Agenda

Meeting: Meeting of the Care and Independence Overview & Scrutiny Committee

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

Date: Thursday 19 January 2017 at 10.00am (PLEASE NOTE START TIME)

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

Business

1. Minutes of the meeting held on 27 October 2016

(Pages 5 to 8)

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 16

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

January 2017. Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);

- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

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.

4. **Yorsexualhealth** – Presentation by Georgina Wilkinson (Public Health) and Tina Ramsey from YorSexualHealth, the provider

5. **Supported Employment -** Report by the Corporate Director of Health and Adult Services

(Pages 9 to 16)

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

(Pages 17 to 21)

7. **Discharges from Hospital -** Report by the Corporate Director of Health and Adult Services

(Pages 22 to 50)

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

(Pages 51 to 61)

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

11 January 2017

Care and Independence
Overview and Scrutiny Committee

1. Membership

County Councillors (13)				
	Councillors Name	*Chairman/Vice Chairman*	*Political Group*	*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	

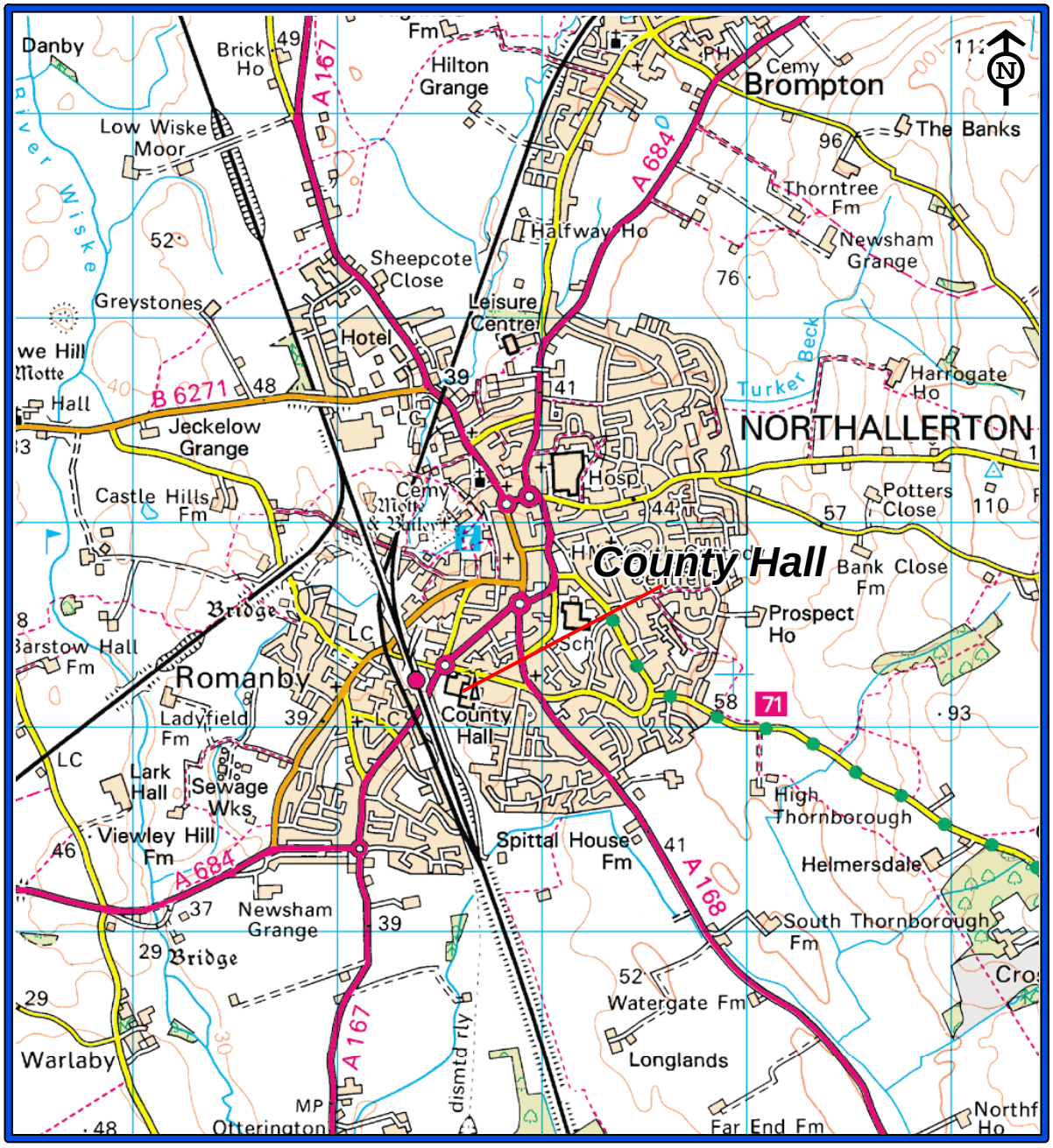
Members other than County Councillors – (3)			
Non Voting			
	Name of Member	*Representative*	*Substitute Member*
1	KNIGHT, Julie	North Yorkshire and York Forum	
2	SNAPE, Jackie	Disability Action Yorkshire	
3	PADGHAM, Mike	Independent Care Group	

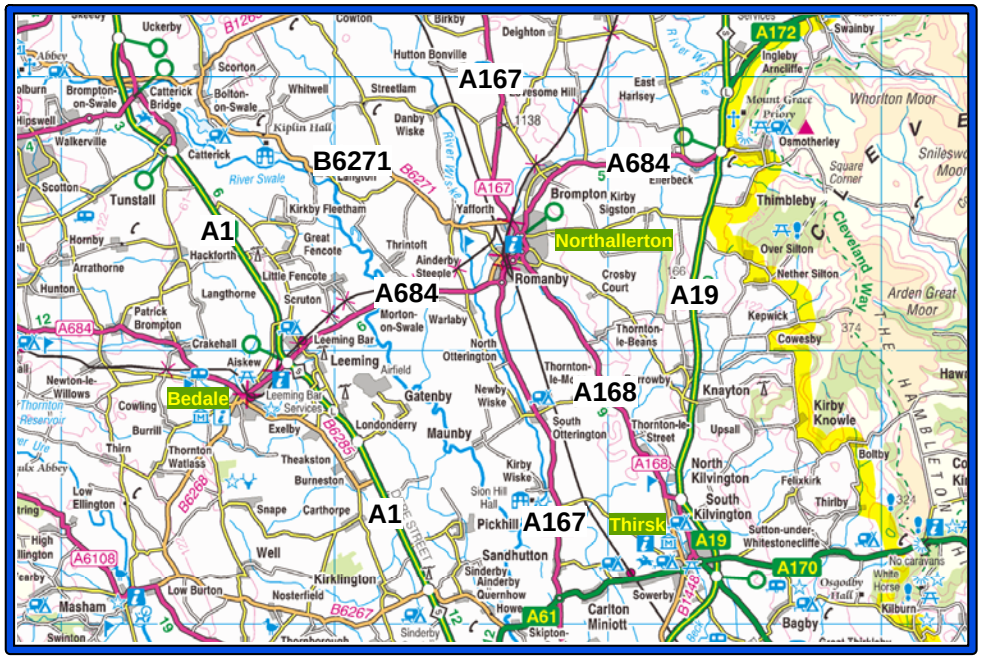
Total Membership – (16)	**Quorum – (4)**

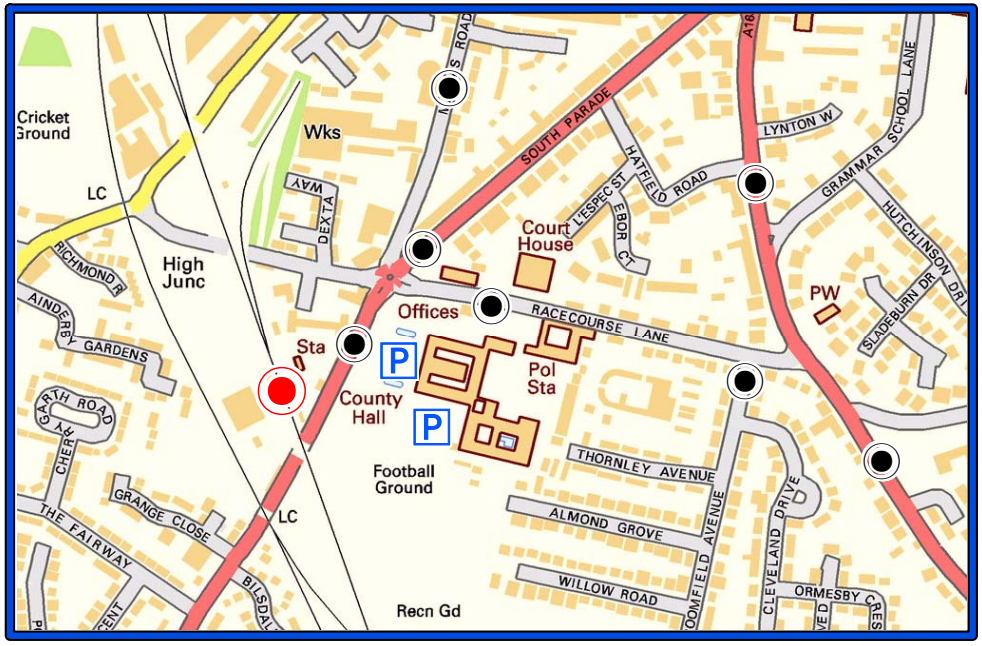
Con	**Lib Dem**	**NY Ind**	**Labour**	**Liberal**	**UKIP**	**Ind**	**Total**
8	**0**	**2**	**1**	**1**	**0**	**0**	**13 ***

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**	
Liberal			
	Councillors Names		
1	CLARK, John		







P **Visitor Parking at County Hall**

Northallerton National Rail Station

Bus Stops

© Crown copyright. All rights reserved. North Yorkshire County Council 100017946 2008 (Produced by Corporate GI Team)

County Hall
Northallerton
North Yorkshire
DL7 8AD

Tel : 0845 8 72 73 74

North Yorkshire County Council

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

Minutes of the meeting held on 27 October 2016 at 10.30 am at County Hall, Northallerton.

Present:-

County Councillor Patrick Mulligan in the Chair.

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

In attendance: County Councillor Clare Wood (Executive Member for Adult Social Care Health Integration).

Officers: Ray Busby (Scrutiny Support Officer, (Policy and Partnerships)), Marie Ann Jackson (Head of Stronger Communities Programme, Policy and Partnerships), Cath Simms (Head of Targeted Prevention, Care and Support), Mike Webster (Assistant Director, Contracting, Procurement and Quality Assurance (Health and Adult Services))

Apologies: County Councillors Bill Hoult and Helen Grant. Added Members: Julie Knight (North Yorkshire and York Forum), Mike Padgham (Independent Care Group) and Jackie Snape (Disability Action Yorkshire),

---

Copies of all documents considered are in the Minute Book

---

110. Minutes

Resolved –

That, the Minutes of the meeting held on 30 June 2016, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

111. Any Declarations of Interest

County Councillor John Savage declared an interest in the item relating to Dementia.

112. 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.

113. Dementia:

(a) Dialogue with Dementia Navigator Providers

Considered -

The report of the Scrutiny Team Leader guiding the Committee's question and answer session with providers of the commissioned service for Dementia Support Workers.

