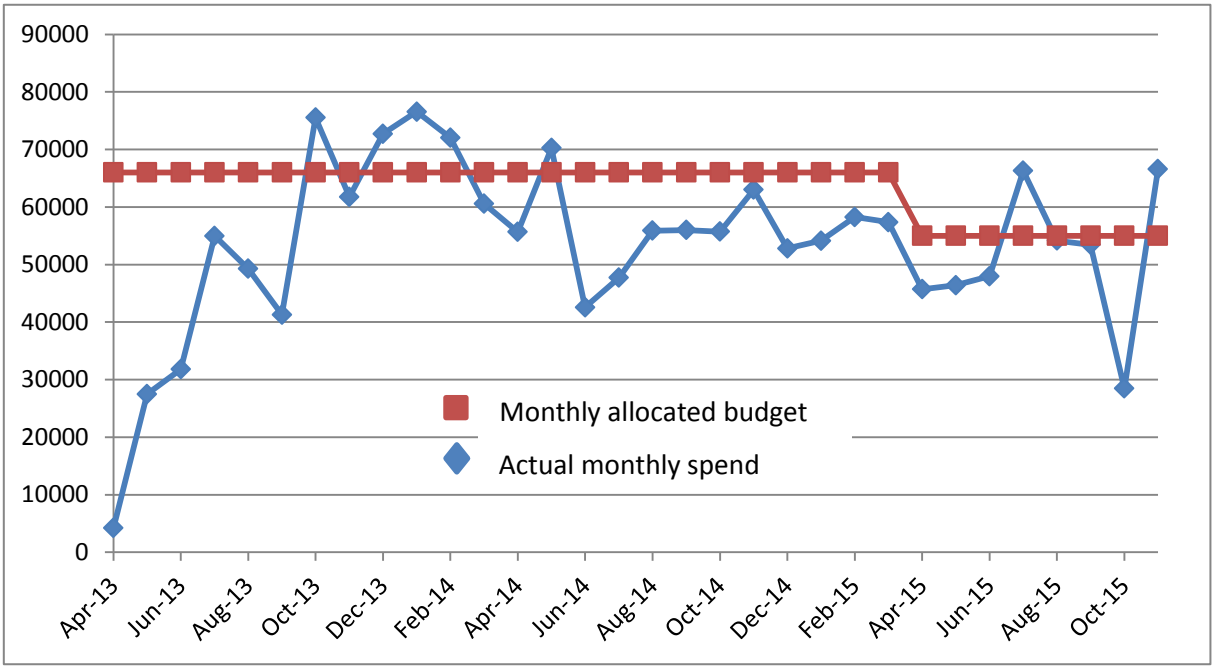
*Available data to date

+Please note this table does not contain data provided by the Rainbow Centre

4.6 **The breakdown of awards:**



4.7 **Monthly spend breakdown (£):**



5 Recommendation

5.1 That the report be noted.

Neil Irving
Assistant Director, Policy and Partnerships
7 January 2016

Report author: Mark Taylor, Policy and Partnerships

NORTH YORKSHIRE COUNTY COUNCIL

Care & Independence Overview & Scrutiny Committee

21 January 2016

Equipment & Telecare 2020 Proposals

1.0 Purpose of Report

1.1 The report details the progress that has and is being made in respect of the service delivery and efficiencies in these two areas

2.0 Introduction

2.1 The Directorate has a statutory duty to provide aids to daily living following a person's assessment. The nature of these aids ranges from simple equipment such as grab rails through to more specialist items such as lifting equipment. There is a consequent variation in the cost of such equipment.

2.2 The range of equipment offered has developed and changed over time, and a significant development in North Yorkshire has been the growth in use of telecare. The basic element of this is a "lifeline" alarm system but more sophisticated developments include pressure mats, door and incontinence alarms that allow people to retain independence, whilst maintaining their safety.

2.3 The 2020 proposals originally looked to review and remodel the services whilst also making savings. However, it was also acknowledged that as these services were often complementary to other community services, they could not be viewed in isolation.

2.4 The savings earmarked against these proposals were £200,000 in 2015/16 and a further £350,000 in 2016/17.

3.0 Equipment Services

3.1 The arrangements for the assessment, provision and delivery of equipment are shared between NYCC and Health via the Clinical Commission Groups (CCGs). There is an equipment budget and also a contract that is currently with the Harrogate and District Foundation Trust (HDFT) for the running costs of the Equipment (Loans) Store. Harrogate and Rural District (HaRD) CCG have lead responsibility for the contract.

