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 30 June 2016 at 10.30 am

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Business

1. Minutes of the meeting held on 21 April 2016

(Pages 6 to 9)

2. Any Declarations of Interest

3. Public Questions or Statements.

Members of the public may ask questions or make statements at this meeting if they have delivered notice (to include the text of the question/statement) to Ray Busby of Policy & Partnerships *(contact details below)* no later than midday on Monday 27 June 2016 Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

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

- 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.

If you are exercising your right to speak at this meeting, but do not wish to be recorded, please inform the Chairman who will instruct those taking a recording to cease while you speak.

Provisional Timings

4. **Dialogue with Providers: Extra Care Brief** - Report of the Scrutiny Team Leader ***10.30am***

(Pages 10 to 14)

5. **North Yorkshire Joint Alcohol Strategy - One year on Report and** Presentation by the Director of Public Health ***11.45am***

(Pages 15 to 46)

6. **Suicide Audit** - Presentation by the Director of Public Health ***12noon***

7. **a) Mental Capacity Act and Deprivation of Liberty Safeguards** - Report of the Corporate Director - Health and Adult Services ***12:15pm***

(Pages 47 to 56)

b) Court of Protection Rules: Presentation by the Corporate Director - Health and Adult Services

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

(Pages 57 to 59)

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

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Northallerton

22 June 2016

Notes:

(a) **Emergency Procedures for Meetings**

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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	

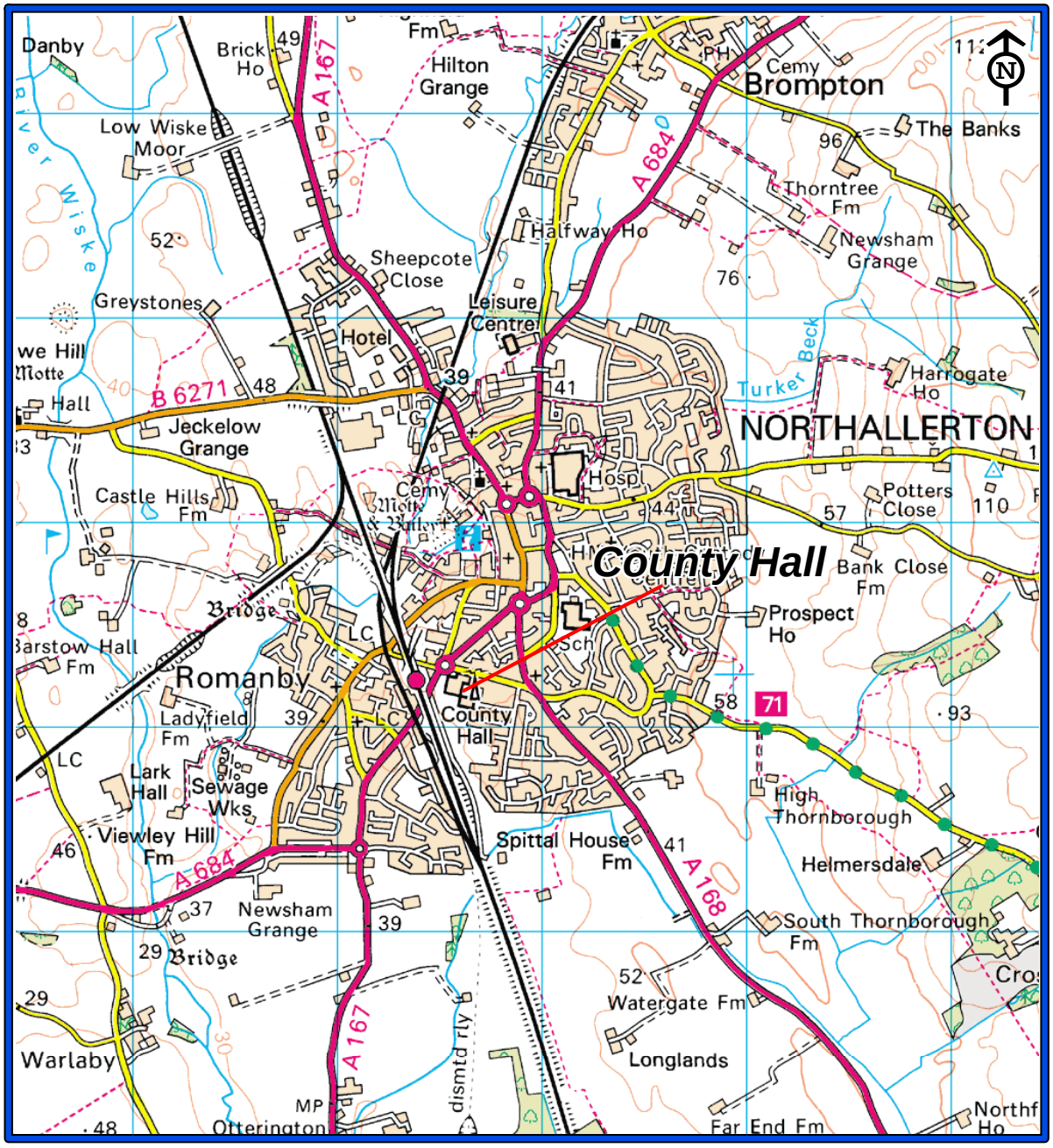
Members other than County Councillors – (3)			
Non Voting			
	Name of Member	*Representative*	*Substitute Member*
1	KNIGHT, Julie	North Yorkshire Centre for Independent Living	
2	SNAPE, Jackie	Disability Action Yorkshire	
3	PADGHAM, Mike	Independent Care Group	

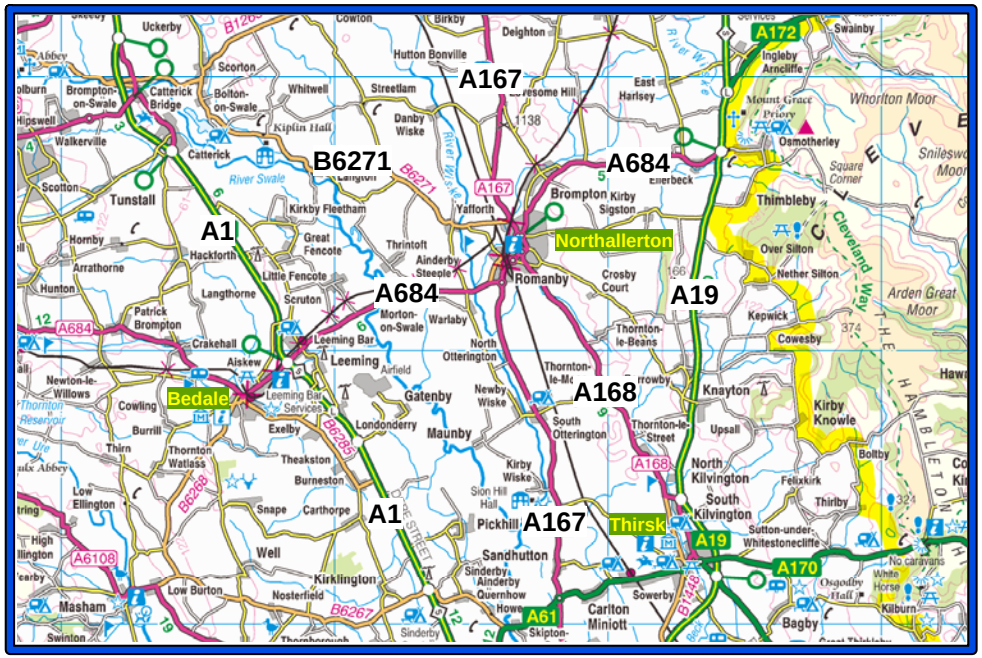
Total Membership – (16)	**Quorum – (4)**

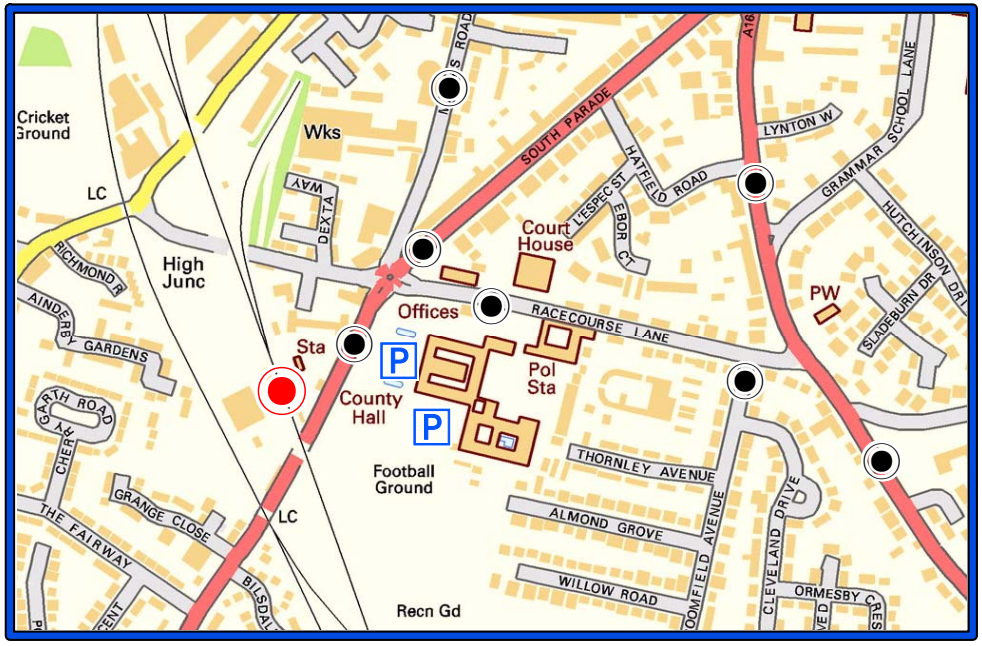
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**0**	**2**	**1**	**1**	**0**	**0**	**13 ***

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**	
5		**5**	
NY Independent		**Labour**	
	Councillors Names		*Councillors Names*
1	HORTON, Peter	**1**	BILLING, David
2	JEFFERSON, Janet	**2**	
3		**3**	
4		**4**	
5		**5**	
Liberal			
	Councillors Names		
1	CLARK, John		







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North Yorkshire County Council

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

Minutes of the meeting held on 21 April 2016 at 10.30 am at County Hall, Northallerton.

Present:-

County Councillor Patrick Mulligan in the Chair.

County Councillors: Val Arnold, Jim Clark, Helen Grant, Bill Hoult, Mike Jordan, John McCartney, Brian Marshall, Heather Moorhouse, Chris Pearson, John Savage and Tim Swales.

Representatives of the Voluntary Sector: Jackie Snape (Disability Action Yorkshire) and Keren Wilson (as substitute for Mike Padgham (Independent Care Group)).

In attendance:

Officers: Mike Webster (Assistant Director, Contracting, Procurement and Quality Assurance (Health and Adult Services)), Mike Rudd (Head of Commissioning - Scarborough & Ryedale, Commissioning and Partnership (Health and Adult Services)), Ray Busby (Scrutiny Support Officer, (Policy and Partnerships)).

Apologies: County Councillors John Ennis and Clare Wood (Executive Member for Adult Social Care Health Integration).

Copies of all documents considered are in the Minute Book

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94. Minutes

Resolved –

That the Minutes of the meeting held on 21 January 2016, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

95. Any Declarations of Interest

Jackie Snape, as Chief Officer of Disability Action Yorkshire, a domiciliary care provider, had given notice and declared an interest in respect of the item relating to "Update on the Domiciliary Care Contracts in Harrogate and Selby: Dialogue with representatives of the two providers".

96. 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.

97. Update on the Domiciliary Care Contracts in Harrogate and Selby: Dialogue with representatives of the two providers

Mike Rudd explained that domiciliary care is a term for care and support provided in the home by care workers to assist someone with their daily life. Health and Adult Services undertook a procurement exercise in 2014 to introduce new "Framework" arrangements for domiciliary care as Phase 1 of a review of home care contracts. The first phase was targeted at care provided in the areas with greatest need and

demand for support in Harrogate, Selby and Scarborough. Through the Frameworks the aim was to reduce the number of providers with whom the council works, to allow for much closer partnership working in order to improve quality and at the same time reduce transactional costs.

Consultation with people receiving services had highlighted two key areas of concern with home care – timeliness of visits and continuity of care. The new specification enhanced the quality standards for providers including these two key areas. The new specifications also help deliver more personalised care, and the outcomes that people want from their support.

Mike Rudd introduced representatives of the two framework domiciliary care providers awarded the contracts for Selby and Harrogate, respectively, until 2019 - Mike Richards from "Riccallcare" and Samantha Harrison from "Continued Care". Both stressed the business pressures of absorbing the increase in the living wage, and the difficulty ensuring a sufficient margin to continue to invest in the business against the backcloth of what is an increasingly complex social care market, with continuing problems recruiting, training and retaining staff.