At a time when an increasing number of people have to deal with the impact of dementia, North Yorkshire County Council and the NHS jointly commissioned a new service which supports people in their own homes. One year into this contract, representatives from the two successful providers - Dementia Forward and Making Space gave an account of their experiences.

Gill Quinn, Chief Officer (Dementia Forward), Roy Tomlinson (Team Leader)) and Steph Johansen, Director of Services (both of Making Spaces) explained how dementia support workers are working effectively on a one-to-one basis with people diagnosed with dementia to help them to continue to enjoy an active and independent life for as long as possible. They are improving people's quality of life, promoting their independence and helping them to plan and to maintain or widen their social networks.

Both organisations are raising awareness through learning programmes, so that people can understand the condition better and develop coping strategies to live as well as possible with dementia. They are successfully providing telephone support, peer support groups, assistance with benefits and services for carers. Support and advice ranges across the whole of the dementia journey from helping people cope with diagnosis, helping them access community support, through to working with people to help them plan in advance for end of life.

The relationship between the two providers and the directorate, as commissioner, was clearly positive and constructive.

Resolved -

That the report and discussions be noted.

(b) Dementia Strategy Update

Considered -

The report of the Corporate Director - Health and Adult Services updating on the work in relation to the North Yorkshire Dementia Strategy.

Resolved -

That the Committee receive a report when the Strategy is finalised by the end of the year and is signed off by Health and Wellbeing Board in February for a formal launch in Spring 2017.

114. North Yorkshire Safeguarding Adults Board Annual Report 2015/16

Considered -

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

In reviewing the Annual Report of the North Yorkshire Safeguarding Board, members welcomed that so many encouraging initiatives were underway. IN particular - because it demonstrates how simple things can often make a big difference – reference was made to the Registered Safe Places scheme. The 'Safe Place' symbol is displayed on their window or door so that people who are out and about and begin to feel anxious or at risk – be it because they have learning difficulties, disabilities, frailty, dementia or mental health problems – can look out for the symbol and enter the Safe Place to get help. Up to 120 public sector organisations across the county – libraries, leisure centres, Citizen's Advice Bureau, Northern Rail stations, community and children's centres – have registered in this first phase and are displaying the Safe Places sticker.

Resolved -

a) That the Annual Report of the Safeguarding Adults Board be noted.
b) Members concluded that the evidence in its report for 2015/16 suggests the Board is in a healthy state - governance arrangements are sound; partnership commitment - especially to training – is good; work on community prevention and awareness is robust, and strategic links with other partnerships in localities is good.

115. Living Well

(a) Living Well Team and Stronger Communities

Considered -

The report of the Scrutiny Team Leader introducing the presentation to the Committee on the Living Well Team.

Resolved -

That the report be noted.

(b) Living Well: One Year on

Considered -

The presentation by Cath Simms, Head of Targeted Prevention, Care and Support (Health and Adult Services)

After their initial briefing last year, the Stronger Communities and Living Well teams, represented by Marie-Ann Jackson and Cath Simms respectively, returned to update on progress. This time, information to committee focussed more on the Living Well Team.

Cath explained that 1400 people countywide have been seen by the Living Well Team between since October 2015 with 34% referrals through Customer Service Centre. People are receiving an average of 7 weeks support but, pleasingly, and in line with original aspirations, 90% of people have not had any further NYCC involvement.

Loneliness and isolation remains a key feature of referrals - 39% people supported present being lonely and/or isolated as the primary reason for seeking support. Interventions have resulted in people developing social connections, attending

community groups, technology, buying simple equipment. Particularly heartening is 53 people having been supported to become volunteers.

What is available in the community and the environment is a significant factor in people's lives; therefore, the links to the sphere of responsibility of the Stronger Communities team are clear. The team has continued to build upon its work with local organisations, community groups and other partners from the public and private sectors across North Yorkshire, identifying opportunities to co-produce a range of local support and services aimed at improving the well-being of people of all ages.

Resolved -

a) That the presentation be noted.
b) Members agreed that, as was originally envisaged when the council committed to this investment, in practice the two teams are complementing each other well.

116. The Annual Report of the Director of Public Health

Considered -

The Annual Report of the Director of Public Health

Resolved -

That consideration of the Annual Report be deferred to a different occasion

117. Work Programme

Considered -

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

Resolved -

That the Work Programme be agreed.

The meeting concluded at 12:40pm

RB

NORTH YORKSHIRE COUNTY COUNCIL

Care & Independence Overview & Scrutiny Committee

Supported Employment

1.0 Purpose of Report

1.1 This information in this report is intended to provide background to what is the fourth in a series of conversations the Committee has had with social care providers. This time it is the turn of the Supported Employment - an in-house service for supporting people with significant disabilities to secure and retain paid employment.

1.2 Representatives of the NYCC Health and Adult Services Supported Employment Service will be at the meeting.

2.0 Supported Employment – an introduction

2.1 The British Association for Supported Employment tells us that Supported Employment has been successfully used for decades as a model for supporting people with significant disabilities to secure and retain paid employment. The model uses a partnership strategy to enable people with disabilities to achieve sustainable long-term employment and businesses to employ valuable workers.

3.0 Service Aims

3.1 The service in North Yorkshire, managed within Health and Adult Services, has as its service aims

"To provide support to disabled adults, adults with autism, adults with learning disabilities family carers, and people with enduring mental health conditions in receipt of adult social care services to find, or maintain or retain paid employment."

4.0 Service Delivery Objectives

4.1 To ensure that people with disabilities receive a high quality, personalised support which enables them to find, access and stay in employment, the service aims:

- To provide a comprehensive assessment of a person's skills, abilities resulting in a vocational/employment related action plan.
- Support to people to find paid employment, both part time and full time.
- Signposting and advice for jobseekers and carers and professionals on a range of employment issues.

- Supporting disabled people to retain their jobs if their support needs change.
- Support and advice to employers on adjustments or training

5.0 Current practice within the generic Supported Employment Team

- There is 25 supported employment staff.
- This consists of 2 team managers and 23 Supported Employment Officers. The team managers are directly managed by the Head of Provider Services.
- The staff are based with 5 areas of the County;
- To support the on-going professional development of the team, NYCC are members of the British Association of Supported Employment (BASE)

5.1 The team currently hold average caseloads of 35 people for full time staff and 22 for part time staff. This is approximately 450 people the service is currently working with.

5.2 The team are also working closely with the Job Centre Plus staff to ensure disabled people referred to the specialist employment services are supported through the process.

5.3 The budget for the service is: £401,400 per annum

6.0 Referral Routes

6.1 Prior to March 2011, self-referrals and referrals from Job Centre Plus were accepted by the service, but this proved to be impractical, with capacity issues being encountered by the team. Currently, standard practice is for all referrals to the service to be made as a result of an assessment and identification of social care needs undertaken by HAS assessment teams. However, signposting and advice is available to anyone who makes an enquiry.

7.0 Context to the development of the service.

7.1 In 1997, following research undertaken by key staff, NYCC Health and Adult Services Directorate adopted the principles of Supported Employment as defined by the British Association of Supported Employment. In line with modern thinking, the intention was to enable the promotion of both paid and voluntary work for people with learning disabilities, many of whom, at the time, were accessing traditional, in house day services.

7.2 The Supported Employment “Service” was made accessible to all disability groups, and referrals widened to include people with physical and sensory impairments, people with enduring mental health conditions and people with autism. From 2008, as part of the implementation of the Carers Strategy, Supported Employment staff have also supported carers wishing to return to

the labour market. In line with this move towards effective, generic based working, just this year staff who supported people with secondary mental health conditions to find employment, training and volunteering, and who operated within the Community Mental Health teams, have been brought into the wider supported employment team.

7.3 Team staff now have specific job titles, roles and specifications geared around supporting all impairment groups in finding and/or maintaining paid work, and providing on the job support as required.

7.4 Supported Employment has thus evolved, as part of HAS transformation of services, into a formal service within wider HAS operational services, centrally managed, and sitting outside of Learning Disability in house provider services.

8.0 Challenges faced by the Supported Employment Team

8.1 Within the current economic situation, there is evidence both within the team and nationally that finding paid work is becoming increasing difficult for disabled job seekers. There is also local evidence that disabled employees are finding it increasingly challenging to maintain their employment as employers have increased expectations of their workforce and are often unwilling to make reasonable adjustments within the workplace.

8.2 The Valuing Employment Now Annual report 2010/11, produced by BASE, highlights the current, key challenges affecting Supported Employment:

8.3 The Government's drive to reduce the reliance and cost of welfare benefits**

- Low expectations of people with learning disabilities to want to work *
- Low expectation by carers of the abilities of disabled people, particularly adult with learning disabilities.*
- Experience that there are often unrealistic expectations and inappropriate referrals of people to the Supported Employment team. Employment still seen as a way to "fill someone's day" *
- Day care providers lack sound business strategies and employment focus.
- Disabled jobseekers often lack the key employability skills required- i.e. ability to travel independently, behaviours, lack of interpersonal or written communication skills or have additionally challenges such as: substance misuse or convictions, cautions and being on bail.
- Evidence that the Government funded work programmes for disabled people are struggling to meet outputs, and many of the organisations are ceasing to deliver the contracts **
- A need for early intervention with young disabled people to support a successful job finding and matching processes*

Ref: Valuing Employment Now Annual report 2010/11 * BASE 2012-15 **

9.0 Current Service Achievements and Trends

9.1 The following section gives members some sense of the scale of activity managed and/or initiated by the in-house team.

9.2 In 2015, 61 people were successfully supported into employment - 17 people with a physical or sensory impairment, 22 with learning disability and 22 people with Autism.

9.3 Approximately 100 have been supported to undertake training, voluntary or work placements.

9.4 These figures do not include people with mental health conditions

9.5 The Employment Officers support people through a strength/asset based approach to achieve their individual and unique aspirations and this is reflected in the diversity of jobs secured including hospitality, catering, cleaning, hospital administration, building and construction, manufacturing, childcare, passenger transport and gardening and grounds maintenance.

9.6 Self-employment is increasingly becoming an option, three people have been successful at achieving this aim, one as a photographer and of the two since finishing at Personalised Learning Pathways (PLP), one has become a self - employed gardener and the other makes and sells crafts. Another PLP leaver is exploring the possibility of becoming a dog walker and another is looking into game designs.

9.7 Three people were supported into apprenticeships, two in business administration admin and one to the joinery trade.

9.8 Many people who are referred to Supported Employment need to undertake training courses before seeking employment and the team signpost and support them to do this.

9.9 This year three people have been supported to attend a 12 week course run by the Princes Trust. Jobseekers have attended Food Hygiene, Customer Service, Health and Safety in order to support them into employment. Others, throughout the county, have attended Adult Learning courses in employment skills or job clubs run in partnership by NYCC Adult Learning and NYCC Supported Employment.

9.10 Voluntary work can also be a useful step on the route to paid employment, providing both experience and references. Jobseekers have been supported to undertake various voluntary roles including working in charity shops, libraries, a stately home and a bird of prey centre.

9.11 Work placements also enable people to explore different types of work and at the same time gain experience in the soft skills around employment. 17 people have been supported by the team to undertake these and some have led to paid employment including a business admin post at NYCC, a vehicle cleaner at NYCC, a kitchen domestic in a private café and a nursery assistant. Other work placements supported by the team include M and S, Boots the Chemist,

Ampleforth College, and placements in nurseries, warehouses, libraries, cafes and one as a boiler engineer.