3.2 Assessments are undertaken by Occupational Therapists who are employed in the community by NYCC and in hospitals by the NHS. Equipment provided following these assessments is procured and delivered via the Loan Store.

3.3 There were originally a number of Loans Stores in the county some of which were run by NYCC and some by health. In 2014 these were all brought together with a central store in Knaresborough and staff transferred to the employment of HDFT. This simplified operation gave a period of time to assess the ongoing viability of the arrangements. Because the contract with HDFT expires in 2016, decisions have had to be made regarding the service's future.

3.4 A key element of these decisions has been to assess the likelihood of achieving the savings attached to the services. These were £108,000 (of the required £200,000) from equipment in 2015/16 and £350,000 from the Loans Store running costs in 2016/17. It has become apparent that in reality the demand for equipment has continued to grow, though this is mainly evident in the increasing use of health funded items, with the result that the CCGs are facing overspends. In terms of social care equipment, the emphasis on prevention and timely discharge from hospital, which is delivering savings elsewhere, has made reductions impossible to achieve.

3.5 The preventative nature of the service has been recognised by the use of Public Health funding as the service clearly meets the national outcomes. Therefore, the required reduction in the HAS budget has been achieved by the appropriate transfer of resource.

3.6 The review of the loans store arrangements has concluded that although there have been some service improvements, notably in areas where deliveries were difficult (Craven and Selby), there is evidence that more radical changes to the service need to be considered. In addition procurement rules mean that HaRD must put the service out to competition.

3.7 A joint procurement between NYCC and the CCGs has just been launched. The timetable for this is attached as Appendix 1. A key area that is now nearing completion is engagement with users of the services to ensure that the new service meets their needs. Alongside the procurement health are running a similar exercise for the provision of wheelchairs. This may indirectly lead to some efficiencies of scale.

3.8 This is a major project which will come to fruition in 2016. Early indications are that there will be some changes as to how equipment is provided. For example delivery maybe directly from the supplier rather than through a store (known as a "retail model").

4.0 Telecare Services

4.1 Telecare services rest solely with NYCC and as a consequence this has been a simpler area to review. The service consists of staff who assess and fit equipment and the purchase of the equipment itself.

4.2 A fundamental review of the processes has resulted in better outcomes for customers and evidence of improved quality. This had included better and more consistent quality control of equipment provided.

4.3 The changes to the service are both a reduction in the staffing budget and changes to existing processes that have resulted in a more efficient service which has made the required saving of £92,000 (the remaining part of the £200,000) in 2015/16. This has not impacted on the provision for users as it centres on better procurement and a reduction in staff numbers.

4.4 Further work is ongoing to retain the achieved changes in culture and to make best use of changes in technology

5.0 Summary

5.1 This 2020 project has highlighted the complex and inter-related nature of these services. Changes elsewhere that have led to an increase in preventative services that have affected the original projections for the savings.

5.2 The end result of the project will be radically different services but ones that will reflect the changing needs of service users.

6.0 Recommendation

6.1 That the report be noted.

Report Author: Mike Webster – Assistant Director
Tel: 01609 798794

Background Documents Nil

Appendix 1

Equipment Services

Project/Procurement Timescales

High-level project/procurement timescales are outlined below:

Key Activity	Timescale / Progress
Engagement to inform service specifications, service models and financial models	**November 2015 – January 2016** Weekly Engagement Project Team Set-Up with representation from all commissioning organisations. Engagement planning underway / events in diary / surveys are being designed to capture views regarding existing and future services from patients, carers, prescribers and the market.
Service Specification design together with service model/finance model design	**November 2015 – January 2016** Weekly project team established to take forward development of service specifications, service model and financial model, with weekly reporting to commissioner's forum (which meets monthly to ensure wider commissioner input). Project team is led by Vale of York CCG (to keep project manageable). Financial input is required from all co-commissioners for Vale of York CCG lead. Financial request shall be received shortly be all commissioners for review and acceptance.
Sign-off of service specification and financial Model	**February 2016** Agreement via commissioners forum and at all co-commissioners, Governing Body Meetings