The two providers described their positive relationship with HAS Directorate, especially when it came to communication and continuity of assessments. In part, this has resulted in referral arrangements for personal care with clients being grouped so that staff can visit clients within a recognised local area thereby reducing travelling time between appointments - a key benefit in a predominantly rural area.

Members agreed that this exercise should help them gauge the progress of Phase 2 of the rollout of the framework domiciliary care to other areas of the county.

Resolved -

That the report be noted.

98. Advocacy - Post Care Act

Considered -

The report of the Assistant Director Commissioning - Health and Adult Services providing an account and update on the Council's preparedness and implementation of the Care Act. The report reviewed how the Directorate was making arrangements for providing advocacy services for people who experience substantial difficulty in being involved with the care and support process.

Mike Webster explained that Advocates provide an independent support to people who, through vulnerability or lack of capacity, need support to help them to make a decision or express what they want to say, or who need someone to act on their behalf or represent their best interests. The Department of Health have suggested there was likely to be a 10% increase in the demand for advocacy as a result of the new Care Act responsibilities. The committee heard how an invitation to tender was sought for one countywide provider with the ability for a consortia to bid, or for a lead provider to sub-contract. A successful tendering process was conducted and, as a result of robust evaluation, "Cloverleaf" have been selected as the new provider; although, they have indicated in their bid submission that they may sub-contract with York Mind and Advocacy Service.

This means a change as the previous provider of the generic advocacy (North Yorkshire Advocacy) was not part of the successful bid.

Resolved -

a) That the report be noted.
b) Members were reassured that plans are in place to work with the outgoing provider to ensure a smooth transfer to the new contract.

99. Group Spokespersons' Discussions on Inspection of Care Homes and Member Involvement

Considered -

The report of Group Spokespersons informing the Committee of recent discussions in the Mid Cycle Briefing about how Members are notified of care provider issues, raised either by the Care Quality Commission (CQC), the regulation authority and/or as a result of the HAS Monitoring of Services via the Contracting, Procurement and Quality Assurance Team.

Ray Busby reminded the committee that at a previous meeting members had heard from the Care Quality Commission's (CQC) Regional Inspector about the inspection of care providers, and particularly new arrangements around increased transparency of inspection findings. Then, the committee noted the CQC's rating systems for providers, which range from: outstanding; good; requires improvement or inadequate. This new system does help inform users about the quality of the provision. When combined with new recently produced CQC area profiles, members of the public can thus be reassured that the commissioning of HAS services is sustained at a high quality level. It is, however, early days for the CQC rating system and many people are clearly struggling to understand what the rating categories actually mean in practice. Constituents regularly contact elected members about issues that they are experiencing locally in relation to family members. The committee, therefore, returned to the question about how elected members are informed about, and possibly connected to, all this information regarding the regulation and inspection of care establishments.

In many instances where a home is rated as requiring improvement by the CQC this might mistakenly cause people to worry that this finding implies something more serious about the standard of care. Currently, discretion lies with the HAS Directorate about how and whether directorate held information is then shared with the local elected member. The consensus was that every effort should be made to keep local members informed. Thus, the current arrangement would continue where officers exercise judgment on the merits of each case as to how information is shared, but members now expected the Director, when balancing competing reasons in any given case, to err of the side of making the local member aware.

Resolved -

The committee agreed to continue the current arrangement whereby a judgment will be made on the merits of each case. This means, for example, where a home is found to be requiring improvement, a judgment will be made based upon those findings and locally held information, as to how this situation should be shared with the local Member. Depending upon the circumstances, a finding of "Inadequate" is more likely to trigger contact with the local member. However, unless truly exceptional circumstances apply, the Committee and the relevant local Member will be notified *automatically* when a provider is suspended or ceases training.

100. Work Programme

Considered -

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

The method and format adopted in the meeting for the Domiciliary Care discussion - that of an open conversation and dialogue with providers - is one that the committee would want to replicate in the future with both in-house and external providers where the scope of their activity matches key areas of the work programme.

Resolved -

That the Work Programme be agreed.

The meeting concluded at 12:50pm

NORTH YORKSHIRE COUNTY COUNCIL

Care & Independence Overview & Scrutiny Committee

30 June 2016

Dialogue with Providers: Extra Care Brief

1.0 Purpose of Report

1.1 To guide the Committee's question and answer session with providers of extra care in the County.

2.0 Background and Format of Topic

2.1 The Committee agreed to hold a series of conversations with providers and organisations that provide social care services in partnership and/or via the council's commissioning arrangements. For this June meeting, it was agreed the focus will be on extra care provision.

2.2 The following will be attending at the meeting:

- Andy Powel, Customer Services Director, Broadacres Housing Association
- Clare Charlton, Head of Extra Care, Housing and Care 21.
- Paula Broadbent, Retirement Solutions Director, Keepmoat (the developer)

2.3 The Chairman will invite each of those representatives present to introduce themselves and, briefly, say something about the organisation they work for - what it does, its mission statement, the nature and status of the business, its size/commercial and community reach etc.

2.4 After this, and before the start of the Q and A session, the Chair will ask the Corporate Director for Health and Adult Services to set the scene by saying something about how the authority's position on extra care and varying operating models in place, the business case, the scale of provision, how it meets need, and any proposed changes plans for the future.

2.5 The long list of proposed questions below have been agreed by your group spokespersons, who don't expect to cover all the points in one meeting; it is for you decide which areas to explore. The list has been sent to the representatives well in advance of the meeting.

3.0 Committee's interest in Extra Care

3.1 Extra care housing is housing designed to have care arrangements on site. This ranges from low to high intensity care with low to high dependence and varies from staying put services such as home help and floating support.

3.2 The rationale for extra care -as far as the authority is concerned - is that:

- extra care housing acts as a preventative model, supporting independence and avoiding admissions into residential care;
- extra care housing is a more cost effective model of care delivery than other models, including residential care and care in the community

3.3 Generally, most extra care housing appears to reflect the three tenets of: (i) flexible care, (ii) independence, and (iii) homeliness. In addition, extra care may fulfil a role as:

- a direct alternative to a care home (or other institutional setting) for those with moderate-high care needs; or
- prolonging a period of independence for those with low or no care needs; or
- a form of housing for older people who anticipate future care needs; or
- Simply an alternative form of housing for those older people regardless of current or anticipated care needs.

4.0 Care considerations - focus on resident and tenant: Possible discussion points

4.1 Is extra care promoting Independence?

a) How does it take the pressure off carers and families who may be struggling to cope with increasing dependency?
b) What is the extra care component typically made up of? Do we distinguish between support, domestic services and care, is that sensible? How do we avoid unhelpful "seams" in service delivery?
c) What is the usual pattern in terms of peoples' care needs when they enter extra? Do they reduce? If so, to what extent? [Issue here is if they reduce to a level where care not required]
d) How do we provide for people with dementia (early and late stages) in an extra care environment?
e) How do we ensure that close attention is paid to initial and ongoing allocations to ensure that overall dependency levels do not rise to high (see question below) - or fall too low for that matter (too low and do not utilise the enabling benefits of extra care housing) - to help shape a vibrant community
f) Do we look to ensure occupancy across the range - learning disabilities, mental health problems?
g) How to balance the need for security and encouraging people to do more for themselves

4.2 A home for living and a healthy home for life

h) How can we secure a good standard of social life -especially when people don't know their neighbours? [is it a question of design of building as well as facilities]
i) What opportunities and time is there for the support staff to genuinely get to know the residents and thus for residents to learn to trust them?
j) Involvement and engagement with residents - How do providers go about ensuring that residents views about facilities and community living are taken into account - what consultation methods are used What do people say. And how do we avoid making people think that consultation about changes is a precursor to reductions?
k) How do we know design reflects people's wishes and aspirations?
l) How difficult is it to build a community spirit when people have mixed levels of dependency and differing levels of need?
m) How do we promote the mutual support of residents to reduce the need for care and support?

4.3 The home in the community

n) Two way community use - How are peoples actively encouraged to participate and volunteer in the community and vice versa? Notwithstanding the need for a security and enclosed environment
o) Links to schemes in the community - digital age inclusion courses, other clubs, hobbies social activities and groups
p) How can the home be a good neighbour - involving the general public?

5.0 Performance and outcomes: Possible discussion points

a) How does the directorate establish/validate that the rationale has been reflected in outcomes and that is delivering the outcomes that were predicted and expected? What qualitative and quantitative data/information do providers and commissioners use?
b) What evidence do we have that it enables people who may be at crisis point to avoid residential accommodation?
c) Demographics, profile, sense of the average length of stay etc

6.0 Strategic issues of wider significance in terms of budgets and activity, policy making: Possible discussion points

6.1 Accountability and challenging decision makers

a) Is extra care in its current form still relevant, is it still modern? Are decisions made earlier on - about models of care and partnership arrangements, for example - still valid?
b) How does it compare to other alternatives (domiciliary care in own home, sheltered housing with support, very short domiciliary care, residential care, EMI

residential or nursing care provision, nursing care) and, locally, what is the relationship between them

c) Financial benefits, ie and actual savings and avoided costs.
d) Are there any concerns that homes will become "residential-lite" homes by stealth - is high and medium dependency where the most cost savings are to be found?
e) Dedicated on site team versus community based care? Which works best?

6.2 Is the rationale and principle that extra care works still valid

f) What changes might the authority need to make for the future?
g) Is the set up - partnership arrangements etc - flexible enough should changes need to be made as policy and statutory needs changes eg Dilnot
h) Are we expecting the financial advantages to remain?

7.0 Partnership concerns and interest - The nature of the relationship. Possible discussion points

7.1 Commissioning options

a) What's the optimum type of contractual arrangement - need for care? Support and domestic services integrated
b) How does the authority assist providers to forge community links?

7.2 Design:

c) What are the key element in making a design positively welcoming to families and individuals? How has thinking on design changed over the years?
d) How can we ensure in design terms that extra care looks and feels like housing first, not an institution - is there is a clear distinction between Extra Care Housing and residential care as recognised by the Care Quality Commission
e) What are the prerequisites that extra care must have from a developer's point of view?
f) Physical layout has to be open enough to promote and reinforce sense of independent belonging whilst promoting enclosed environment that places considerable value of safety. Is there, therefore, a danger that the layout, structure becomes outdated? What happens about refurbishments? Where does the capital investment come from
g) New build or more opportunities for conversion?

8.0 Commercial/Business considerations

a) Living Wage, recruitment and retention, the problems of staff turnover, Terms and Conditions and the profile of staff – gender, age. permanent, temporary, sessional, relief, level of experience etc
b) Self-directed support and its impact upon the viability of providers
c) Are people opting in or out of existing options and services? Influence of personal budgets - does that improve or challenge viability for providers

d) staff training - what's needed etc., thoughts generally
e) The rural dimension - problems running extra care in a predominantly rural environment.
f) Regulation - How this is perceived by providers, the extent to which it is helpful/a burden. Experiences of the CQC regime.
g) Standards in personal/domiciliary care.

BRYON HUNTER
SCRUTINY TEAM LEADER

County Hall,
NORTHALLERTON.

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Contact Details: Tel: 01609 532655
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21 June 2016

Measuring the impact
North Yorkshire Joint Alcohol Strategy
One year on

Health and Wellbeing Board
North Yorkshire

Acknowledgements

Lincoln Sargeant, Director of Public Health

Clare Beard, Consultant in Public Health

Claire Robinson, Health Improvement Manager

Angela Hall, Health Improvement Manager

Ed O'Malley, Public Health Intelligence Analyst

Claire Lawrence, Health Improvement Officer

Caroline Townsend, Health Improvement Officer

The Public Health team would also like to thank the following people and organisations for providing case studies and updates for this report.

Jenny Christie, Customer Relations and Marketing Officer, DrugTrain Ltd

Jo Ireland, Customers, Communities and Partnerships Manager, Scarborough Borough Council

David Miller, Acting Section Head North Yorkshire Trading Standards

Honor Byford, Team Leader, Road Safety & Travel Awareness, Highways and Transportation (BES)

North Yorkshire Horizons

North Yorkshire Police

Contents

Glossary

Binge Drinking
The definition of binge drinking used by the NHS and National Office of Statistics usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk.

Preloading
Taken here to mean the drinking of alcohol in the home prior to going out into the night time economy

Identification and Brief Advice
Simple brief advice entails structured advice lasting 5-10 minutes, based on an evidence based approach called FRAMES, commonly delivered by non-alcohol specialists

Tier 2 Service
Lifestyle weight management programmes for overweight or obese adults are multi-component programmes that aim to reduce a person's energy intake and help them to be more physically active by changing their behaviour. They may include weight management programmes, courses or clubs

The Department of Health defines the following as:

Hazardous drinking
These people are drinking above recognised sensible drinking levels that increases the risk of harmful consequences to the individual and others. Sometimes referred to as 'increasing risk' drinking

Harmful drinking
This group are drinking above recommended levels for sensible drinking and experiencing physical and/or mental harm directly related to alcohol consumption. Sometimes referred to as 'higher risk' drinking

Dependent drinking
This group are drinking above recommended levels, experiencing an increased drive to use alcohol and feel it is difficult to function without alcohol. Characterised by craving, tolerance and a preoccupation in spite of harmful consequences.