9.12 Job retention is becoming an increasing part of the role and 30 people have been supported to retain their jobs. This work can entail negotiating with employers, liaising with CAB and employment lawyers and attending disciplinary hearings/meetings and tribunals, all of which can be resource intensive and time consuming.

9.13 Preparation for Adulthood/ Personal learning Pathways- The team currently receive referrals for young people on the employment pathway element of Personalised Learning Pathways and get to know them through initially attending reviews and then working alongside the Hub and Blueberry Academy staff to support individuals to attain their desired outcomes. The team is currently supporting 10 young people

9.14 Autism- In November 2015 the team achieved Autism Accreditation with the National Autistic Society for their work supporting people with Autism into employment.

9.15 Drop in sessions specifically aimed at people with Autism have been established across the county with over 30 people attending sessions so far.

9.16 Recruitment within NYCC - the team are aiming to secure more paid employment for people with disabilities or additional needs within NYCC. A trial offered a work placement to somebody in County Hall which has since led to a permanent job.

9.17 The team are working with NYCC services managers to carve out jobs for people with disabilities. As an example, Fleet transport recently created a special post for a mini bus washer, and other roles were carved in residential services for cleaners and kitchen assistants.

9.18 Internally, NYCC Resourcing and Reward section are working strategically to support reasonable adjustments and active recruitment of people with disabilities and social care needs and the team are working towards developing Supported Internship model within the council.

9.19 Coffee Cart- the team supported the development of the coffee cart initiative since May 2015. This initiative was funded through the Innovations Fund and managed by Creative Support. The aim of the coffee cart was to support disabled people to gain the interpersonal and practical skills which can be used in the workplace. Trainees undertook a 16 week programme with the cart with the aim of achieving work or further training through help from the SE team. 16 people undertook training placements at the coffee cart, 2 people gained paid employment, with another 2 undertaking further training following the end of their work. Although the coffee cart has now ceased, a supported employment offer for disabled jobseekers has been embedded in the contract with the catering provider Cater leisure which currently provides the canteen service within County Hall.

10.0 Service Outcomes

10.1 Guidance relating to employment within “Valuing People Now” and “No Health without Mental Health” and more recently the Five Year Forward Plan for Mental Health, agreed national indicators relating to employment outcomes. These aimed to set minimum targets to increase the proportion of people with Learning Disabilities and Mental Health in paid employment and/or training.

10.2 The current employment rates are 74% of the general population. 43% of people with mental health problems are in employment. 65% of people with other health conditions.

10.3 ASCOF (Adult Social Outcomes Framework) figures show that in North Yorkshire 10.7% of people with an LD are in employment against a national average of 6%. This is against national target of 46% for people with LD.

LTS004

Accommodation and employment status of working age clients with a Primary Support Reason of Learning Disability

Period: 01/04/15 - 31/03/16 (all tables)

Table 1 Employment by Gender	Paid - less than 16 hours a week	Paid - 16 hours or more a week)	Not in Paid Employment (seeking work)	Not in Paid Employment (not actively seeking work / retired)	Unknown	Total
Gender	Employed		Not in paid employment			
Males aged 18-64	65	36	52	665	62	880
Females aged 18-64	50	11	31	484	50	626
Total	115	47	83	1149	112	1506

THIS TABLE CONTAINS DATA USED FOR THE ADULT SOCIAL CARE OUTCOMES FRAMEWORK (ASCOF) MEASURE 1E

this 'grand total' should m

10.4 Figures for people with MH in North Yorkshire are at 13.9%, which compares favourably against a national average of 6.8%.

10.5 Preparation for Adulthood- the Supported Employment Service is a key part of the implementation of the model. The primary outcome for young people with disabilities leaving school or college is to find paid work. The role of the team will be to introduce the concept of work at an earlier age than is currently been offered.

10.6 The team will work with young people with social care needs from aged 14, supporting the young person and their family to look at vocational options, secure Saturday jobs and part time work in preparation for leaving full time education and reduce the long term reliance on Health and Adult Services.

10.7 A supported internship is one type of study programme specifically aimed at young people aged 16 to 24 who have a statement of special educational needs, a Learning Difficulty Assessment, or an EHC plan, who want to move into employment and need extra support to do so. NYCC have small capital grants to stimulate the market in relation to Supported Internships.

10.8 The service continues to develop a partnership approach with day service providers, with support from HAS Commissioning Team, to encourage the development of innovative practice to assist people using services to achieve

their potential through employment focussed training to make the transition from day services to employment/ volunteering/self-employment.

10.9 Working with NYCC Resourcing and Reward to support managers to understand and develop reasonable adjustments in the workplace including job craving and work trials and enable retention of personnel who are risk of losing their job and requiring social care support through the Disability Confident Campaign.

10.10 Work with the Living Well team to identify and provide increased employment support to people who although may not demonstrate initially a social care need longer term without employment require social care invention or have increasing health needs.

10.11 Re-launch and refresh the Employment Pathways web based resource which provides on line advice for job seekers. Link for this resource can be found on: www.northyorks.gov.uk/employmentpathways.

10.12 Consolidate the SE Offer at the reablement point of the assessment pathway for working age adults.

11.0 Evi**dence of the effectiveness of Supported Employment**.

11.1 Recently the NDTi (National Development Team for inclusion) undertook a national research project looking at the funding, delivery and outcomes of employment support. A full copy of the research is available here http://www.ndti.org.uk/uploads/files/The_cost_effectiveness_of_Employment_Support_for_People_with_Disabilities,_NDTi,_March_2014_final_v2.pdfA summary of the evidence is available here http://www.ndti.org.uk/uploads/files/SSCR_4_page_summary_Phase_3.pdf

11.2 From the research it is worth noting:

- There is evidence for individualised support models and not workshop/classroom based preparation
- Nationally the average cost of a job outcome was £8,217 but employment support providers working to a best practice model had an average cost of £2,818 for each job outcome.
- Employment support providers who use best practice raise job outcomes from 38% to 43 %.
- Good services are equally successful in supporting people with greater levels of disability to gain or retain employment.
- It is important to focus funding and support on both job gaining and retaining
- Successful employment outcomes were most likely where organisations featured a prioritising on employment, clear definitions, a strategic plan,

the use of a knowledge/evidence base and the use of measurement systems.

- Anecdotal evidence of the potential risks of not providing employment intervention/support for people with low levels of social care needs as a preventative measure could result in people requiring more intensive social care support later.

12.0 Development of a North Yorkshire Employment strategy for adults with learning disability

12.1 As part of the Health and Social Care Learning Disability Self-Assessment Framework (SAF) as requested form the Dept. of Health, it is a requirement that North Yorkshire have an up to date employment strategy.

12.2 The Transforming Care Partnership has responsibility for the undertaking of the SAF and subsequent actions and therefore has requested the Head of Provider Services with the Learning Disability Partnership Board (LDPB) and with support from Inclusion North develop a draft strategy for consultation.

12.3 An engagement event in December 2015 was held with the LDPB lo understand the key messages from people with LD about employment. Inclusion North and NYCC key staff have developed these findings into an initial draft and have consulted with the National Development Team for Inclusion (NDTi) to ensure the strategy is in line with national good practice.

13.0 Recommendation

13.1 Members discuss the Supported Employment Service with the representatives present.

Joss Harbron
Head of Provider Services, Care and Support (HAS)

11 January 2017
Background Documents Nil

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

19th January 2017

Annual Report of the Older People's Champion

A LOOK BACK IN HISTORY

1. This will be my eleventh and last report to North Yorkshire County Council on my activities as your Older People's Champion. It all began in the mid-nineties when North Yorkshire bid for funding from the Government of the day, with the idea of developing a means of engaging actively with older people across the whole County so that we could consult with older people when we developed new services for them. Our bid was one of 28 across the country which was successful.

2. A forum was set up in each district and one representative from each district came together on a regular basis and formed the North Yorkshire Forum for Older People. The Project Manager was someone who is now working with Age UK in North Craven, Sue Bradley and Micky Johnson was our designated older person. Micky still works for the older people in North Yorkshire and more recently took part in the thorough review of our bus and community bus services.

3. Our first strategy was called “Our Future Lives” and when we consulted on this strategy, we soon learned that the last thing an older person wanted, was to go into a residential or nursing home at the end of their lives. The policy of changing our 29 residential homes into extra care facilities was developed following the publication of our first strategy.

4. I chaired Social Services (children and adults) at the time and in 1997 because the Government could not think of a better title, the notion of appointing Older People's Champions was born. It was believed that a member of the Executive should hold that post to give it the high profile it deserved.

5. A national review was held after 12 months and I presented at the Queen Elizabeth's Conference Hall in London. The conclusions of myself and the Director of Social Services was that my most useful role was that of a conduit between older people and the County Council and Government and essentially in that role I should develop a good network at regional and national level. The review also suggested that an executive/cabinet member did not have the time to develop the role as it should be developed. When I stepped down as Executive member of Social Services and became the executive member for Community Services and Safer Communities it gave me the opportunity to develop my role.

6. My aim was to champion opportunities for older people, ensure they were well informed so that they could make the right choices, which would improve the quality of their lives in their later years. This meant that I needed to take every opportunity to raise older people's interests and attend Seminars, Conferences so that I was up to date with Government thinking, at the same time I was a Non-Executive Director of North Yorkshire Health Authority. The County Council had ten years working with a

Health Authority which was coterminous with our own boundaries.

FUTURE YEARS THE YORKSHIRE & HUMBER FORUM ON AGEING

7. I was elected by the older people of North Yorkshire to represent them on the new Regional Forum on Ageing. I became chair of that organisation which I had helped develop with Age Concern. A position I have held for 11 years and it is through this group I have been able to develop my national interests for older people. I have held 14 workshops to raise awareness of Loneliness across Yorkshire and the Humber. Two of them in North Yorkshire at Scarborough and Harrogate.

AGE ACTION ALLIANCE

8. Five years ago, the Age Action Alliance was developed jointly by Age UK and Government its work is done through a number of working groups and Future Years joined the Isolation and Loneliness Working Group. I became a member of the Campaign to End Loneliness in the months following. I now find myself totally committed to reducing isolation and loneliness at every opportunity and this has been my objective in everything I have done as a county councillor and Campaign Ambassador during this last year.

THE PREVENTION STRATEGY

9. I was delighted when the County Council set up its Living Well Team, headed by Cath Simms, more information on which is outlined in the Appendix. Over the last 2/3 years I have worked very closely with the County Council and the villages of Gargrave, Embsay and Grassington to ensure they were able to set up their own Community libraries. The biggest percentage of the volunteers are older people and all three have become social hubs.

10. I have particularly but not exclusively, supported applications for funding from my **locality budget** from Village Hall Management Committees for building repairs and maintenance using it for this purpose means that whole communities have benefitted. Without a village hall where would local people meet and get together in such isolated villages? Where would community libraries find a home?

11. **The Venturer, the Community timetabled bus service** has been a huge success. Faced with no bus service of any description north and east of Grassington the villagers got together. I organised public meetings to discuss the situation and two villagers came forward and developed a business case for a timetabled bus service. I organised many meetings in the early stages with officers from County Hall. The targets for income have been exceeded and the service has carried many full fare paying passengers. In the height of Summer, we left people at the roadside. Definitely not one of our aims!