Restricted Procurement Process - PQQ **PQQ Launched** **PQQ Evaluation Process**	**March / April 2016** 21st March 2016 April 2016
Restricted Procurement Process – ITT **ITT Launched, Return and Evaluation**	**May – July 2016**
Approval / Sign-Off - Contract Award	**21st July 2016 – 4th August 2016**
Alcatel Period	**5th August – 15th August 2016**
Tender Award	**16th August 2016**
Mobilisation	**17th August 2016 – 30th November 2016**
Service Start	**1st December 2016**

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

21 January 2016

WORK PROGRAMME REPORT

1.0 Purpose of Report

1.1. The Committee has agreed the attached work programme (Appendix 1).

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 Safeguarding Training

3.1. In line with agreement reached at the last committee, your group spokespersons discussed the options for trading for elected members on Safeguarding.

3.2. It was agreed that a session be arranged in the Spring to cover the responsibilities of NYCC in relation to adults and children, and that it be jointly delivered

3.3. It will include:

- principles/issues common to both or where there are links eg during transition or where an adult may be a risk to children; and
- where there are differences eg legislation and the right of an adult with capacity to make their own choices

3.4. This is likely to be a separate session, rather than including it as part of a wider session covering other issues for Councillors. We would estimate that this would be about 2-2.5hours, but will be clearer once the content is developed.

3.5. All Councillors will be invited, and we will aim for the session to be delivered in March, dependent on availability of dates.

3.6. The overall aim of the session will be that Councillors understand their responsibilities in relation to safeguarding, focusing in particular around how to recognise and report it.

3.7. Areas that will be covered include:

- Understanding what Safeguarding is. This would include some stories to demonstrate the different types, possibly using a short video.
- What a Councillor would do if they considered they had come across a Safeguarding issue
- Identifying the Local Authority's responsibilities – that it has the overall responsibility for safeguarding, but links to many other local agendas
- Understanding a Councillor's role in relation to Safeguarding - this will include their general role as a community leader, but also their role if they are Members of Overview and Scrutiny, or members of bodies that have a safeguarding remit
- Understanding Safeguarding Boards - what these are and what they do, including responsibilities around Serious Case Reviews/Safeguarding Adult Reviews.

4.0 Recommendations

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

BRYON HUNTER
SCRUTINY TEAM LEADER
County Hall,
Northallerton

Author and Presenter of Report: Ray Busby
Contact Details: Tel: 01609 532655
E-mail: ray.busby@northyorks.gov.uk

13 January 2016

Appendix 1

Care and Independence Overview and Scrutiny Committee – Work Programme Schedule 2015

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 (10.30am) Group Spokespersons Committee		31 Mar 2016		14 Sept 2016	1 Dec 2016	2 Mar 2017	11 May 2017
Scheduled Committee Meetings (10.30am)	21 Jan 2016	21 Apr 2016	30 June 2016	27 Oct 2016	19 Jan 2017	27 Apr 2017	

MEETING	SUBJECT	AIMS/TERMS OF REFERENCE	ACTION/BY WHOM
21 April 2016	Complex needs	Current situation and progress against 2020 Savings requirement.	HAS
	Smoking Cessation	Update on the public health strategy	HAS -Public Health
	Mental Health Strategy	HWB adoption of the strategy and intended plan of action	HAS
	Assessment Reablement Pathway	Possible update.	HAS

Care and Independence Overview and Scrutiny Committee – Work Programme Schedule 2015			
	Independent Advocacy (Information and Advice)	As part of the committee's assement of directorate preparedness for the Care Act. Under the Care Act, HAS and its partnership organisations must make a referral for an Independent Advocate for any adult they are working with who has substantial difficulty with: • understanding information • retaining information • using information to make a decision • communicating their views, wishes and feelings • not having an appropriate relative, friend or carer to support their involvement.	HAS
30 June 2016	Domiciliary Care update	Progress on the commissioning process. Dialogue with providers.	HAS
27 October 2016	Targeted Prevention and Support. (NYCC Savings Target item)	How the relevant savings target is being achieved. How the impact upon service users is being managed, focussing on the evidence regarding the effect of the range of preventative services funded by the council for people who already have low level health and/or social care needs and their carers.	HAS
19 January 2017			
27 April 2017			

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

Additional issues (to those above) which will be picked up at Mid-Cycle Briefings and which may also be brought to the subsequent Committee include:

	Workforce, Employment of Care Workers, Assessment and Re-ablement, The Care Cost Gap