Executive Summary

Background

The current report is the first annual report of the North Yorkshire Joint Alcohol Strategy 2014 – 2019. The report describes the three outcome areas underpinning the alcohol strategy. It includes the main developments against these outcome areas, and the impact of increased investment in the alcohol strategy including new investment in Identification and Brief Advice (IBA) to assess changes in people's behaviours and contribute to reducing alcohol-related harms.

Introduction

In January 2015 North Yorkshire County Council (NYCC) published a joint alcohol strategy. The strategy aimed to galvanise partners to collectively reduce the harms from alcohol. The strategy identified three outcome areas; establish responsible and sensible drinking as the norm; identify and support those who need help into treatment through recovery and to reduce alcohol related crime and disorder. The alcohol strategy intended to continue to build on the on-going work across North Yorkshire (NY) informed by the latest data and using the best evidence of what works and what is available.

The report draws together key data and evidence and identifies significant developments within each of the three outcome areas. The report aims to evaluate the impact of the alcohol strategy in North Yorkshire and answer; how and to what extent has implementing the strategy and interventions (taken together and/or individually) changed peoples behaviours and contributed to reducing alcohol-related harms?

What does the data tell us?

National Picture

The Office for National Statistics (ONS) Opinions and Lifestyle Survey, Adult Drinking Habits in Great Britain, 2013 released in 2015 stated that: more than one in five adults (21%) said that they do not drink alcohol at all. This has increased slightly since 2005 (19%). Young adults (aged 16 to 24) were primarily responsible for this change, with the proportion of young adults who reported that they do not drink alcohol at all increasing by over 40% between 2005 and 2013.

The proportion of adults who binged at least once in the week before interview decreased from 18% in 2005 to 15% in 2013. Young adults were responsible for the decrease in binge drinking, with the proportion of who had binged falling by more than a third since 2005, from 29% to 18%.

The proportion of young adults who drank frequently has fallen by more than two-thirds since 2005. Only one in 50 young adults drank alcohol frequently in 2013.

Local Data

The Growing Up in North Yorkshire Survey 2014 reports that the use of alcohol is in decline among all young people, e.g. notable increase

from 47% to 83% of Year 6 pupils who say they never drink alcohol between 2012 and 2014.

North Yorkshire is following the England trend in that there has been an overall increase in the rate for men dying from alcohol specific conditions. The trend in alcohol specific death amongst men varies between district areas. Ryedale district has seen a marked downward trend between 2009 -11 and is below the England average. Richmondshire (9 alcohol specific deaths between 2011-13) has been consistently rising towards the England average (16.6 between 2011-13). Craven has also seen a slight rise in the latest reporting period (9.9 in 2010-2012 to 11.9 in 2011-13). Scarborough has shown the highest level of variance over the time period.

North Yorkshire is following the England trend in relation to the rate for women dying from alcohol specific conditions, and has seen a levelling in the rate of deaths, after a slight increase for those dying from alcohol specific conditions. In women the trend in alcohol specific deaths varies between district areas. Scarborough has been consistently above the England average (8.6 alcohol specific deaths between 2011-13). Richmondshire has seen the most rapidly rising increase (4 between 2009-11 to 10.6 in 2011-13). Craven has shown a slight decline (9.7 in 2007-09 to 5.5 in 2010-13, Selby has also seen a decline in the most recent period (5.8 in 2011-13). The rest of the areas have shown an increase. (Source: LAPE alcohol Profiles 2013, ONS Mortality statistics.)

The rate of alcohol related admissions in England has been increasing inexorably over the last decade and has more than doubled between 2006-07 and 2010-11.

In North Yorkshire, the trend is still increasing up to the most currently available data and of most concern is the gap between North Yorkshire and England continuing to narrow.

What has been achieved?

The strategy identified three outcome areas:

1. Establish responsible and sensible drinking as the norm
2. Identify and support those who need help into treatment through recovery
3. Reduce alcohol related crime and disorder
4. Since the launch of the strategy in January 2015 we have:

- Financially invested in Personal, Social and Health Education (PSHE) in schools.
- Financially invested in trading standards support the alcohol agenda.
- Increased awareness of the harms of alcohol.
- Commissioned access to alcohol identification and brief advice (IBA) training for non-specialists.
- Developed a North Yorkshire multi agency alcohol pathway.
- Increased provision of alcohol IBA across North Yorkshire.
- Seen significant numbers of referrals for specialist alcohol treatment and recovery support
- Developed alcohol profiles to support licensing decisions.

Conclusions

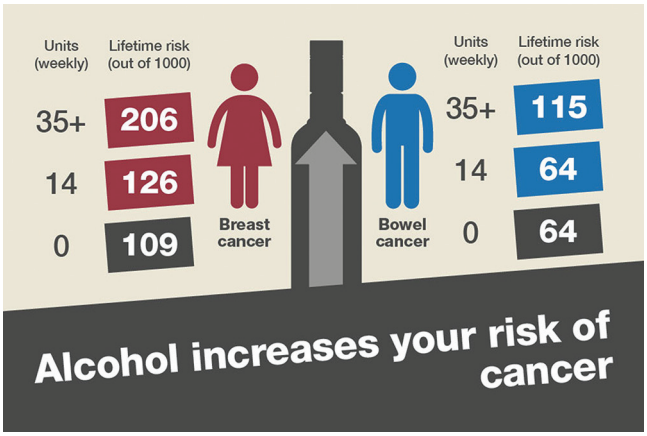
This report emphasises the commitment for all key stakeholders to address the harms associated with alcohol and the impact on people and communities in North Yorkshire. There has been a change in the pattern of drinking nationally and this is no different in North Yorkshire. We have seen an increase in preloading and there has been a sharp decline in the amount of alcohol consumed in pubs in the same period. Consumption on the whole may not have changed, just moved into the home.

For us in North Yorkshire we are majorly concerned about the older age groups, 40+ year olds, who are drinking more than the recommend levels which present immediate consequences for the health, social care and criminal justice services, and store up health problems for the entire system down the line.

Binge drinking estimates produced by Public Health England (PHE) show that all of the districts across North Yorkshire have higher levels of binge drinking apart from Scarborough, when compared with the national average. This emphasises that here in North Yorkshire we still need to focus on this area.

The progress made in 2015 has seen an increase in awareness of alcohol harms across North Yorkshire; access to training and support for those who can address alcohol use amongst individuals, and provide evidence based advice; and the North Yorkshire Horizons Service has seen a significant shift in new referrals for specialist treatment and recovery support – the vast majority are for dependent drinkers

There is still lot more to do to adequately and effectively address alcohol and it's associated consequences, but with the support of key partners across North Yorkshire, we can continue to realise the vision that we present here.



Introduction

In 2012 the National Alcohol Strategy stated that alcohol related problems have developed for a number of reasons; a combination of irresponsibility, ignorance and poor habits – by society, businesses, individuals and parents. It also described how alcohol use has become viewed as an acceptable approach for stress relief and states that cheap alcohol is too readily available. This was seen as a public health challenge in North Yorkshire, and in 2015 the first joint alcohol strategy was jointly published by statutory and non-statutory partners. This report will: describe the main components of North Yorkshire's joint alcohol strategy and the proposed evaluation to assess the impact of the strategy; present some key findings to date; and offer some interpretations, reflections and learning from the work.

National Policy Change

Whilst writing this report the UK Chief Medical Officer has proposed an amendment to the national alcohol guidelines for men and women: Alcohol Guidelines Review Summary January 2016 . The new guidelines have been developed to help inform the public about the known health risks of different levels and patterns of drinking, particularly for people who want to know how to minimise long term health risks from regular drinking of alcohol.

The UK Chief Medical Officer considered and accepted the advice of the expert group and agreed on three main recommendations:

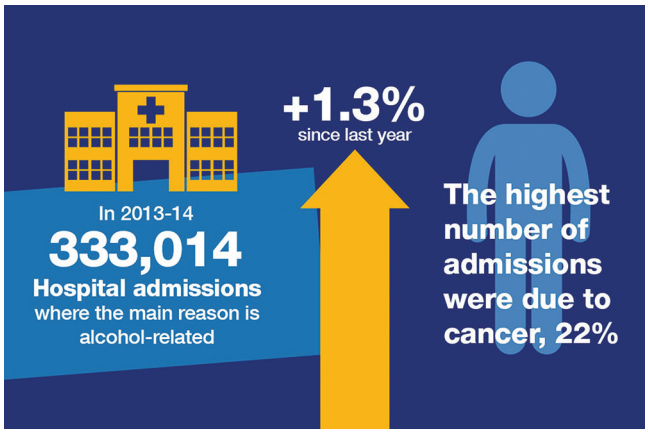
- A weekly guideline on regular drinking
- Advice on single episodes of drinking
- A guideline on pregnancy and drinking

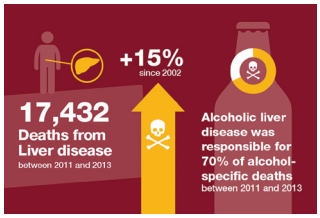
Background

North Yorkshire's Joint Alcohol Strategy vision is; 'Working together to reduce the harms caused by alcohol to individuals, families, communities and businesses in North Yorkshire, while ensure that people are able to enjoy alcohol responsibly'.

To enable us to achieve the vision we have identified three outcome areas:

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





Vision

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

Outcomes

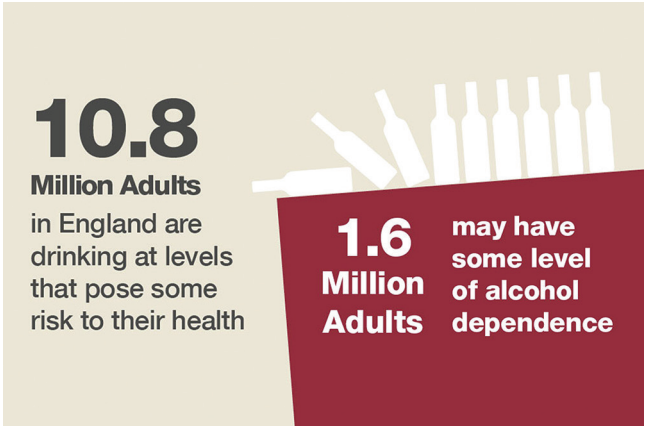
- Establish responsible and sensible drinking as the norm
- Identify and support those who need help into treatment through recovery
- Reduce alcohol related crime and disorder

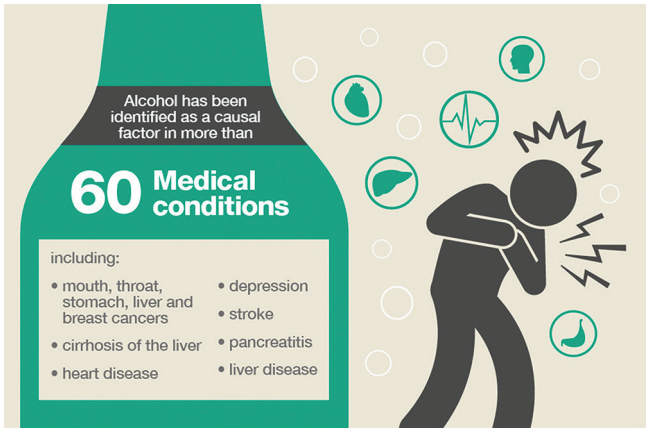
Underpinning values

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

Actions | Actions | Actions

There was no single implementation date for the associated interventions. Some were continuations of activities already taking place; others supplemented existing activity, notably the new interventions including the new provision of alcohol IBA and the procurement of the new North Yorkshire Horizons Service. The way in which these changes have been implemented, has varied across North Yorkshire.





What we said we would do

Establish responsible and sensible drinking as the norm

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

What we did

Personal Social and Health Education (PSHE)

Public Health has invested £30,000 into Education and Skills. Education and Skills will design and deliver an evidence based programme of support to schools on PSHE to support delivery of local public health priorities including drug and alcohol education. This service commenced in January 2016 and so far five schools have signed up to the principles of delivering additional priorities and a further four have tentatively agreed. The service will be evaluated during year one.

Schools have been chosen using data from the Growing Up in North Yorkshire survey. Schools have been prioritised targeting those with higher numbers than the North Yorkshire average for drinking alcohol in the last seven days. Schools are being contacted to identify their individual priorities. The plan is to extend the provision to clusters of primary schools.