12. In Craven the CCG (Clinical Commissioning Group) gave funding for a pilot to develop Village Agents. I chaired the Steering Group, with the end of funding from Health we successfully applied for funding from Age UK £40,000, this enabled further work to be done by those village agents still in post.

13. Embsay particularly benefitted from the Village Agent's work and as a result a Steering Group was formed to develop **Embsay and Eastby Good Neighbours**. I co - chair this group with the Vicar of Embsay Church. This is now working well but the most asked for service is transport to hospital or the GP Practice. With the help of County (Marion Tweed Rycroft) we applied for funding from Stronger Communities

to augment the funding received initially from Rural Action Yorkshire.

14. Added to this we applied to “Awards for All” to develop a **Befriending Scheme** for Embsay and Eastby residents. The funding will provide for a co-ordinator for twelve months to continue the development of this scheme begun by our Village Agent.

15. At Buckden Parish Council meeting last month they were discussing having a village 'champion' who called on older people living alone to ensure all is well. I introduced them to Marion Tweed-Rycroft via email and I am confident something will be develop from this link and with a small grant to build a **'resilient community.**” I shall be well pleased.

FROM A NATIONAL PERSPECTIVE - THE CAMPAIGN TO END LONELINESS

16. I am now designated an **Ambassador for the Campaign to End Loneliness.** Following the successful recruitment for ambassadors who can give talks on the subject, I attended a training event in York and was asked to help with the training.

17. I was invited to speak at the launch of Leeds Beckett University and the publication of the findings from the project **“Together for Health”** funded by the DH. Some really good and sound evidence was produced for this project and a tool to measure the improvement of a person's wellbeing was used after connecting the person to a social activity. Knaresborough Age UK was a participant in this research. I was on the steering group for North Yorkshire when the project was being set up.

18. I spoke at the Annual Conference of **'Minding the Gap'**, held in Sheffield last year. I used the latest powerpoint presentation and the emphasis was on identifying those in the community who may be suffering from the effects of loneliness this was based on the publication of the 'Missing Millions', an excellent publication. The outcome of the conference was a call for the use of social prescriptions nationally.

19. I was invited to attend the Strategy meeting of the Campaign, planning for the next five years and attended the 5th birthday of the Campaign in June where the document **'The Missing Millions** was officially launched.

20. I spoke for the Campaign at a Hub event in Brighton organised by the Brighton and Hove Local Authority and at a Scrutiny meeting of Harrogate BC as an ambassador.

21. There is an increase in the number of invitations to advise and speak on the subject of loneliness. The Campaign ensures I am invited to most of the events where the publication of research on the matter of loneliness is being launched. The latest was the launch of the findings from the research done by the Red Cross and The Co-op in partnership

22. This piece of work **'Trapped in a Bubble'** concentrated on getting to a better understanding of the triggers for loneliness. The partners are setting some targets e.g. Bringing social connection to 12,500 people in England. They are to use their members to act as befrienders and to date they have raised £4m for the Campaign.

23. I have accepted an invitation to be a trustee of a soon to be launched charity **'Linking Lives UK'.** Jeremy Sharpe who has successfully launched the Link Visiting Scheme in the South of England, feels it is time to widen the opportunities for churches to bring people of all ages together across the whole of the country. Local

Churches provide unique opportunities due to the number of older and single people who attend church. **How can your church reach and support isolated older people?**

24. The Bishop of Ripon invited me to be a member of a group who are active in their faith to come together to identify the local issues of isolation. Some work has been carried out by the Diocesan Rural Officer he has developed some social activitie using the ' Men in Sheds' ideas. There is a growing number of single older men who are committing suicide and this needs to be addressed.

25. Current work in progress is the setting up of a project through my own GP Practice Manager with a local pharmacy and the Living Well officer for Craven, to identify those who may be lonely in the locality of the practice.

26. I have enjoyed my work with older people, beginning when I used to teach retired people luncheon cookery. Becoming Chair of Social Services was a turning point in my life. It was in this role that I fully recognised the great need 'out there' in North Yorkshire.

27. I must thank officers in North Yorkshire who have worked with me to achieve that which local residents in my division wanted. Libraries, Community Transport, HAS particularly in the prevention work, Highways, most recently constructed a dropped kerb to make it easy for someone with an electric wheelchair to get to her 'local shop' and lastly Education who were so supportive of me when I chaired the Governing Board of Upper Wharfedale School, with one exception, when I was not supported in my idea to federate the primary Schools in Upper Wharfedale with the UWS to develop a hub and spoke federation with one headteacher. Officers have unstintingly given of their time. No one achieves anything on their own, so having the right partners round one table is a 'given'.

28. I shall continue with:

- my national work and involvement in the Campaign to End Loneliness.(It is the only working Group of the AAA where my travel expenses are reimbursed by the DH.)

- My work with the older people in North Yorkshire, through the Yorkshire & Humber Advisory Forum.

Councillor Shelagh Marshall OBE
Older People's Champion NYCC 2017

Appendix

Living well in North Yorkshire

Working with people who are lonely or socially isolated, the Living Well team is helping people to become more connected to their communities and helping people to prevent or resolve issues before they become a crisis. By the end of December 2016, the team had responded to nearly 2000 referrals since its launch in October 2015.

The predominant reason for referral is loneliness and isolation, although most people present with several reasons, including bereavement and loss of confidence. Living Well coordinators work with individuals over an average period of 7 weeks, providing face to face information advice and guidance, support to build self-confidence, help to access community activities and practical support, for example ways of maximising a person's income.

Success is dependent on people increasing their confidence, skills and motivation to find their own solutions to improve health and well-being. The team works alongside the council's Stronger Communities team to ensure that there are a range of good quality community options in place.

The Living Well Team recently won the council's people's choice award for innovation, in recognition that the team is already making a huge contribution to the targeted prevention agenda in North Yorkshire. It is a radical, innovative approach which maximises benefits from partnerships and uses creative approaches to support individuals and achieve positive individual outcomes.

For Edna, who lives alone and felt isolated in her home after the loss of a loved one, she valued the way that Living Well took the time to get to know what was important to her and helped her to get her life back. Edna says 'I now know that there really is life after 80'

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

19th JANUARY 2017

DISCHARGES FROM HOSPITAL

1. **Purpose of Report**

1.1. The purpose of this report is to provide Care and Independence Overview Scrutiny Committee members with information about delayed discharges from hospital across North Yorkshire and plans to build upon the progress made to address delays jointly with NHS partners.

2. Background

National Context

2.1. Unnecessary delays in discharging people from hospital are a long standing issue nationally. It is a particular issue relating to older people (aged 65 and over) because according to a report by the National Audit Office[1]:-

- Older patients account for 62% of the total bed days spent in hospital
- The number of emergency admissions of older people has increased by 18% between 2010/11 and 2014/15
- 50% of older patients are admitted following a visit to accident and emergency and
- Using the only official data relating to delays in discharging patients i.e. 'delayed transfers of care' (DToC) it is estimated that 85% of patients captured by this measure are aged 65 and over.

2.2. The National Audit Office report identifies a substantial increase in bed days taken up by patients with a delayed transfer in acute hospitals of 31% over the two year period 2013 to 2015.

2.3. The main drivers for the increase are attributed to the number of days spent waiting for a package of home care and waiting for a nursing home placement or availability.

2.4. The cost to the NHS of treating older patients who no longer need to be in hospital is estimated to be £820million a year.

2.5. The impact on older people is also significant. The muscle strength that older people can lose per day of treatment in a hospital bed the report states is around 5%. The subsequent impact on a person's independence is therefore evident along with the impact on the wider care system of needing to provide support earlier than would otherwise have been the case.

[1] Discharging older patients from hospital NAO May 2016

2.6. The 2015-16 Better Care Fund (BCF) policy framework required that local areas set targets against five key metrics one of which was delayed transfers of care from hospital.

2.7. The focus on reducing these delays has been further reinforced by the 2016/17 BCF policy framework which introduced two new national conditions that required local areas to fund NHS commissioned out-of-hospital services and develop a clear, focused action plan for managing delayed transfers of care, including locally agreed targets. These conditions needed to be met along with a number of other conditions for local BCF plans to be assured by NHS England.

2.8. While 2017-19 BCF guidance has not yet been published, indications are that there will no longer be a national condition relating to DToC. It is likely however that the national DToC metric will remain. Notwithstanding this, addressing delays will continue to be an important part of local social care and health improvement plans moving forward.

What is a delayed transfer of care and how are delays reported?

2.9. A delayed transfer of care occurs when a patient is considered ready to depart from their acute or non-acute health care and is still occupying a bed. A patient is considered ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer **AND**
b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
c. The patient is safe to discharge/transfer.

2.10. There are currently two main ways of reporting delayed transfers of care. The first reports on the **number of delayed days.** NHS England compiles monthly delayed transfers of care data through a central return that is split into two parts:-

- the number of patients whose transfer of care is delayed at midnight on the last Thursday of each month.
- the total number of delayed days within the month.

2.11. Delayed transfers of care are categorised by:-

- The organisation responsible for the delay – NHS, Adult Social Care or Both;
- The reason for delay;
- The type of care the patient receives – acute or non-acute.

Data are published approximately 6 weeks after the end of each month.

2.12. The second reports on the **number of patients** affected by delayed transfers using an average number of patients per month against local population figures and is part of the Adult Social Care Outcomes Framework (ASCOF).

2.13. The Care and Support (Discharge of Hospital Patients) Regulations 2014 enables the NHS to recover reimbursement from local authorities in respect of a patient's delayed transfer of care where the local authority; namely Adult

Social Care is responsible for the delay. This is however generally seen as counter to joint working and as such few reimbursements have been sought by Hospital Trusts over the past few years.

3. Delayed Transfers of Care in North Yorkshire

3.1. Attached as appendix 1 is a performance briefing covering both the number of delayed days and the number of patients affected by delayed transfers. The report covers full year data for April 2015 to March 2016 and current performance up to October 2016. Please note the different data timeframes in the headings.

3.2. The headlines from this report are as follows:-

Financial Year Performance [April 2015- March 2016]

- For the year April 2015 – March 2016 data indicates there were **14,290** delayed transfer **days** for patients resident in North Yorkshire who were the subject of a transfer of care from hospital. [Table 1 Page 5]

- The NHS was solely responsible for **60%** (8,596) of the total delayed days with social care being solely responsible for **34%** (4,801) Both the NHS and social care were jointly responsible for the remaining **6%** (893) i.e. the patient requires both health and social care support upon discharge. [Table 2 Page 5]

Current Performance [November 2015-October 2016]

- Month by month data up to May 2016 highlighted a level of volatility in delayed days attributable to adult social care. The period June to October 2016 however shows that there has been a steady and significant increase in the number of days attributable to social care. [Chart 1 Page 1]

- Within this the following three hospital trusts currently account for **91%** of adult social care delayed days attributable to North Yorkshire
    - York 46% [70% in 2015/16]
    - South Tees 25% [0% in 2015/16]
    - Tees Esk and Wear Valleys (TEWV) Mental health provider trust 20% [20% 2015/16]

- This increase is in part explained by South Tees Hospital Trust beginning to report adult social care delays for the first time since 2014. The Trust reported 237 days attributable to social care in June 2016 which accounted for 63% of the increase in that month, and has continued to report high levels of adult social care delays rising to 460 in October 2016.