In addition, all NY schools have been invited to participate in a free theatre in education programme focused on alcohol aimed at Year 7 and Year 8 pupils that will tour in early January 2016. All schools have also been encouraged to order and use the free alcohol education trust teaching resource. This resource is PSHE association accredited, DfE approved and rated in the top most 50 effective programmes by the Early Intervention Foundation.

Trading Standards and Licensing

Public Health has invested over £400,000 for the next four years into the Trading Standards Service to:

- Prevent the sale of age restricted products to minors.
- Prevent the sale of illicit and counterfeit alcohol and tobacco.
- Help businesses comply with their legislative and social obligations regarding the sale of alcohol and tobacco.
- Reduce anti-social behaviour caused by the increased use of alcohol and tobacco.

There was a 52% increase in alcohol related complaints received by the team during January to July 2015. The majority of complaints (approx. 30%) pertain to businesses on the east coast. There are plans to initiate an Alcohol

Respect Campaign in the area. This is a period of guidance and support for retailers which commences and concludes with a controlled yet unannounced test purchase attempt by minors. The period of education aims to provide retailers with the tools and confidence to refuse sales to minors which should be reflected in a reduced number of test purchases.

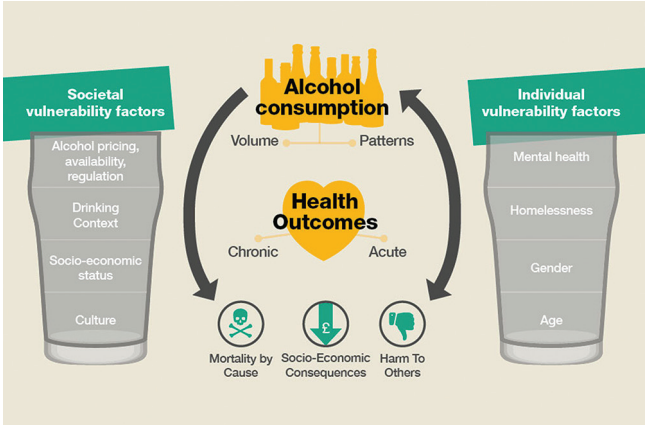
There has been an increase in test purchasing across North Yorkshire during the period January to July 2015. Fourteen attempted test purchases across North Yorkshire were made and only one sale occurred.

There has been continued work with the Scarborough Community Safety team to patrol the locations within the town which are frequented by young people drinking alcohol. Alcohol has been seized by the Police and seven local retailers were warned about 'proxy sales', i.e. those over 18 buying alcohol for those under 18. It is the intention to repeat this initiative as part of the Alcohol Respect Campaign.

As a result of the Alcohol Strategy there has been an improvement in relationships and intelligence sharing with each of the Districts and associated partner agencies.

Quote from Graham Venn, Assistant Director, Trading Standards and Planning Services:

'The Alcohol Strategy engenders a robust approach to localised alcohol concerns whilst allowing us the scope to work with businesses to provide a strong, safe and fair environment in which they can operate.'



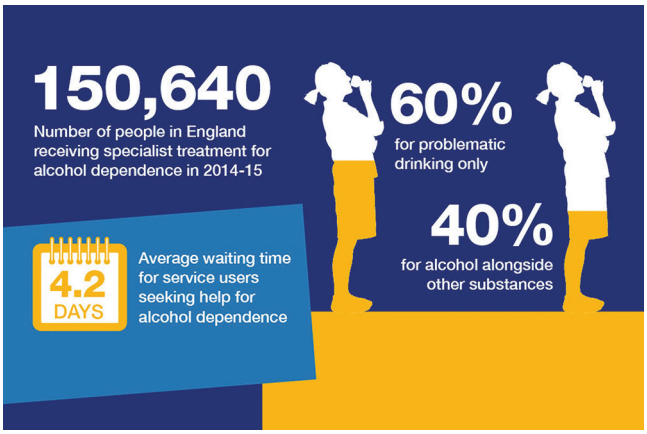
Increase awareness of the harms of alcohol

Increasing people's knowledge about the risks associated with increased alcohol use is a key within the Joint Alcohol Strategy. The section below demonstrates how we have worked to increase awareness of alcohol amongst the population.

North Yorkshire supported the national Dry January 2015 campaign, and findings from Public Health England and Alcohol Concern partnership in support of Dry January 2015 produced some good results:

- Nationally over 70 local authorities took part in the campaign using Dry January to start a different conversation about alcohol with staff and residents.
- Two hundred and twelve NHS organisations took part in Dry January by promoting the campaign to staff.
- In North Yorkshire 541 people signed up to take part in Dry January 2015.

Public Health is currently supporting Dry January 2016 and has issued press releases and blogs.



What we said we would do

Identify and support those who need help into treatment through recovery

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

What we did

North Yorkshire Alcohol Pathway

The Public Health Team led a Task and Finish Group to develop a North Yorkshire Alcohol Pathway as part of the implementation of the Joint Alcohol Strategy.

The Task and Finish Group was established in December 2014 and comprised representation from a range of organisations and professionals, including the North Yorkshire Horizons Service, the Compass REACH Service, The Cambridge Centre, North Yorkshire Police, Community Pharmacy North Yorkshire, Yorkshire Ambulance Service, Consultant Psychiatrist – Tees, Esk and Wear Valley NHS Trust. Scarborough and Ryedale, Hambleton, Richmondshire and Whitby, Harrogate and District and Airedale, Wharfedale, Craven Clinical Commissioning Groups were corresponding members of the group throughout the development process. The Local Medical Committee and the Clinical Director for Adult Mental Health Services within Tees, Esk and Wear Valley NHS Trust were consulted on the final pathway.

The pathway was approved by the Task and Finish Group in the summer of 2015.

The pathway covers the life-course, and translates the evidence base on how to appropriately and effectively identify and address alcohol use and misuse to the North Yorkshire context. It is a tool to support practitioners who work with children, young people, families and adults to navigate best practice on raising the issue of alcohol, screening for alcohol consumption, delivering structured brief advice and referring to specialist alcohol services where appropriate.

The Public Health Team is currently in the process of embedding the pathway within practice across North Yorkshire. It is hoped that it will soon be available as a web based tool which practitioners can navigate, similar to the National Institute for Health and Care Excellence alcohol pathway.

The Public Health Team intends to review progress in implementing the pathway on an annual basis. The first annual review meeting is scheduled in April 2016.

Training

In April 2015 the Public Health Team commissioned DrugTrain to deliver free Identification and Brief Intervention (IBA) training to target professional (but non-alcohol specialist) groups across North Yorkshire. The training is aimed at those who work with over 16 year olds.

The training has been commissioned for a two year period and aims to ensure that the content of the North Yorkshire Alcohol Pathway can be realised. Early identification of problematic drinking and delivery of structured brief advice in conjunction with provision of an evidence based patient information leaflet is the appropriate course of action for those whose drinking has the potential to or is causing harm. The training will equip relevant professionals with the necessary skills to provide this intervention, as well as identify when they should refer to specialist alcohol services.

The main group who will benefit from IBA are the increasing and higher risk drinkers. It is likely that the majority of these people will be seen by someone in the health, social care, and housing or criminal justice sectors each year.

Therefore, a wide range of staff need to be trained to:

- Identify those at risk of alcohol related harm
- Offer brief advice
- Refer on to appropriate services when required.

Ideally workers will be undertaking IBA with all their patients or clients and a number of opportunities exist.

One in eight increasing or higher risk recipients of IBA reduce their drinking to lower-risk levels after brief advice. The effects persist for periods up to two to four years after intervention and perhaps as long as nine to ten years .

In the first three quarters of 2015, 502 people completed IBA training and include the following groups:

- Pharmacies
- Criminal Justice Agencies (police, custody)
- Lifestyle service staff
- Adult social care staff
- Children's social care staff (Staff delivering IBA to parents not YP)
- GPs/Practice Nurses
- Primary health care
- Mental health care staff
- Other healthcare staff (sexual health, maternity, occupational health, dental and staff from services commissioned from the voluntary, community and private sector)

On average for these first two quarters:

- 93% of people felt that information was pitched at the right level
- 73% found the trainer very competent
- 94% reported they thought it was either very or quite beneficial to their work
- 90% would recommend the course to a colleague

Pharmacy quote

'It really was excellent. It was especially good to have it in Skipton, as we got to see the North Yorkshire Horizons base and talk to the workers and volunteers there. We are hoping to set up collaboration between us, where a volunteer will come down to our Pharmacy to talk to our customers about alcohol awareness. It really was the best training day I have been to for a long time!' 22nd October 2015

Housing provider quote

'I found this training very beneficial and will be using the motivational techniques discussed today – the whole training I found very informative and I enjoyed the interactive/quiz part.' 15th June 2015

Increase access to Alcohol IBA

In line with the North Yorkshire Alcohol Pathway, the Public Health Team has identified opportunities to increase access to Alcohol Identification and Brief advice (IBA). Public Health has commissioned pharmacies to deliver IBA across the County. There are 13 pharmacies across North Yorkshire delivering this service and work is continuing to increase this provision across the county within custody, probation services and GP settings.

North Yorkshire Horizons

The North Yorkshire Horizons Service is a specialist, integrated adult drug and alcohol service across North Yorkshire. It commenced on 1st October 2014 with an overarching aim to support as many people to recover from alcohol and drugs dependence as possible.

The service is delivered by DISC and Lifeline along with their sub-contractors Spectrum Community Health and Changing Lives. The Service comprises a Treatment Service and a Recovery and Mentoring Service, although they work within an integrated service.

The service is delivered from 5 hubs across North Yorkshire: Harrogate, Northallerton, Skipton, Selby and Scarborough. A clinical service is also cited at Malton Hospital, and treatment and recovery groups, including peer led recovery groups, are cited across a wide range of community venues in all Districts. The service also facilitates access to mutual aid fellowships such as NA and AA. GPs are also supported to provide services within their practices, and pharmacy based needle exchange and opiate substitution supervised consumption services are provided by pharmacies.

The service is delivered by a wide range of professionals, including but not exclusively GPs with a special interest, non-medical prescribers, nurses, recovery co-ordinators, peer mentors and volunteers.

Through agreement with Commissioners within the Public Health Team, the Service is currently prioritising provision of treatment

and recovery support for dependent drinkers (AUDIT screening score of 20+). Treatment will typically involve preparation for and completion of a medically assisted alcohol detoxification, including prescription of relevant medications, a programme of psychosocial support, followed by up to 6 months of support from the Recovery and Mentoring Service.

The service has been given flexibility by Commissioners to use financial resources to achieve outcomes in line with need. Commissioners expected the service would see a re-balance in terms of the proportion of service users engaged due to drugs and alcohol. Historically, financial resources prioritised drug treatment services. The vast majority of new referrals each month are for dependent drinkers, many with very complex health needs and/ or long term conditions.

Performance and outcomes – key headlines:

Single Point of Contact

The service single point of contact has consistently received around 1,000 calls per week overall. Around a quarter of these are for professional information, advice and guidance.

Referrals

There have been 3596 referrals made to the service between 1 October 2014 and 26 January 2016: 2016 (56%) were for individuals who considered problematic drinking to be their primary concern, or where a professional made that judgement and made a referral to the service on their behalf. Please refer to the table below. Please note that these figures represent the total number referrals over the period, some individuals may have been referred more than once.

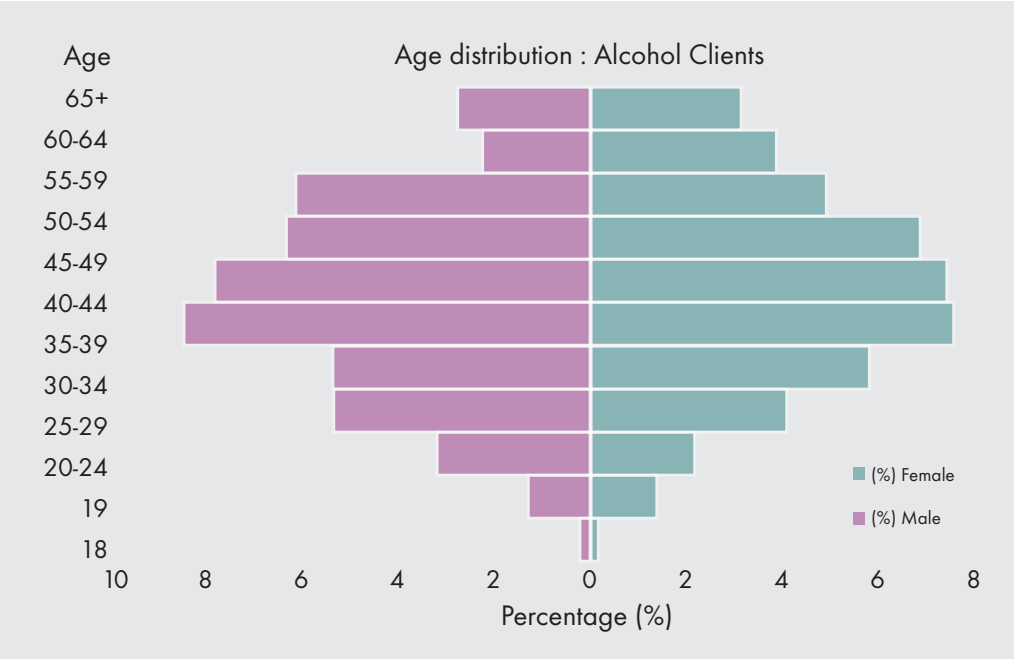
Substance	Total
Alcohol	2016
Drugs	1580
Total	3596

The following table outlines how referrals for alcohol have increased since North Yorkshire Horizons was implemented, and demonstrates the comparison to drug referrals.

Substance	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Total
Alcohol	98	93	65	146	142	151	155	145	175	168	109	127	117	104	132	89	2016
Drugs	47	35	44	78	68	93	175	187	169	112	140	108	91	90	99	44	1580
Total	145	128	109	224	210	244	330	332	344	280	249	235	208	194	231	133	3596

Age profile

The chart on the right shows the percentage of alcohol clients accessing North Yorkshire Horizons by age, the largest proportion being those people aged 40-44 years for both males and females (Source NYCC Horizons 2016).



Successful completions

North Yorkshire Horizons report that there have been 295 successful completions by alcohol only clients between November 2014 and November 2015. A successful completion represents mutual agreement between the service user and the North Yorkshire Horizons Service that structured treatment goals have been achieved. Service users are offered up to six months of continued support by the Recovery and Mentoring Service of North Yorkshire Horizons, as well as access to peer and mutual aid support, including from fellowships such as Alcoholics Anonymous.

NDTMS report 306 (33.5%) successful completions by alcohol only clients between 01/12/2014 – 30/11/2015 which indicates a positive direction of travel (increasing successful outcomes) from the baseline of 221 (28.3%) between 01/04/2014 – 30/03/2015.

Re-presentations

In November 2015, the service reported that 13 individuals who had previously successfully completed structured treatment had re-presented. Please note that this figures does not account for individuals who may have presented to services outside of North Yorkshire.

In November 2015, NDTMS reported that 19 (14.0%) who had previously successfully completed treatment (01/12/2014 to 31/05/2015) had represented, which indicates a positive direction of travel (lower representations) from the baseline of 26 (14.1%) for successful completions between 01/04/2015 to 30/09/2014 and including representations up to 31/03/2015.

CS

Case Study - Recovery & Mentoring Service

October 2015 Case Study – Harrogate Alcohol Client

Client, aged 43, was transferred over to North Yorkshire Horizons in October 2014 for her alcohol use; at this time her initial engagement with our service being quite poor. She had scored 39 on the AUDIT alcohol screening tool, averaging consumption of 30 units of alcohol per day. Client suffered from agoraphobia and is quite socially isolated, meaning each appointment took place at home. Alternate appointments between the Treatment and Recovery & Mentoring teams meant that contact was regular but client held a lot of ambivalence to change and her alcohol use led to quite a chaotic lifestyle. She disengaged from the service in early 2015 but was successfully re-engaged by Recovery & Mentoring team.

The client completed an assisted alcohol detoxification with her GP in February 2015, but had a relapse less than two weeks later. Support was offered by both teams within North Yorkshire Horizons throughout this process but her overall engagement in appointments remained poor.

We continued to support the client, and follow a safe alcohol self-reduction programme in early March 2015, preparing her for a planned community assisted alcohol detoxification programme with the North Yorkshire Horizons Treatment Service.

The client started and completed the planned detoxification programme in March 2015 - supported by the Recovery & Mentoring and Treatment teams. A lot of support was given to the client around this time by the Recovery & Mentoring worker, centering on improving her peer group, eliciting motivation, building recovery capital such as hobbies and interests and looking at ways of getting back in to work eventually. Intensive PSI (structured psychosocial intervention) work also helped her gain a better understanding of her relationship with alcohol. The Recovery & Mentoring team facilitated her access to mutual aid groups as well, as her agoraphobia eased whilst abstinent.

The client maintained abstinence from alcohol following the planned assisted alcohol detoxification programme until June 2015, around the time of the planned withdrawal of structured treatment support, as she has successfully completed her treatment goals and was in recovery. She unfortunately had a relapse and continues to drink alcohol. The clients GP agreed to carry out a second assisted detoxification programme, and this was under taken in July 2015. Both the treatment and R&M worker agreed to offer intensive support throughout this to ensure maintenance of this detox. Engagement by the client improved significantly and she has now successfully exited structured treatment support with North Yorkshire Horizons, and remains supported by the recovery & mentoring service for on-going community based recovery support. Her recent Audit score was 4 and she remains abstinent.

Written by Dan Atkinson, R&M Lead worker, North Yorkshire Horizons

CS

Case study: Chaotic gentleman with chronic, dependent alcohol use with symptomatic signs of liver damage.

Gentleman lives in rural area, is a poor attender to appointments, has poor engagement with keyworker, symptomatic signs of decompensating liver, and does not attend hospital reviews and frequent use of ambulance service/999 calls.

Drinking 35 units daily, poor diet, poor mobility and social isolation. Recurrent nose bleeds and ascites (swelling of stomach).

Actions:

- Liaison with GP and local hospital to put in place assertive outreach model by the clinic team
- Safe reduction in alcohol commenced
- Support to aunty who was main carer
- Information of how to manage nose bleeds given to client and aunty
- Supported to hospital appointments for regular check ups
- Worked to plan with GP to manage community detox but due to recurrent nose bleed was admitted to hospital
- Liaison with acute admission ward and discussed planned detox and offered support to the ward staff to manage the detox on the ward
- Visited on the ward regularly to manage motivation and support to aunty
- Involved with discharge planning and the nursing team completed the detox at home successfully

Outcome:

- Good, therapeutic relationship with client and nursing team
- Successful detox from alcohol
- Relapse prevention work continues
- Symptoms of liver damage improving
- Has maintained abstinence
- Continues to develop self-help around health and well-being
- Attending all outpatient appointments independently

Written by Karen Jordan, Clinical Team Manager, North Yorkshire Horizons

The North Yorkshire drug and alcohol related deaths enquiry process

The enquiry process collates information on alcohol related deaths of individuals resident in North Yorkshire, from agencies involved in the individuals' care and from Coroners where applicable.

The panel usually reviews the deaths of those who were known to the North Yorkshire Horizons Service in detail at panel meetings, as more information is available on these individuals.

Since 1 January 2015 there have been a total of 28 deaths reported by North Yorkshire Horizons staff of individuals who were either in contact with or had been referred to North Yorkshire Horizons, and who were misusing alcohol.

Of the 28 deaths reported, 23 were cases in which alcohol was the only problem substance known. For a further five cases drug misuse was also a factor or implicated in the death (including one case where death was identified as being due to an accidental overdose of heroin exacerbated by alcohol use). Of the individuals, three had been referred to North Yorkshire Horizons but had not received either an initial (triage) or comprehensive assessment with the service prior to death.

Of the 28 deaths reported, 22 were males and six were females. The age of individuals ranged from 30 to 65 years old, and the average age at death was 47.

Seventeen of these individuals were receiving treatment for conditions other than alcohol dependence from their GP (service user self-report or confirmed) at the time of death. Six of those individuals were being treated by their GP for mental health issues at the time of death, but overall 20 of the individuals had identified mental health issues as part of their assessment with North Yorkshire Horizons, and seven others were marked as 'not known'. nineteen were unemployed, many of whom were on long term sick benefit, and only two reported to be in work at the time of death.

Qualitative data indicates that the majority of these deaths were known to be of long-term problematic drinkers, many with significant health issues.

There were nine who had self-reported and/or confirmed long-term health conditions such as:

- Liver cancer
- Hepatic encephalopathy
- Alcoholic cardiomyopathy
- Chronic pancreatitis
- COPD
- Deep vein thrombosis
- Hepatitis C
- Seizures
- Potential fluid on the brain
- High cholesterol
- Depression
- Severe anxiety

Seven were known to have liver disease.

Causes of death were not confirmed for all deaths reported, but where they were established, they covered a wide range of causes including deaths due to liver disease, cancer, suicide, pneumonia and cardiac disease.

Seven individuals died in hospital and only one of those was thought to have died of an overdose. Of those who died outside of hospital, a further six may have died due to long term conditions associated with alcohol dependence, e.g. cirrhosis of the liver, alcoholic cardiomyopathy.

Findings from the enquiry process throughout 2015 shows that many of the individuals who have died are either contacting or being referred to the specialist drug and alcohol service when their alcohol dependency has already begun to have a significant impact upon their physical health, and when they are already quite poorly.

North Yorkshire Horizons have a robust internal process in place for reviewing all deaths of service users, and have identified and implemented useful learning as a result of this. With specific regard to reviews of alcohol related deaths, this has led to a stronger focus within the service on reviewing and supporting management of alcohol users physical health needs/ long term conditions, as well as establishing pathways for support of end of life care with Macmillan Nurses and other relevant organisations.

The most recent panel meeting in January 2016 identified the following learning that is relevant to the broader health and social care system:

- Identification of problematic alcohol consumption at the earliest opportunity is critical to improving outcomes. Referrers to the North Yorkshire Horizons Service are encouraged to include the client/ patients AUDIT score on the referral – in section 2. This assists the service to respond appropriately and effectively, in line with individual needs.
- Referrers are encouraged to use the North Yorkshire Horizons referral form to make a referral – available from the Single Point of Contact (01723 330730) or the service website: www.nyhorizons.org.uk. Referrers are specifically encouraged to prioritise completion of sections 1-3, section 4 -AUDIT score, section 5, and section 9. Furthermore, all referrers are asked to clarify any risks to self or others posed by the individual being referred. This assists the service to respond appropriately and effectively, in line with individual needs.
- Referrers of dependent drinkers are encouraged to maintain engagement with the individual in the period leading up to their assessment with North Yorkshire Horizons. North Yorkshire Horizons will confirm the outcome of referrals by GPs with a letter. The enquiry process is showing that many of those who are referred to North Yorkshire Horizons for alcohol dependence, who have subsequently died, are very poorly and fail to engage.

NHS Health Checks

In North Yorkshire Public Health commission NHS Health Checks. The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart

disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. As part of this check lifestyle issues are addressed including; alcohol consumption, smoking, and physical activity. In North Yorkshire 71 out of the 74 practices are registered to deliver the NHS Health Checks.

In North Yorkshire the percentage of NHS Health Check uptake by those who were offered one in 2014-15 was 41.2%. North Yorkshire falls below the current national average; there will need to be significant improvements in uptake to reach the national target of 75% uptake.

The referrals to lifestyle; including alcohol and stop smoking related services were significantly higher in the Airedale, Wharfedale & Craven CCG when compared to the North Yorkshire average of 1.5%.

In terms of the NHS Health Check outreach services, two outreach services have been commissioned to pilot a more targeted, opportunistic, community outreach approach to the NHS Health Check programme in North Yorkshire. One service will have a particular focus on the Scarborough population and the other more rural communities, particularly the farming community. The aim of both services is to increase the number of NHS Health Checks received by the eligible population. NYCC has awarded a contract to ICE Creates Ltd for the above services. Both outreach services will commence on 23 November 2015 and be delivered over 12 months.

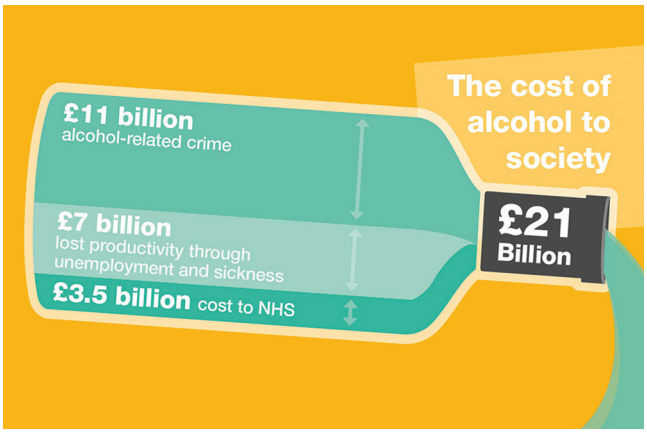
Alcohol and Obesity

Although there is no clear causal relationship between alcohol consumption and obesity, there are associations between alcohol and obesity and these are heavily influenced by lifestyle, genetic and social factors. Many people are not aware of the calories contained in alcoholic drinks and the effects of alcohol on body weight may be more pronounced in overweight and obese people. The Public Health team have invested in a tier 2 lifestyle service in each district; staff members in each district are currently being trained to offer alcohol identification and brief advice support to people accessing the tier 2 service.