- Reporting of adult social care delays by York Teaching Foundation Trust, which covers York, Malton, Selby and Scarborough Hospitals has continued to be relatively consistent month on month. [NB the Trust is part of the Emergency Care Improvement Programme, a clinically led programme that offers intensive practical help and support to improve care]

- There has been a steady and significant rise over the year in adult social care delays reported by TEWV from 58 in April 2016 to 338 in October 2016.

Comparative Performance [April 2016-October 2016]

- In respect of **delayed days** North Yorkshire's performance compares better against shire counties than with regional authorities though rankings have slipped across all categories since April 2016.

- Compared with other counties, as at October 2016 North Yorkshire is ranked 9th lowest out of 27 (4th in 2015/16) for total delayed days and 17th (12th in April) for days attributable to adult social care [Chart 2 Page 2]

- Compared with regional authorities, as at October 2016, North Yorkshire has remained ranked 3rd highest* for days attributable to adult social care and 3rd highest (5th in 2015/16) for total delayed days [*Highest means higher number of delays] [Chart 3 Page 2]

- Comparative rankings for total delayed days are good but poorer for delays attributable to adult social care.

- Comparative performance follows a similar pattern when using the Adult Social Care Outcome Framework measure which reports the **number of patients** affected by delayed transfers. [Chart 6&7 Page 4]

Reasons for Delay [April 2015- March 2016]

- For 2015/16 the three most prevalent reasons for delays account for **56%** of **all** delayed days as follows:-
    - Patient family choice
    - Awaiting a care package in own home
    - Awaiting nursing care

  [Chart 8 Page 6]

- For **social care** delays three reasons account for **81%** of delayed days:-
    - Awaiting care package in own home **39%**
    - Awaiting residential home placement or availability **22%**
    - Awaiting nursing home placement or availability **21%**

4. Plans to address delays jointly with NHS partners

4.1. A locally agreed target and action plan for reducing delayed transfers of care has been developed as part of the 2016/17 North Yorkshire Better Care Fund plan on the basis of maintaining the outturn position for 2015/16.

4.2. This is **14,290** delayed days across the North Yorkshire and gives a rate per 100, 000 population 18+ of **244.8.** Consequently maintaining the same rate will result in a 2016/17 outturn of no more than **14,330.** See table 1 below

Table 1 Historic performance and target outturn for 2016/17

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Annual	10,970	13,939	12,004	13,225	14,290	14,330

DToC days						
Monthly average	914	1161	1000	1102	1191	1194
Population Base	484,100	484,432	487,301	489,218	486,577	487,856
Rate per month	188.8	239.8	205.3	225.3	244.8	244.8

4.3. In setting the target, consideration was given to historically good performance, the current financial context, the expected increase in population and in particular the ability of social care providers (the care market) to respond to demand and provide the right service, in the right place, at the right time and at the right price.

4.4. The care market in North Yorkshire is already operating at 90-97% capacity in different localities, five years ahead of nationally projected occupancy levels. Near full employment makes recruitment and retention particularly challenging and the transactional costs and logistical requirements of remote rural and coastal areas, means that the normal market assumptions that apply to most of England do not apply in large parts of the County.

4.5. While partners agreed that a stretch target would not be realistic at this time, there remains a strong ambition across the partnership to further reduce delayed transfers of care and improve the health and independence of local people in line with the aims of the Better Care Fund and the Joint Health and Wellbeing Strategy.

4.6. A summary action plan, which outlines the governance arrangements for each locality, is in place as part of the Better Care Fund Plan. More detailed plans are being developed and agreed at locality level jointly through transformation boards, and operationally through newly established A&E Boards (previously Systems Resilience Groups). This approach recognises the diversity of each locality within North Yorkshire.

4.7. Locality plans will reflect local population needs and ensure that all relevant acute and community trusts are engaged. Each locality will have identified delayed transfers of care leads for both health and social care who will be responsible for ensuring that progress is monitored, understood and shared.

4.8. Locality plans will address issues affecting the efficiency of existing discharge processes, and drive a better system of discharge planning by encouraging the development of proactive rather than the reactive planning that still exists in some areas.

4.9. In particular, patient journeys will be carefully scrutinised to identify improvements against the eight areas in the 'High Impact Change Model' designed to reduce delayed transfers of care as follows:-

- Early Discharge Planning
- Systems to Monitor Patient Flow
- Multi-Disciplinary Discharge Teams including the voluntary and community sector

- Home First/Discharge to Assess
- Seven-Day Service
- Trusted Assessors
- Focus on Choice and
- Enhancing Health in Care Homes.

Appendix 2 shows a more detailed description of the High Impact Change Model

4.10. Appendix 1 (Page7) shows that a number of specific actions are being taken by Health and Adult Services to address social care delays. More recent and focussed work being undertaken by the County Council to better understand performance in relation to social care delays includes the following improvements:-

- Daily communication with acute hospitals over those in DToC situations and the general position of the hospital
- Working with Hospitals to improve patient flow for non DToC patients especially over the Christmas period
- Improved communication channels at senior management level between the trusts and Health and Adult Services
- Production of a daily Health and Adult Services Situation Report.
- Weekly resilience meeting now attended by all Care and support Heads of Service and Assistant Directors
- Development of specific locality plans by Health and Adult Services to address social care delays

4.11. Performance against delayed transfers of care is reported to the North Yorkshire Health and Wellbeing Board (NYHWB) via the Joint Health and Wellbeing Strategy Performance Dashboard quarterly via a Better Care Fund briefing note to the North Yorkshire Commissioner Forum

5. Conclusions

5.1. While delays are increasing month on month it should be recognised that this is in the context of a worsening situation across the country and comparative performance in North Yorkshire remains good.

5.2. The provision of social care is critical to preventing unnecessary delays in discharge from hospital but there are some significant challenges for social care in North Yorkshire, in particular capacity within the care market and the ability of social care providers to respond to demand.

5.3. Partners are actively working together to address delayed discharges in North Yorkshire through locality transformation boards, systems resilience groups and the HWB

6. Recommendations

6.1 Care and Independence Overview Scrutiny Committee members note the content of the report and the action being taken with partners to address delays transfers of care in North Yorkshire.

Name: Michaela Pinchard
Job Title: Head of Integration
Location: HAS Building County Hall

Author: Michaela Pinchard
Contact Details: Tel 01609 532648
E-mail Michaela.pinchard@northyorks.gov.uk

Presenter of Report: Amanda Reynolds

Background Documents:
Discharging Older Patients from Hospital National Audit Office May 2016
Better Care Fund Policy Framework 2016/17 DOH & DCLG Jan 2016

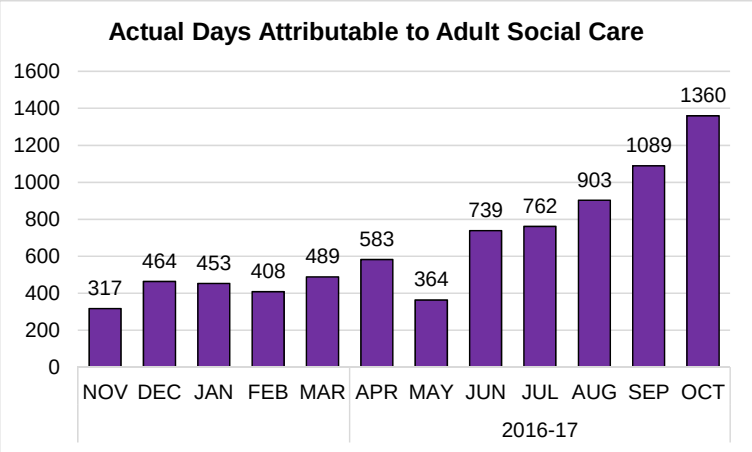
Annexes: Appendix 1 Delayed Transfers of Care Performance Briefing
Appendix 2 High Impact Change Model

Appendix 1

DELAYED TRANSFERS OF CARE PERFORMANCE

Current Performance: November 2015-October 2016

Key Trends Chart 1



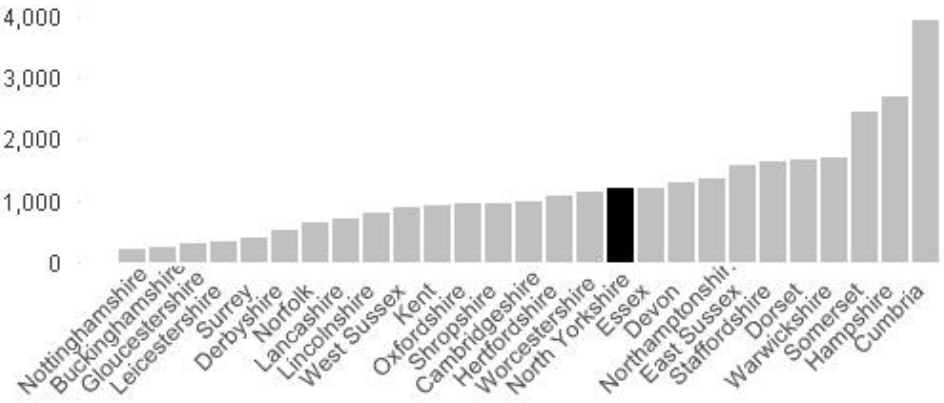
- Month by month data up to May 2016 highlighted a level of volatility in delayed days attributable to adult social care. Since June however there has been a steady and significant increase each month in the number of days attributable to adult social care.
- Within this three trusts account for 91% of adult social care days attributed to North Yorkshire: York Teaching Hospitals - 46%, South Tees - 25%, and the mental health provider trust, Tees Esk and Wear Valleys (TEWV) - 20%.
- In June 2016, South Tees reported 237 days attributable to adult social care, the first time the trust had reported adult social care days since April 2014. This accounted for 63% of the increase in June, and the trust has continued to report high levels of adult social care days each month since, rising to 460 days in October.
- The York trust accounted for 46% of North Yorkshire's adult social care days for the year to October, down from 60% in Q1 (70% in 2015/16). South Tees' share increased to 25% in October from 14% in Q1 (0% in 2015/160. York's reporting of adult social care days has been relatively consistent month on month.
- TEWV's adult social care days have shown a steady and significant rise over the year, up from 58 in April to 338 in October. TEWV is showing a significant increase across all categories of days year on year.

Comparative Performance: April-October 2016

<u>Shire Counties</u>

- Rank has slipped from 12/27 in April to 17/27 in October for days attributable to adult social care (below), maintaining mid-table performance despite the slow shift towards the worse end of the performance rankings.
- Ranked 9th lowest (best) for total delayed days, compared with 4th for 2015/16.
- Ranked 4th lowest (best) shire county for NHS days, compared with 1st for 2015/16.

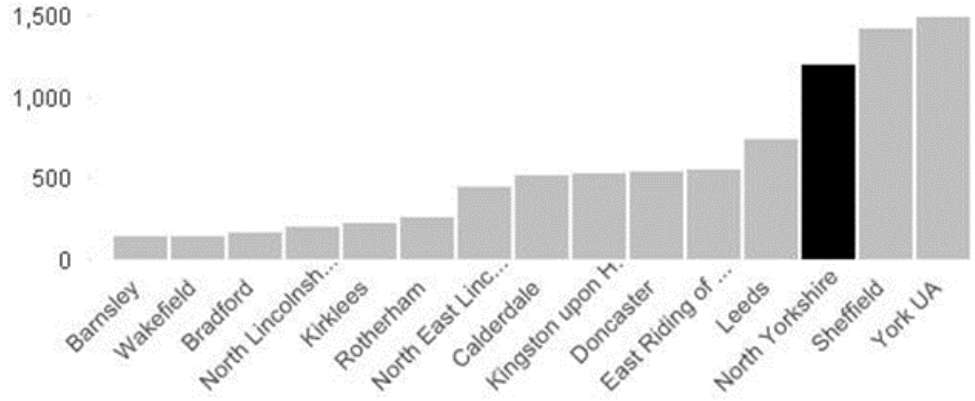
Chart 2



Regional Authorities

- Rank has remained consistently at 3rd highest (worst) for days attributable to adult social care (below), with the gap between local performance and mid-table performance increasing steadily over the year.
- Rank has worsened from 5th highest in April to 3rd highest in October for total delayed days.
- Rank down from 7/15 to 11/15 for NHS days.