Local action

Scarborough Pilot

Scarborough Council is committed to responding to the issues associated with increased alcohol use and has a coordinated approach. A pilot to assess the scale of the problem has been set up within Scarborough Police Custody. The pilot will enable trained custody staff to use appropriate tools to identify an individuals' risk from alcohol use. This will ensure that individuals with an increased risk from alcohol use are given appropriate support and interventions.



Scarborough Local Alcohol Action Area (LAAA)

The government launched a new project in February 2014 to tackle the harmful effects of excessive drinking.

Twenty areas across England and Wales were set up as Local Alcohol Action Areas (LAAAs) including Scarborough to combat drink-fuelled crime and disorder and the damage caused to people's health. Work in the LAAAs was focused on promoting diverse night time economies.

As a result of this work Scarborough Borough Council establishes a multi-agency meeting to develop a clear plan and objectives which included:

- Keep People Safe and Reduce Harm
- Develop a more diverse Night Time Economy and make progress towards achieving the Purple Flag Standard

What we said we would do

Reduce alcohol-related crime and disorder

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

What we did

Influencing Licensing Decisions – Public Health as a Responsible Authority

In 2012 changes to the 2013 Licensing Act made Directors of Public Health a responsible authority. Managing availability is one of the most effective ways to reduce alcohol related harm. By focusing on prevention there is huge scope to improve the effectiveness of licensing through data and partnerships, which is where Public Health can excel thereby impacting on our population's health.

As a response to the change in legislation Public Health has been working with colleagues to influence reviews of districts Statement of Licensing Policy and also developing local profiles which include health and police data to support the licensing process and provide alcohol related data for districts.

Harrogate is the first to develop a Local Profile with support from colleagues from Police, Harrogate Borough Council and Trading Standards. The information within the profile is provided to anyone applying for a licence to sell alcohol or provide late night refreshment. It may be used by residents or other interested people who make a representation against an application. It will also be provided to the Licensing subcommittee at any subsequent licensing hearing.

95 Alive Partnership

Public Health has invested into the 95 Alive Partnership over a five year period; the impact of alcohol on the roads is one of the key areas being addressed.

The NYCC Road Safety team delivered two major drink-drug driving media and engagement programmes during June and November-December 2015, coordinated with the police enforcement operations. Each programme delivered a campaign, media launch and press release with wide local, regional print media and radio and TV coverage. Local engagement events were held at market towns, major employers including the County Council itself and military bases including RAF Leeming, Claro Barracks, Ripon and Head Quarters North East Brigade at Imphal Barracks, York.

These events used a driving simulator that was programmed to simulate the effects of different levels of alcohol on the candidates driving. This is an impactful method of showing how alcohol affects judgement both for the driver and those watching. A sustained output of related social media and Facebook posts and tweets reached an average audience per tweet of 2,400 and an overall reach of over 183,000 per campaign.

Public engagement events were held in every District and at local agricultural shows with support from local Neighbourhood Police and Fire & Rescue service officers. Briefing notes with data and programme aims were compiled for them by the NYCC team to ensure these local non-specialist officers had plenty of information to enable them to discuss issues and answer enquiries.

During the Christmas Drink and Drug Campaign the total number of arrests between 1 December 2015 and 1 January 2016 was 124; an increase of 21 arrests (17%) on the same period in 2014. The highest breath test reading was 180ug/100ml of breath. The maximum alcohol limit for drivers allowed by law in England and Wales is 35ug/100ml.

There has been a significant increase in the number of arrests for drug driving this year; this is mainly due to the introduction of the new Drugwipe Test and Section 5A drug limit offence. There have been a total of 27 arrests as a direct result of positive saliva based roadside drug screening tests.

These results reflect North Yorkshire Police's determination to take drink and drug drivers off the road and are a credit to all who took part in the operation.

A further drug driving publicity and engagement campaign will be delivered in February-March 2016 linking with the national Think! campaign, police enforcement operations and roadside drug testing on the first anniversary of the revised drug driving legislation.

Outcomes Framework

An outcomes framework for the Joint Alcohol Strategy was developed in January 2015 with the most up to date data available for the key population level indicators that partners agreed would be indicative of progress. Where data was available, the team projected forward five years to identify trends. Although significant change cannot be measured in one year, the following changes have occurred.

Health

There is no new data for under 18 alcohol specific admissions to hospital, and prevalence of increasing and higher risk drinking, since the strategy was published.

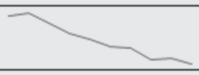
Community

A comparison of local police data from 2013 and 2014 indicates that the percentage of serious and fatal collisions involving alcohol has decreased by nearly a third. However, the same time period shows the percentage of slight collisions involving alcohol has seen a slight increase of 0.6%.

Crime

The local North Yorkshire Police data from 2013/14 and 2014/15 shows a 5.2% increase in domestic abuse incidents related to alcohol. There was also a similar increase (4.5%) in the percentage of sexual crimes related to alcohol.

Health

	Year	Gender	Age group	North Yorkshire	Unit	North Yorkshire Trend	Years of data available	North Yorkshire 5 Year Projection	England
Under 18s alcohol-specific hospital admissions	2010/11 - 12/13	Persons	<18 yrs	48.5	Rate per 100,000 population	#	0	#VALUE!	44.9
2.18 - Admission episodes for alcohol-related conditions - narrow definition	2013/14	Persons	All ages	595.7	#N/A		6	686.7	645.1
4.05ii - Under 75 mortality rate from cancer considered preventable	2012 - 14	Persons	<75 yrs	72.1	Rate per 100,000 population		12	66.9	83.0
4.05ii - Under 75 mortality rate from cancer considered preventable	2012 - 14	Male	<75 yrs	79.4	Rate per 100,000 population		12	66.9	90.5
4.05ii - Under 75 mortality rate from cancer considered preventable	2012 - 14	Female	<75 yrs	65.5	Rate per 100,000 population		12	66.9	76.1
4.06i - Under 75 mortality rate from liver disease	2012 - 14	Persons	<75 yrs	13.2	Rate per 100,000 population		12	15.6	17.8
4.06i - Under 75 mortality rate from liver disease	2012 - 14	Male	<75 yrs	17.4	Rate per 100,000 population		12	15.6	23.4
4.06i - Under 75 mortality rate from liver disease	2012 - 14	Female	<75 yrs	9.2	Rate per 100,000 population		12	15.6	12.4
Increasing and higher risk drinking	2009	Persons	16+ yrs	24.1	%	#	0	#VALUE!	22.3

Community

	Year	Gender	Age group	North Yorkshire	Unit	North Yorkshire Trend	Years of data available	North Yorkshire 5 Year Projection	England
1.01i - Children in poverty (all dependent children under 20)	2012	Persons	0-19 yrs	10.5	%		7	12.6	18.6
1.01ii - Children in poverty (under 16s)	2012	Persons	<16 yrs	11.0	%		7	12.1	19.2
1.05 - 16-18 year olds not in education employment or training	2014	Persons	16-18 yrs	3.3	%		4	2.0	4.7
Percentage of alcohol treatment users: Parent living with children	2014/15	Persons	<18 yrs	29.2	%		#	#N/A	26.0
Percentage of alcohol treatment users: Parent not living with children	2014/15	Persons	<18 yrs	24.0	%		#	#VALUE!	25.9
Percentage of alcohol treatment users: Not Parent - No Children Contact	2014/15	Persons	<18 yrs	37.8	%		#	#N/A	45.8
Percentage of fatal collisions involving drink	2014	Persons	All ages	17.5	%		7	30.0	0.0
Percentage of serious collisions involving drink	2014	Persons	All ages	10.2	%		7	12.9	0.0
Percentage of slight collisions involving drink	2014	Persons	All ages	4.1	%		7	3.5	0.0
Percentage of total collisions involving drink	2014	Persons	All ages	5.4	%		7	5.9	0.0

Crime

	Year	Gender	Age group	North Yorkshire	Unit	North Yorkshire Trend	Years of data available	North Yorkshire	England
1.04 - First time entrants to the youth justice system	2014	Persons	10-17 yrs	379.3	Rate per 100,000 population		5	-179.8	409.1
1.11 - Domestic Abuse	2013/14	Persons	16+ yrs	15.3	Rate per 100,000 population		4	22.6	19.4
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2011/12 - 13/14	Persons	All ages	36.1	Rate per 100,000 population		3	13.3	52.4
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2014/15	Persons	All ages	8.7	Rate per 100,000 population		5	8.9	13.5
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2014/15	Persons	All ages	1.2	Rate per 100,000 population		5	1.6	1.4
Percentage of violent crime related to alcohol	2014/15	Persons	18+ yrs	28.5	%		5	52.8	0.0
Percentage of criminal damage related to alcohol	2014/15	Persons	18+ yrs	8.0	%		5	8.4	0.0
Percentage of ASB related to alcohol	2014/15	Persons	18+ yrs	16.9	%		5	22.4	0.0
Percentage of sexual crime related to alcohol	2014/15	Persons	18+ yrs	12.3	%		5	5.8	0.0
Percentage of domestic violence related to alcohol	2014/15	Persons	18+ yrs	35.5	%		5	50.1	0.0

Next Steps

Since the launch of the strategy in January 2015 partners have worked hard to address the issues associated with alcohol across North Yorkshire. The commitment to address alcohol related harm will continue to be a priority of the Public Health team and we will continue to work with colleagues to:

1. Continue to invest in Alcohol IBA training
2. Increase the provision of Alcohol IBA in North Yorkshire to include:

- Criminal justice settings
- Adult Social Care
- General Practices

3. Extend the provision of local alcohol profiles across each district.
4. Develop social marketing campaigns to raise awareness of harms associated with alcohol.
5. Embed the alcohol pathway in health, mental health and social care contracts, working with CCG, Tees Esk and Wear Valley NHS Trust and social care colleagues.
6. Ensure changes to drinking guidelines are incorporated
7. Further work to raise awareness of the Be Clear on Cancer campaigns and links between certain cancers and alcohol.
8. Ensure lessons learnt and recommendations from the North Yorkshire Suicide Audit are prioritised within the alcohol implementation plan
9. Continue to strengthen the treatment and recovery offer of the North Yorkshire Horizons Service

Appendix 1: Definitions

New alcohol guidelines

The alcohol limit for men has been lowered to be the same as for women. The UK's Chief Medical Officer (CMO) guideline for both men and women is that:

- You are safest not to drink regularly more than 14 units per week. This is to keep health risks from drinking alcohol to a low level
- If you do drink as much as 14 units week it is best to spread this evenly across the week.

One-off drinking

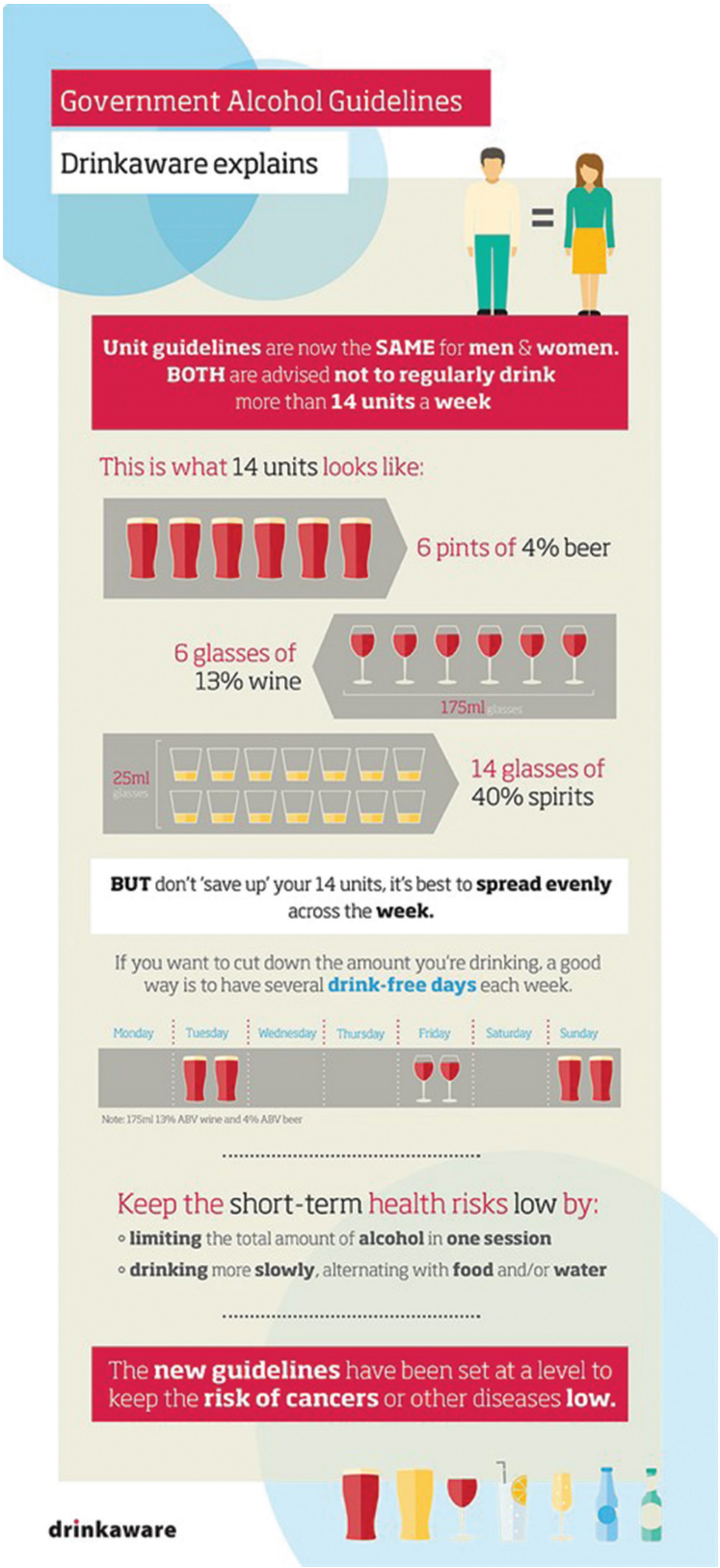
If you have one or two heavy drinking sessions you increase the risks of death from long-term illnesses, accidents and injuries. When it comes to single drinking occasions you can keep the short term health risks at a low level by sticking to a few simple rules:

- Limiting the total amount of alcohol you drink on any occasion;
- Drinking more slowly, drinking with food, and alternating with water.