Chart 3



2015-16 Financial Year Performance

Overview

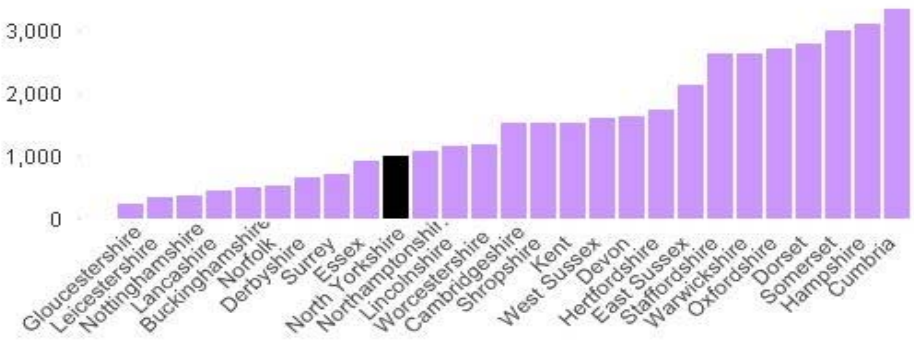
- Comparative rankings for the rate of total delayed days per 100,000 population are good, but comparative performance for days attributable to adult social care is poorer (see below).
- Delayed days attributable to adult social care were up 20% month on month in March, and total delayed days were up 7%. Year on year, adult social care days were up 83% in March compared with 45% nationally and across the region.
- North Yorkshire continued to be well below the national average for all categories of delay in March.
- Days attributable to the NHS were up 4% month on month in March, accounting for 64% of all days. NHS days were up 64% year on year in March compared with 14% nationally and 11% across the region.

Comparative Performance

Counties

- Ranked 10/27 for days attributable to adult social care (see below – rate per 100,000).
- Ranked 4th lowest (best) for total delayed days.
- Despite the sustained increase in NHS days in March, ranked as the lowest (best) shire county.

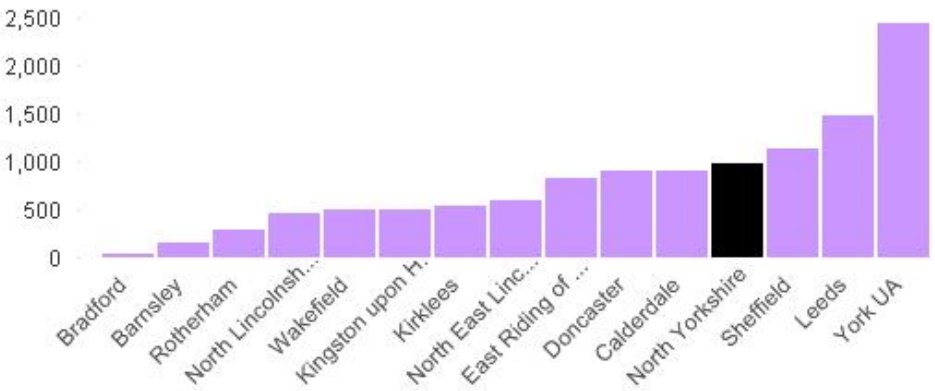
Chart 4



Regional Authorities

- Ranked 4th highest (worst) for days attributable to adult social care (see below – rate per 100,000).
- Ranked 9/15 for total delayed days.
- Ranked 6/15 for NHS days.

Chart 5



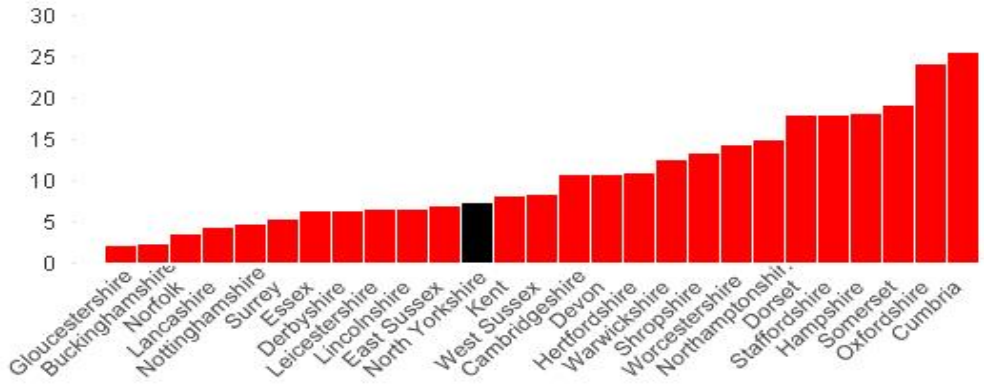
ASCOF Measures

The ASCOF measures report on the number of patients affected by delayed transfers of care, using an average number of patients per month against local population figures.

Shire Counties

- Ranked 12/27 for 'adult social care' and both adult social care and health' patients (see below). Performance as at May 2016 has improved ranking to 10/27.
- Ranked 4th lowest (best) for 'all patients'.

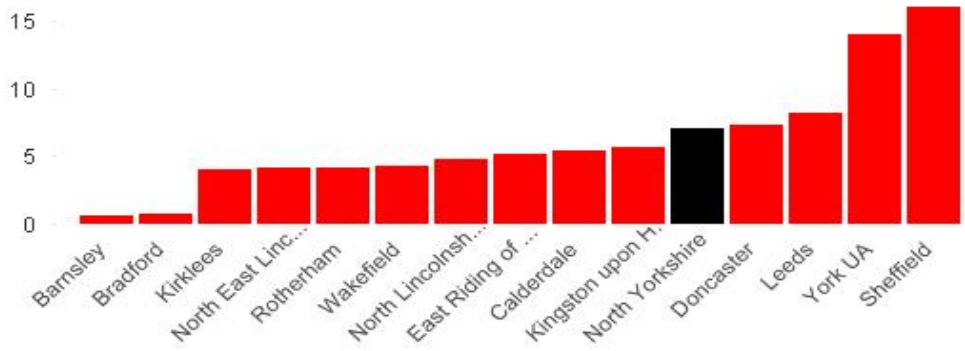
Chart 6



Regional Authorities

- Ranked 11/15 (5h worst) for 'adult social care and both adult social care and health' patients (see below). Performance as at May 2016 shows no change to ranking at 11/15.
- Ranked 8/15 for all patients.

Chart 7



2015-16 Financial Year Performance – Variations

The table below shows delayed transfer days for patients resident in North Yorkshire who were the subject of a transfer of care for the listed health trusts during 2015/16.

Table 1

	Total Days		NHS Days		Social Care Days		Both Days	
Provider Organisation	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
York Teaching Hospital NHS Foundation Trust [1]	5667	40%	2133	25%	3367	70%	167	19%
South Tees Hospitals NHS Foundation Trust [2]	3338	23%	3338	39%	0	0%	0	0%
Harrogate & District NHS Foundation Trust	2287	16%	1955	23%	281	6%	51	6%
Tees, Esk & Wear Valleys NHS Foundation Trust	1674	12%	84	1%	952	20%	638	71%
Airedale NHS Foundation Trust	652	5%	652	8%	0	0%	0	0%
Mid Yorkshire Hospitals NHS Trust	287	2%	249	3%	38	1%	0	0%
Leeds Teaching Hospitals NHS Trust	113	1%	23	0%	90	2%	0	0%
Other	272	2%	162	2%	73	2%	37	4%
Total	**14290**	**100%**	**8596**	**100%**	**4801**	**100%**	**893**	**100%**

[1]Includes York and Scarborough hospitals. [2] Includes James Cook University and The Friarage hospitals

- Two health trusts accounted for 63% of delayed days in 2015/16 (York 40% and South Tees 23%). Four trusts accounted for 91% of delayed days.
- 90% of social care days were accounted for by two trusts – York and TEWV. Whilst York accounted for 40% of total days, but accounted for 70% of social care days.
- Similarly, two trusts accounted for 90% of 'both' days – York and TEWV, with TEWV accounting for 71%.

Table 2

Provider Org Name	NHS Days	Social Care Days	Both Days
York Teaching Hospital NHS Foundation Trust	38%	59%	3%
South Tees Hospitals NHS Foundation Trust	100%	0%	0%
Harrogate & District NHS Foundation Trust	85%	12%	2%
Tees, Esk & Wear Valleys NHS Foundation Trust	5%	57%	38%
Airedale NHS Foundation Trust	100%	0%	0%
Mid Yorkshire Hospitals NHS Trust	87%	13%	0%
Leeds Teaching Hospitals NHS Trust	20%	80%	0%
Other	60%	27%	14%
Total	60%	34%	6%

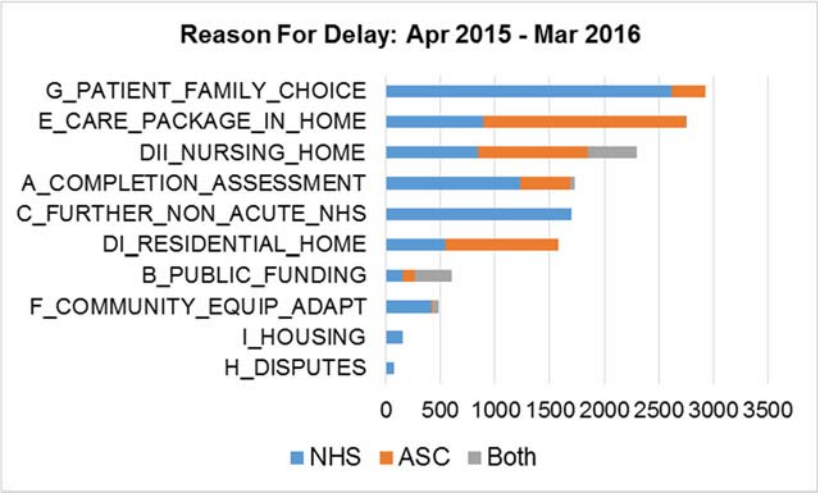
- NHS days accounted for over 60% of total days and social care days for 34%.
- Two trusts accounting for a significant proportion of total delayed days reported a majority of their delayed days as being attributable to social care – York (59%) and TEWV (57%).
- The South Tees and Airedale Trusts reported all days as being NHS attributable days.

- Only TEWV (38%) reported a significant proportion of delayed days as being attributable to both health and adult social care.

2015-16 Financial Year Performance – Reasons for Delay

- The three most prevalent reasons for delay account for 56% of all delayed days. Whilst health accounts for 55% of these days, the pattern of attribution for individual reasons is markedly different (see below).