How much is 14 units of alcohol?

One unit is 10ml of pure alcohol. Because alcoholic drinks come in different strengths and sizes units are a good way of telling how strong your drink is. It's not as simple as one drink, one unit.

The new alcohol unit guidelines are equivalent to six pints of average strength beer or six 175ml glasses of average strength wine.



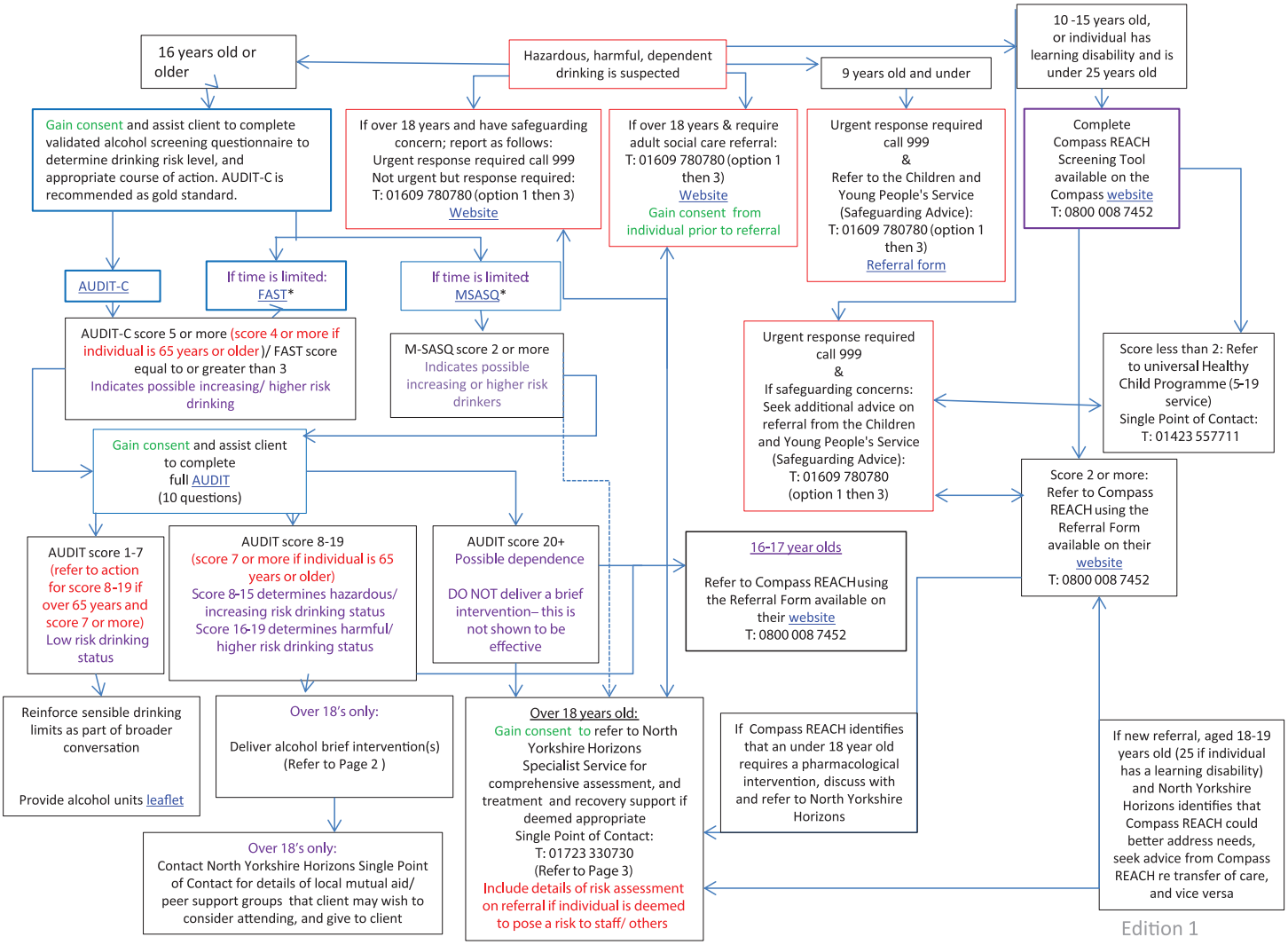
Alcohol and pregnancy

The Chief Medical Officer (CMO) guidance is that pregnant women should not drink any alcohol at all.

- If you are pregnant or planning pregnancy, the safest option is not to drink alcohol.
- This is to keep the risks to your baby to a minimum. The more you drink the greater the risk to your baby.

Appendix 2: North Yorkshire Alcohol Pathway

Identification of drinking status and evidence based next steps



Edition 1

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http://www.alcoholeducationtrust.org/

Primary Healthcare European Project on Alcohol - Are brief interventions effective in reducing hazardous and harmful alcohol consumption? 2005 at http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir354/doc9888.html and Kaner, E.F.S. et al. 2007. Effectiveness of brief alcohol interventions in primary care populations [Systematic Review] Cochrane Database of Systematic Reviews (2)

Measuring the impact
North Yorkshire Joint Alcohol Strategy
One year on

Health and Wellbeing Board
North Yorkshire

Please let us know what you think about North Yorkshire's Alcohol Strategy

You can tell us what you think about the strategy by emailing your views to **nypublichealth@northyorks.gov.uk,** Drug and Alcohol **http://www.nypartnerships.org.uk/smpb** or writing to:

Public Health
Health and Adult Services
North Yorkshire County Council
County Hall
Northallerton
North Yorkshire
DL7 8DD

If you would like this information in another language or format such as Braille, large print or audio, please ask us. **Tel: 01609 780 780**
Email: communications@northyorks.gov.uk

Find out more about North Yorkshire's Health and Wellbeing Board at **www.nypartnerships.org.uk**

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NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

Mental Capacity Act and Deprivation of Liberty Safeguards

30th June 2016

1. PURPOSE OF REPORT

1.1 This paper briefs Members of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and its significance for the Directorate. This issue is of particular significance for the Committee because:

a) it affects some of the most vulnerable adults in our communities;
b) embedding the Mental Capacity Act into governance arrangements for the local authorities is a key objective for the Government. Following the guidance set by ADASS for local authorities is a means of achieving this, the committee needs to be reassured of the progress made and steps taken to implement the Mental Capacity Act into Governance arrangements and fully integrate it into working practice.
c) safeguarding adults is a particular responsibility for Members of this Committee; and
d) latest developments in connection with Deprivation of Liberty and the Deprivation of Liberty Safeguards are having a direct impact upon Directorate obligations and resources. In addition to recognising the additional burdens, it is important that the Committee reassures itself that all possible steps are being taken to ensure compliance with national guidelines from ADASS.

2. THE MENTAL CAPACITY ACT

2. 1 The Mental Capacity Act (MCA) has been in force since 2007. The purpose of the Act is to ensure that the vulnerable people of our society are protected by a process in law in regards to decisions making for care, treatment and financial decisions and:

- their human rights are given true weight by health and social care professionals by ensuring that people are involved in decision making and by ensuring that those who have capacity are empowered to make their own decisions;
- ensuring that those that lack capacity to make a decision have their views fully taken into account including their past and present wishes in regards to best interest decisions made on their behalf; and
- those who take an interest/are involved in the care of a person who may lack capacity are fully involved in the process and have their views taken into account as part of the best interest process.

2. 2 A major review of the MCA and DoLS came with the House of Lords Post Legislative Scrutiny Committee review in 2014. Their view about the Mental Capacity Act overall was that it was a good piece of legislation but the take up of it was variable

amongst professionals and it was not embedded within services. A number of recommendations were made by the Select Committee which included:

- The Government's need to address the low awareness amongst those affected by the MCA and DoLS, their families, carers, professionals and the wider public;
- a requirement that there would be assessments completed on how the core principles are used for decision making, which should include the banking sector;
- that the Government works with the Association of Directors of Adult Social Services (ADASS) and NHS England to encourage the wider use of commissioning as a tool for ensuring compliance with the MCA;
- that overall responsibility for the MCA be given to a single body; and
- that a comprehensive review of the Deprivation of Liberty Safeguards be undertaken.

2.3 Following the Select Committee's recommendations the Government responded by implementing the following:

- The responsibility to overview the MCA has been given to a select group of legal and medical professionals chaired by Baroness Finlay (National MCA Forum).
- The Law Commission completed a review of the Deprivation of Liberty Safeguards.
- Work has been undertaken by ADASS in order to aid local authorities and the NHS to fully embed the MCA into Governance arrangements by introducing an LGA/ADASS MCA implementation tool.

2.4 In order to be fully embedded, the Mental Capacity Act needs to become an Integral part of any governance reporting arrangements. The principles should form part of any decision making involving a variety of professionals working within the local authority who are required to obtain consent from people who use the services. There should be overarching policies and procedures which are followed by all staff to ensure compliance with the MCA and this should be underpinned by robust governance arrangements.

2.5 With this in mind it was agreed that there was a need to determine how the Mental Capacity Act was embedded within North Yorkshire County Council and within its wider partners. Pressures arising from the Cheshire West judgment have meant that there has not been the capacity within Health and Adult Services to carry out strategic and policy development around the MCA and DoLS within the Directorate, and with partners. As a result, a fixed term post has been established to ensure that the Governance arrangements and strategy and policy around MCA and DoLS reflect legislation and national best practice.

3. DEPRIVATON OF LIBERTY SAFEGUARDS

3.1 The Deprivation of Liberty Safeguards (DoLS) apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care. They were introduced in 2009 to rectify breaches to Article 5 of the European Convention of Human Rights (ECHR) following the case of *Bournewood v United Kingdom*. They provide legal protection for vulnerable people who are, or may become, deprived of their liberty within a hospital or care home. They exist to provide a proper legal process and suitable protection in circumstances where, for a person's best interest, deprivation of liberty appears to be unavoidable.

DoLS apply to anyone:

- aged 18 and over;
- who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability;
- who lacks the capacity to give informed consent to the arrangements made or their care and / or treatment; and for whom deprivation of liberty (within the meaning of Article 5 of the European Commission for Human Rights (ECHR)) is considered after an independent assessment to be necessary in their best interests to protect them from harm.

3.2 The Deprivation of Liberty Safeguards applies to people residing in care homes or hospitals, but not to those living in their own homes or in supported living.(Deprivation of liberty can still apply in these settings, but the authorising mechanism is the Court of Protection). The manager of the hospital or care home wishing to make a DoLS application is called the managing authority, the supervisory body arranging the deprivation of liberty assessment is the local authority.

3.3 Following the Supreme Court Judgment in March 2014 there was an unprecedented increase in applications. Referrals continue to increase, and in 2015/16 we accepted a total 3076 referrals. Prior to March 2014 we received on average 100 referrals a year, in 2014/15 we accepted approximately 1500 referrals.

3.4 The increase in workload is being managed by applying the ADASS prioritisation tool. This enables the most at risk people to have access to the relevant safeguards, but does result in a back log of ‘low priority’ referrals going back to July 2015. This group however, continue to receive regular statutory social care reviews**,** and we are sustaining the agreed prioritised workload. Four local authorities have recently launched a judicial review asking for the increase in DoLs cases as a result of the 2014 Cheshire West judgement to be treated as a ‘new burden’.