Chart 8



- Three reasons account for 81% of delayed days attributable to social care, with one accounting for almost half of this total:

E) Awaiting care package in own home	39%
Di) Awaiting residential home placement or availability	22%
Dii) Awaiting nursing home placement or availability	21%

  - York and Harrogate broadly follow this pattern;
  - TEWV has significantly fewer delays due to E) Awaiting care package in own home (6%) and significantly more due to B) Awaiting public funding – 11% compared with 2% for the county. The latter possibly reflects the trust's policy change, whereby it wants to be involved in the review/reassessment of all cases.
  - For the Leeds Trust, all social care delays are due to A) Awaiting completion of assessment.

Specific Market issues affecting Scarborough and York Hospitals

Given that the hospitals in question cover a large geographical area, and that York District Hospital also takes in takes in a mix of patients from South Hambleton and Harrogate there are a number of reasons impacting the DToC days.

Currently, while there are a number of residential vacancies in Scarborough town, this is not reflected across the more rural parts of Scarborough District, Ryedale and Selby, with only 1 standard residential vacancy available in Selby District. Nursing vacancies are also scarce across the whole county and are often above scale rates. Geographical location and people's choice are often deciding factors in whether a vacancy is suitable or not. Two homes in Scarborough were given notice to close in mid-August

Domiciliary care is difficult to source around the county for a range of reasons, however the primary one being recruitment and retention. In Scarborough large numbers of people are employed in seasonal holiday work and across the county capacity is reduced because of holiday commitments. It is becoming increasingly difficult to source individual packages that are not in centres of population, with providers not willing to extend their services more than a few mile from these centres. The situation in Selby is further complicated by the fact that the number of main framework providers in that area has recently reduced from three to two. The loss of the bridge at Tadcaster is an on-going issue with providers reluctant to have split runs on both sides of the river.

Actions taken to reduce DToC.

- Additional assessment staff are now located in York and Scarborough Hospitals and availability of staff has been increased in the other acute hospitals.
- The “Reset” procedure for restarting existing Dom care packages following a short stay in hospital is up and working in Scarborough and Friarage Hospitals
- Some additional step down beds have been purchased at Station View as part of Harrogate Vanguard arrangements
- There is on-going work to develop the community care market (including Personal Assistant Networks) to reduce reliance on traditional home care services.
- We are working with Scarborough Hospital on a pilot “Discharge to assess” scheme for less complex cases.
- There is on-going joint work with the NHS in the Selby and Malton Hubs to reduce the numbers needing to go into hospital.
- START teams continue to rehabilitate people coming out of hospital and are supporting increased numbers of people.

More recent and focussed work being undertaken by the County Council to better understand performance in relation to social care delays includes the following improvements:-

- Daily communication with acute hospitals over those in DToC situations and the general position of the hospital
- Working with Hospitals to improve patient flow for non DToC patients especially over the Christmas period
- Improved communication channels at senior management level between the trusts and Health and Adult Services
- Production of a daily Health and Adult Services Situation Report.
- Weekly resilience meeting now attended by all Care and support Heads of Service and Assistant Directors
- Development of specific locality plans by Health and Adult Services to address social care delays

High Impact Change Model

Managing Transfers of Care

HIGH IMPACT CHANGES FOR MANAGING TRANSFERS OF CARE

- Ensuring people do not stay in hospital for longer than they need to is an important issue – maintaining patient flow, having access to responsive health and care services and supporting families are essential.

- We learnt valuable lessons from the Health and Care system across the Country last winter about what works well and we have built those into a High Impact Change model .

- This model has been endorsed in a joint meeting between local government leaders and Secretaries of State for Health and for Communities and Local Government in October.

- We know there is no simple solution to creating an effective system of health and social care, but local government , the NHS and Department of Health are committed to working together to identifying what can be done to improve our current ways of working.

A number of practical tools compliment the high impact changes for reducing transfers of care

- **NHS High Impact Changes :** Guidance for SRGs
- **Winter Pressures** : A Guide for Council Scrutiny
- **Safer, Better, Faster** : ECIST good practice guide
- **NHS England Quick Guides:** Solutions to common issues

It may also be helpful to consider:

- **Role of the Health and Wellbeing Board :** Oversight and system leadership
- **Mental Health :** Access to services and accommodation
- **Voluntary sector** : Capacity and capability
- **Telehealth and Telecare** : supporting people to remain independent

Working with local systems, we have identified a number of high impact changes that can support local health and care systems reduce delayed transfers of care…

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

We have developed this tool as part of our winter resilience sector led improvement programme

- The 8 changes which are outlined have been developed through last year's Helping People Home Team's work (a joint DH, DCLG, NHS England, ADASS and LGA programme).

- They have also been tested within a number of local systems that the Emergency Care Intensive Support Team (ECIST) have worked with.

- Given the pressures on local health and care systems, especially around patients flow and discharge, we want to support local systems with practical support.

- This tool has been developed at pace with some co-design to help local systems over this winter. It is to encourage areas to consider new interventions for this winter, but also to assess how effective current systems are working.

- Support on how to implement any of these changes is on offer from the ECIST and the LGA Care and Health improvement Advisors.

Changes

Change 1: Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Not yet established	Plans in place	Established	Mature	Exemplary
Early discharge planning in the community for elective admissions is not yet in place.	CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning.	Joint pre admission discharge planning is in place in primary care .	GPs and DNs lead the discussions about early discharge planning for elective admissions	Early discharge planning occurs for all planned admissions by an integrated community health and social care team.
Discharge planning does not start in A+E	Plans are in place to develop discharge planning in A+E for emergency admissions	Emergency admissions have a provisional discharge date set in within 48hrs	Emergency admissions have discharge dates set which whole hospital are committed to delivering	Evidence shows X% patients go home on date agreed on admission

Changes

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Not yet established	Plans in place	Established	Mature	Exemplary
No relationship between demand and capacity in care pathways Capacity available not related to current demand Bottlenecks occur regularly in the Trust and in the community There is no ability to increase capacity when admissions increase – tipping point reached quickly Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Analysis of demand underway to calculate capacity needed for each care pathway Analysis of demand variations underway to identify current variations Analysis of causes of bottlenecks underway and practice changes being designed Analysis of admissions variation ongoing with capacity increase plans being developed Staff training in place to ensure understanding of the need to increase senior clinical capacity	Policy agreed and plan in place to match capacity to care pathway demand Analysis completed and practice change rolled out across Trust and in community Analysis completed and practice changes being put in place and evaluated Staff understand the need to increase capacity when admissions increase Staff understand the need to increase senior clinical support when necessary	Capacity usually matches demand along the care pathway Capacity usually matches demand 24/7 to match real variation Bottlenecks rarely occur and are quickly tackled when they do Capacity is usually automatically increased when admissions increase Senior clinical decision making support is usually available and increased when necessary	Capacity always matches demand along the whole care pathway Capacity always matches demand 24/7 reflecting real variations There are no bottlenecks caused by process or supply failure Capacity is always automatically increased when admissions increase Senior clinical decision making support available and increased automatically when necessary to carry out assessment and reviews 24/7

Changes

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.
Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Not yet established	Plans in place	Established	Mature	Exemplary
Separate discharge planning processes in place	Discussion ongoing to create Integrated health and ASC discharge teams	Joint NHS and ASC discharge team in place	Joint teams trust each others assessments and discharge plans	Integrated teams using single assessment and discharge process
No daily MDT meeting in place	Discussion to introduce MDTs on all wards with Trust and community health and ASC	Daily MDT attended by ASC, voluntary sector and community health	Integrated teams cover all MDTs including community health provision to pull patients out	Integrated service supports MDTs using joint assessment and discharge processes
CHC assessments carried out in hospital and taking “too” long	Discussion between CCG and Trust to establish discharge to assess arrangements	Discharge to assess arrangements in place with care sector and community health providers	CHC and complex assessments done outside hospital in peoples homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges

Changes

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Not yet established	Plans in place	Established	Mature	Exemplary
People are still assessed for care on an acute hospital ward	Nursing capacity in community being created to do complex assessments in the community	People usually return home with reablement support for assessment	People return home with reablement support from integrated team	All patients return home for assessment and reablement after being declared fit for discharge
People enter residential /nursing care too early in their care career	Systems analysing which people can go home instead of into care – plans for self funder advice	People usually only enter a care / nursing home when their needs cannot be met t through care at home	Most people return home for assessment before making a decision about future care	People always return home whenever possible supported by integrated health and social care support
People wait in hospital to be assessed by care home staff	Work being done to identify homes less responsive to assess people quickly	Care homes assess people usually within 48 hours	Care homes usually assess people in hospital within 24 hours	Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours

Changes

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Not yet established	Plans in place	Established	Mature	Exemplary
Discharge and social care teams assess and organise care during office hours 5 days a week	Plan to move to 7 day working being drawn up	Health and social care teams working to new 7 day working patterns	Health and social care teams providing 7 day working	Seamless provision of care regardless of time of day or week
OOHs emergency teams provide non office hours and weekend support	New contracts and rotas for health and social care staff being drawn up and negotiated	New contracts agreed and in place	New staffing rotas and contracts in place across all disciplines	New staffing rotas and contracts in place and working seamlessly
Care services only assess and start new care Monday – Friday	Negotiations with care providers to assess and restart care at weekends	Staff ask and expect care providers to assess at weekends	Most care providers assess and restart care at weekends	All care providers assess and restart care 24/7
Diagnostics ,pharmacy and patient transport only available Mon-Fri	Hospital departments have plans in place to open in the evenings and at weekends	Hospital departments open 24/7 whenever possible	Whole system commitment usually enabling care to restart within 24hrs 7 days a week	Whole system commitment enabling care always to restart within 24hrs 7 days a week

Changes

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Not yet established	Plans in place	Established	Mature	Exemplary
Assessments done separately by health and social care	Plan for training of health and social care staff	Assessments done by different organisations accepted and resources committed	Discharge and social care teams assessing on behalf of health and social care	Integrated assessment teams committing joint pooled resources
Multiple assessments requested from different professionals	One assessment form /system being discussed	One assessment format agreed between organisations /professions	Single assessment in place	Resources from pooled budget accessed by single assessment without separate organisational sign off
Care providers insist on assessing for the service or home	Care providers discussing joint approach of assessing on each others behalf	Care providers share responsibility of assessment	Some care providers assess on each others behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system

Changes

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Not yet established	Plans in place	Established	Mature	Exemplary
No advice or information available at admission No choice protocol in place No voluntary sector provision in place to support self funders	Draft pre admission leaflet and information being prepared Choice protocol being written or updated to reduce < 7 days Health and social care commissioners co designing contracts with voluntary sectors	Admission advice and information leaflets in place and being used New choice protocol implemented and understood by staff Voluntary sector provision in place In the Trust proving advice and information	Patients and relatives aware that they need to make arrangements for discharge quickly Choice protocol used proactively to challenge people Voluntary sector provision integrated in discharge teams to support people home from hospital	Patients and relatives planning for discharge from point of admission All staff understand choice and can discuss discharge proactively Voluntary sector fully integrated as part of health and social care team both in the trust and the community

Changes

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Not yet established	Plans in place	Established	Mature	Exemplary
Care homes unsupported by local community and primary care	CCG and ASC commissioners working with care providers to identify need	Community and primary care support provided to care homes on request	Care homes manage the increased acuity in the care home	Care homes integrated into the whole health and social care community and primary care support
High numbers of referrals to A+E from care homes especially in evenings and at weekends	Specific high referring care homes identified and plans in place to address	Dedicated intensive support to high referring homes in place	No unnecessary admissions from care homes at weekends	No variation in the flow of people from care homes into hospital during the week
Evidence of poor health indicators in CQC inspections	Analysis of poor care identifies homes where extra support and training needed	Quality and safeguarding plans in place to support care homes	Community health and social care teams working proactively to improve quality in care homes	Care homes CQC rates reflect high quality care

Impact Change	Where are you	What do you need to do	When will it be done by	How will you know it is successful
Early Discharge Planning				
Systems to Monitor Patient flow				
Multi-Disciplinary Multi-Agency Discharge Teams (Including Voluntary and Community sector)				
Home First Discharge to Assess				
Seven-Day Services				
Trusted Assessors				
Focus on Choice				
Enhancing Health in Care homes				

Contact details

Sarah Mitchell

Director Towards Excellence in Adult Social Care Programme(TEASC), Local Government Association

sarah.mitchell@local.gov.uk

Better Care Exchange website

https://bettercare.tibbr.com/tibbr/web/login

Emergency Care Improvement Programme website

http://www.ecip.nhs.uk/

NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

19 January 2017

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 Public Health items:

North Yorkshire Horizons

3.1. At its meeting last year the committee met representatives of the providers of the service "New Horizons", the specialist drug and alcohol service commissioned by public health. Shortly after this your Chairman and I attended a presentation on the evaluation conducted by Liverpool John Moores University. A copy of the summary report is attached.