4. DEPRIVATION OF LIBERTY IN THE COMMUNITY (DoL)

4.1 The Supreme Court Cheshire West judgment also extended the judgment to people living in supported accommodation in the community for example supported living schemes and domestic settings.

4.2 A scoping exercise was undertaking to identify how many people may potentially be deprived of liberty in supported living schemes. The scoping tool was divided into six priority levels, level 1 being people in supported living schemes within learning disabilities that have waking staff or are under continuous supervision and control. The total number of priority 1's that have been identified amounts to 264**.** Work will now need to be undertaken in order to authorise these via the Court of Protection.

4.3 An action plan has been agreed to prioritise the workload required to meet applications for Court of Protection authorised 'DoL' in community settings, and a priority system is being applied for applications to Court of Protection.

4.4 Application to the Court of Protection (CoP) for DoL will be made for those people who have been identified as priority 1 on the scoping exercise. However, there are still others identified as potentially being deprived of liberty but who have been identified as a lower priority. Due to resource implications it is only possible to complete 100 a year. The scoping tool did not look at those within domestic settings which Cheshire West judgment extends to. The new legislation to replace DoLS should address these risks, but they are likely to remain until its enactment.

4.5 It is estimated that costs of completing the CoP process is £2500 per case if all elements were purchased including Social Work assessment time, doctors assessment, litigation friend, solicitor rate, court application, hearing costs, and barrister costs. It is estimated that each 50 applications would equate to a full time social Care Assessor, to complete the process. An additional two Social Care Assessors are being recruited to complete the bulk of the applications, provide a quality assurance role, guidance and develop expertise.

4.6 After the initial authorisation, cases will have to be reviewed regularly, potentially every 8 weeks, any changes made to the care plan that make it more restrictive will need to be referred back to the court, and it will have to go back to the court at least every twelve months and additional services and processes will need to be developed.

5. THE LAW COMMISSION'S CONSULTATION AND INTERIM STATEMENT

5.1 The Law Commission completed a report for consultation in July 2015. The recommendations were around a new system of safeguards called Protective Care. Broadly speaking the proposed protective care scheme had three aspects: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme. However, there was a view from Government that the original proposals were unrealistic, and too expensive to implement in the current economic situation.

5.2 On 19th May 2016 the Law Commission produced an interim statement following the response to the consultation. It reaffirms the "compelling case" for replacing DoLS and the scale of workloads and pressure on resources mean that "any notion that the existing system can be patched up to cope, even in the short term,

was deemed not to be sustainable". It accepts that reform must "demonstrably reduce the administrative burden", and provide "maximum benefit for the minimum cost". A much more limited scope scheme is being proposed, with less complexity and, presumably reduced costs (although a revised impact assessment will be needed). A summary of the proposals is attached as Appendix A.

5.3 The Law Commission will produce their full report and draft bill in December 2016 with implementation estimated to be by the end of 2019. Following publication of the report, an impact assessment will need to be completed in order to ascertain the impact for the County Council.

6. LGA/ADASS MCA IMPROVEMENT TOOL

6.1 In order to self-assess against national standards and practice, we have completed the LGA/ADASS MCA/DoLS improvement tool. This has been developed with funding from the Department of Health and support from the LGA and ADASS. Its key areas of focus have been used in a number of peer challenges and as a means of self-assessment to assess a service, identify and promote good practice and to highlight areas for further development. It describes the characteristics of a well-performing and ambitious organisation in the following themes:

a) Outcomes for, and the experiences of, people who use services
What has been achieved by Adult Safeguarding and the quality and experience for people who have used the services and support.

b) **Leadership, Strategy and Working together**
The overall vision for Adult Safeguarding in regards to the MCA; the strategy that is used to achieve that vision and how this is led at all levels in the organisations involved.

c) Commissioning, Service Delivery and Effective Practice
How services are commissioned in relation to local needs and then how they are actually provided, including the involvement of people using services.

d) Performance and Resource Management
How the performance and resources of the service, including its people, are managed.

6.2 The self-assessment has identified a number of areas of good practice within the directorate in relation to training and the deprivation of liberty safeguards. There are however, a number of areas where the need for further work has been identified, the details of which are set out in Appendix B:

- Governance;
- Information;
- Performance;

- Communications and Engagement;
- Quality;
- Practice;
- Training; and
- Partnership Working

7. CONCLUSIONS

7.1 There continues to be an increase in DoLS applications, the volume of which cannot be met within the original time frames, the prioritisation tool is in place but this means that there will always be a number of applications identified as being low priority that have not been authorised. This situation has been accepted nationally with more local authorities implementing the ADASS implementation tool into practice. There is, however, still a low litigation risk in regards to the outstanding applications that may be deprived of liberty without authorisation.

7.2 The added DoL Court of Protection applications which are waiting to be completed add to the administrative, resource and financial burden for North Yorkshire County Council.

7.3 The implementation of the LG/ADASS action plan will greatly strengthen the County Council's and Safeguarding Adult Board's governance and reporting arrangements in regards to the Mental Capacity Act and Deprivation of Liberty Safeguards.

7.4 The action plan will ensure that the people within services who may have been deprived of their liberty, have their views heard, and that the views of their families/carers and the Independent Mental Capacity Act Advocacy are fed back in order to shape future practice.

8. RECOMMENDATIONS

It is recommended that the Committee recognises:

a) NYCC as a Supervisory Body, alongside other local authorities nationally, continues to see an increase in Deprivation of Liberty authorisations which cannot all be met;
b) The approach taken to the Deprivation of Liberty in the community and Court of Protection applications, which will mean that some applications will be prioritised;
c) the actions identified following completion of the self-improvement tool to develop MCA practice; and
d) that the burden in regards to Deprivation of Liberty Safeguards is unlikely to change within the next 2-4 years.

MIKE WEBSTER
Assistant Director (Quality & Engagement)
Health & Adult Services

Appendix A

1. Summary of Interim Statement by Law Commission

1.1 The responsibility of establishing the case for a DoL would be shifted from the provider of the care to commissioner (ie usually the local authority or CCG), using a) a capacity assessment; (b) objective medical evidence of the need for a deprivation of liberty on account of the person's mental health; (c) arranging provision of advocacy (or assistance from "an appropriate person"); (d) consultation with family members and others; (e) an existing care plan. There would still be rights to reviews, and appeal. There is no indication as to how applications will be made for self-payers or for people who are jointly funded.

1.2 The role of the Best Interest Assessor (BIA), which had been strengthened in the role of the Advanced Mental capacity Practitioner (AMCP) in the original proposals, is considerably reduced. There may be 'a defined group of people who should receive additional independent oversight of the DoL' by an AMCP, but the central role of the AMCP as independently scrutinising and authorising the DoL in every case is lost, and the current universal role of the BIA is dropped. This means a proportion of those deprived of liberty will apparently have no independent oversight, this is perhaps the most controversial aspect of the new proposals as the reason why the threshold for deprived of liberty was lowered in the *Cheshire West* judgment was to promote independent scrutiny. This new approach would be a single scheme applied uniformly across every setting, ie dropping plans for the dedicated hospital / hospice scheme in the original consultation.

1.3 The proposal to amend the Mental Health Act (MHA) is also dropped, on the basis that the policy aim can be met by provision that the existing powers under MHA should be used for patients who are compliant and lack capacity to consent to admission and treatment for their mental disorder. This in itself brings in its own set of resource issues for mental health hospitals.

1.4 The impact on inquests from Cheshire West should still be addressed by an amendment to the Coroners and Justice Act 2009 to explicitly remove the proposed scheme from the definition of 'state detention', which triggers the need for an inquest, in some cases with a jury.

1.5 A decision on the proposal for a tribunal to replace the Court of Protection urisdiction is still under consideration.

1.6 One of the most controversial aspects has been the terminology used. The favourite alternatives suggested were "liberty safeguards", followed by "capacity safeguards", and the Law Commission asks for further suggestions.

2. Implications

2.1 There is a lack of detail about how moving the responsibility for establishing when a DoL is occurring from the care provider to the commissioning body (NHS or LA) will work.

2.2 There is no indication as to whether the 'Cheshire West' Acid test for deprivation of liberty will remain or whether deprivation of liberty will be officially defined in the new legislation but even if it remains the same the new scheme could reduce the administrative burden and financial costs for NYCC for the following reasons:

- Local Authorities will no longer be responsible for those funded by health.
- Provisions for local authorities to rely on existing assessments (where appropriate) when considering a deprivation of liberty.
- The new scheme will be extended to supported living, shared lives and a person's own home, so authorisation through Court of Protection may not be required.
- The amendments to the MCA will mean new ways of working for social care staff and other professionals making best interest decisions, there will be a notable shift in regards to how best interest decisions are made.

Appendix B

Actions Identified following completion of LGA/ADASS MCA Improvement Tool

Governance

- The governance arrangements to be strengthened around MCA and DoLS both within the directorate and the Safeguarding Adults Board.
- development of a range of governance documents, including a Risk Register, Communications and Engagement Plan, Training Strategy and broadening and updating the existing Operational plan;

Information

- Review and update of North Yorkshire County Council website for the MCA and DoLS page to include more guidance for providers and families including a Q and A section.
- An MCA intranet page to be developed for staff providing information on good practice for MCA/DoLS as well as case law updates.
- A webinar to be introduced for providers on pertinent MCA and DoLS issues.

Performance

Whilst some data is currently produced on DoLS, this needs to be expanded to include data around MCA, and other areas identified within the self-assessment eg monitoring of trends. This will be included as part of the regular directorate Performance reports to the leadership team.

Communications and Engagement

- Engagement with people who use the services, family/carers and Relevant Person Representatives for feedback in regards to MCA/DoLS;
- IMCA feedback to be completed in order to gain a wider picture in regards to the experiences of people who use the services.

Quality

Work has begun to include more information about MCA and DoLS in the Quality Assurance baseline prompt sheet, and we are working with the Independent Care Group to develop a self-assessment to be sent to all providers to look at specific areas around, MCA,DoLS and person centred care prior to visits. Further consideration of the requirements of MCA/DoLS within standard commissioning contracts is needed.

Practice

There is an existing workplan around DoLS, reflecting the changes brought about by the Supreme Court judgment and subsequent HASLT decisions. These will be incorporated with the additional actions identified from the self-assessment. They include:

- a review of a sample of DoLS conditions in order to ascertain whether DoLS has improved the care of people who use services in relation to restrictions implemented as part of the care arrangements.;
- monitoring the level of contact with individuals of family members who are Relevant Person Representatives;

- a review of the best interest decision form to include a balance sheet approach which looks at the pros and cons of each decision as part of the best interest decision making process;
- Observations of DoLS assessments to be carried out in order to fully complete the relevant questions on the indicator tool;

Training

The North Yorkshire Safeguarding Adults, MCA and DoLS Training Strategy is the process of being reviewed. Methods of engaging more with providers/managing authorities are being explored,

As part of the review of performance data, we will improve the information available on the number of staff trained, and the basic classroom MCA training will be amended to ensure that staff are aware of the best interest balance sheet approach.

Partnership Working

- Tracking of Dols applications to be undertaken to ensure providers are applying for DoLs when required to do so and flagging up those providers that are not making applications.
- The exploration of MCA in the wider sense, e.g financial institutions such as banks, solicitors as well as health, GP's.
- MCA development with care and support plans
- Safeguarding policies and training to include MCA and DoLs procedure
- A review of the MCA forum including terms of reference and the purpose of the group
- A partner self-assessment based on MCA standards to be sent to all partners to determine how embedded the MCA is within partner organisations.

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

30 June 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 Recommendations

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

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

MEETING	SUBJECT	AIMS/TERMS OF REFERENCE	ACTION/BY WHOM
27 October 2016	Living Well Team/Stronger Communities	Update on progress of Living Well Team and Stronger Communities programme one year on..	HAS/PPP
	Director of Public Health Annual Report	That the Committee consider and comment on the North Yorkshire Director for Public Health Annual Report	DPH
	Local Account	To review, pass comment and make suggestions for any amendments.	HAS
	Annual Safeguarding Board Report	Chairman of Board preents Annual report.Dialogue about comittment of partners to Safeguiarding agenda.	HAS
	Dementia Strategy Update and Q and A with Navigators	The strategy and action plan are being worked up over the summer with a view being published at the end of November.	HAS
19 January 2017	Sexual Health Service Reconfiguration: Update by Provider	Update on progress.	Public Health
	Substance Misuse Service Update Providers	An update on the progress of this commissioned service.	Public Health
27 April 2017	Dialogue with Care Quality Commission Representative	Follow up to disussion with CQC about inspection regime.	CQC
	START/ in house Domicilliary Care	A possible Q and A session with in-house providers. To be agreed by Group Spokespersons	HAS

Care and Independence Overview and Scrutiny Committee – Work Programme Schedule 2015			
	Supported Employment	A possible Q and A session with in-house providers. To be agreed by Group Spokespersons	

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