Yorsexualhealth

3.2. From April 2013, North Yorkshire County Council became responsible to arrange for the provision of open access sexual health services for everyone present in their area. Last year, group spokespersons received a presentation at the start of the commissioned service. One year on, Georgina Wilkinson (Public Health) and Tina Ramsey from YorSexualHealth, the provider, presented an update. Recognising that this issue had not yet been aired in full committee, and mindful of the significant reach of the service, your group spokespersons have arranged for a presentation to be made at your meeting.

4.0 Emerging thoughts on Commissioning and the Continuing Dialogue with Social Care Providers

4.1. You have held a number of planned conversations with providers and organisations that provide social care services in partnership and/or via the council's commissioning.

4.2. Group spokespersons talked about their initial views and findings. For those members, what stands out is the positive and constructive relationship between

all the providers and the directorate, as commissioner.

4.3. When reporting to Council, the Chairman added his perspective on some initial reactions from these conversations:

a) Effective action is best delivered in partnership;
b) There is good understanding the needs of users and other communities by engaging with the third sector organisations to access their specialist knowledge;
c) It is important to consult potential providers well in advance of commissioning new services, working with them to set priority outcomes;
d) Contracting processes and subsequent communication with providers is transparent and fair;
e) Contracts facilitate risk sharing, wherever appropriate, as a way of achieving efficiency and effectiveness;
f) There is regular review of the impact that the service is having;
g) There is a determination to seek and use feedback from service users, communities and providers so that commissioning is in tune with local needs;
h) Contract monitoring is good, but because there is good information sharing, terms can be flexible, allowing appropriate changes to be made.
i) The success of these contractual relationships stems in part from people's willingness to use resources imaginatively rather than protectively.

4.4. Members will remember the Framework Domiciliary Care Providers stressing 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. You heard similar comments from others, but not, perhaps, with the same high degree of anxiety.

4.5. Admittedly we have just scratched the surface of social care commissioning complexities and the state of the social care market, but group spokespersons are keen to capture these findings.

4.6. In terms of other work, group spokespersons also want to move the issue a step forward by reviewing the linkages between strategic policies and commissioning, and the commissioning process; a focus on how service user and provider views are harnessed to ensure commissioning is in tune with local needs; and how we guarantee compliance with the very best practice standards.

4.7. In what will be the fourth of our series of conversations with providers, you turn next to Supported Employment - an in-house service for supporting people with significant disabilities to secure and retain paid employment.

5.0 Botton Village: Yorkshire Coast and Moors Area Committee

5.1. An update on Botton Village was given considered at the Yorkshire Coast and Moors Area Committee. At the conclusion of the debate, the area committee again asked the Care and Independence Overview and Scrutiny Committee to look into the situation at Botton.

5.2. When you were last updated on events at Botton Village, you decided not to act on a similar request from the area committee. In essence, you wanted to maintain a neutral stance. Your reasons for doing so were:

- *The relationship between the Trust and the co-workers is an internal business matter.*
- *How the current dispute regarding that relationship is resolved is an internal operational matter for the Camphill Village Trust.*
- *It would not be appropriate to scrutinise the preferred care arrangements of one particular provider.*
- *The Committee's remit it exercises its responsibilities towards vulnerable adults in a strategic way in the context of policy development and review, not by reviewing the individual circumstances of service users and/or how individual providers work with and support them.*
- *The Committee was mindful that the legal proceedings have yet to run their full course. Any scrutiny work whilst legal action was continuing would be not only premature, but also inadvisable.*
- *The contribution that Botton makes of the wider community is essentially a local matter; it is primarily, therefore, an Area Committee concern.*

5.3. That said, Members acknowledged that this was a complicated issue and one in which many people believed Members could legitimately could take an interest. Recognising this, the committee agreed that the most practical approach was for group spokespersons to keep a weather eye on developments, principally through HAS Officer briefings, but have the discretion to refer the matter back to the committee should there be any significant developments.

5.4. On each such occasion when group spokespersons have been updated, they have decided that whilst there might have been developments - some of these being acknowledged as significant as a local level - there has been nothing in the information presented that would warrant referring the matter to full committee and/or a departure from the decision to take a neutral position.

5.5. **Members instructions are sought on the request from the Area Committee**

6.0 Safeguarding Training

6.1. An update will be given at the meeting on plans to hold a workshop/training session on adults safeguarding for members of this committee. Current thinking is to convene this on the Thursday 2 March 2017, the date of the next Mid Cycle Briefing.

7.0 Recommendations

7.1. This committee is recommended to consider the attached work programme and determine whether any further amendments should be made at this stage.

DANIEL HARRY
SCRUTINY TEAM LEADER
County Hall,
Northallerton

Author and Presenter of Report: Ray Busby
Contact Details: Tel: 01609 532655
E-mail: ray.busby@northyorks.gov.uk
9 January 2017

Care and Independence Overview and Scrutiny Committee

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 Details

Committee Meetings	Thursday 19 January 2017 at 10.30am
	Thursday 27 April 2017 at 10.30am
	Thursday 29 June 2017 at 10.30am
	Thursday 28 September 2017 at 10.30am
	Thursday 14 December 2017 at 10.30am
	Thursday 22 March 2017 at 10.30am
Mid Cycle Briefings	Thursday 2 March 2017 at 10.30am
	Thursday 11 May 2017 at 10.30am
	Thursday 24 August 2017 at 10.30am (date may be changed)
	Thursday 9 November 2017 at 10.30am
	Thursday 15 February 2017 at 10.30am

Programme

BUSINESS FOR THURSDAY 19 JANUARY 2017			
SUBJECT	**AIMS/PURPOSE**	**COMMENTS**	**LEAD**
Supported Employment	A dialogue with leadership and personnel from the North Yorkshire Supported Employment Service focussing on outcomes for service users and performance against National Occupational standards.	Part of the series of conversations with social care providers with whom the authority has a contractual and/or partnership relationship.	Joss Harbron (HAS)

BUSINESS FOR THURSDAY 19 JANUARY 2017			
Yorsexual Health Service	Dialogue with provider one year into the commissioned service.	Update on service refereand attendance by the Service Managers	Public Health
Substance Misuse Service (New Horizons)	Group Spokespersons to report on their dialogue with provider now that the commissioned service is into its second year.	Update on service with short written briefing and attendance by the Service Managers	Public Health
Delayed Transfers of Care	Information about delayed discharges from hospital across North Yorkshire and plans to build upon the progress made to address delays jointly with NHS partners.		Michaela Pinchard
Older Peoples Champion Annual Report	County Councillor Shelagh Marshall's reports on her activities as Older Peoples Champion		Shelagh Marshall
BUSINESS FOR THURSDAY 27 APRIL 2017			
SUBJECT	**AIMS/PURPOSE**	**COMMENTS**	**LEAD**
Dialogue with Care Quality Commission Representative	Follow up to discussion with CQC about inspection regime.		
START/ in house Domicilliary Care	A possible Q and A session with in-house providers.	To be agreed by Group Spokespersons	Dale Owens/Joss Harbron
Assessment Reablement Pathway	Update		Mike Webster
Independent Advocacy	Dialogue with Providers		Avril Hunter

Mid Cycle Briefing Items

Date	Probable Item
2 March 2017	Complaints and Commendations
	Possible NYLAF update
	NY Alcohol Strategy Update
	Assessment Reablement Patthway Update

Date	Probable Item
	Suicide Audit report
	Commissioning - linkages between strategic policies and commissioning, and the commissioning process

An Evaluation of North Yorkshire Horizons Drug and Alcohol Treatment and Recovery Service

PHI Public Health Institute
LIVERPOOL JOHN MOORES UNIVERSITY

BACKGROUND

Public health involves doing work to help people to live healthy lifestyles, prevent disease and help people live for longer. In the UK, substance misuse (the use of drugs and/or alcohol which is harmful for health) is a particular public health problem. Substance misuse is known to cause diseases and early death. In 2014, one in every nine people in their 20s and 30s who died did so because of drug misuse. In 2013/14, over one million admissions to hospital were linked to alcohol. The UK government recognise the importance of investing in services to help reduce the number of people affected by substance misuse.

In the past, services have focused on helping someone to stop using drugs and/or alcohol. More recently, there has been a focus on also encouraging these people to address the wider problems that might be caused by (or be causing) their dependence on drugs and/or alcohol. For example, helping someone to develop friendships, get a job, live in stable housing and improve any money problems can be important in helping a person to stop using drugs and/or alcohol. Support from other people can be particularly important in helping people feel comfortable to access services and in developing friendships and positive relationships with other people.

HELPING PEOPLE TO REDUCE AND STOP HARMFUL DRUG/ALCOHOL USE IN NORTH YORKSHIRE…

North Yorkshire County Council understand the importance of helping people affected by substance misuse to get as much support as possible. In October 2014, they started a service called North Yorkshire Horizons. This helps people to get the treatment they need to reduce and stop using drugs and/or alcohol and also helps them to get the wider support they need. This includes:

- Support to improve their mental health
- Meeting people in similar situations to share experiences and problems
- Support with housing and advice on debt
- Opportunities to volunteer and support to get a job

To learn if and how this service helps people, researchers from the Public Health Institute (PHI) at Liverpool John Moores University (LJMU) conducted an evaluation.

The service is delivered in two ways: a ***Treatment arm***: support for people to reduce their substance misuse and a ***Recovery and Mentoring arm***: supporting recovery and transition from structured treatment, helping people get the wider support they need.

WHAT DID THEY DO?

Researchers used a number of different methods to find out who had used North Yorkshire Horizons and how it had helped them. The evaluation commenced in October 2014 and finished in October 2016. Data were collected over an 18-month period. Researchers gained ethical approval from LJMU to carry out the research to make sure that all people using, delivering and managing the service would be treated open and fairly in the research, and to make sure everyone had opportunity to fully consent to taking part. Researchers looked at:

Information collected about the people that had used the service: This included information collected by the service about the types of people using the service, their history of substance misuse, service waiting times, the types of treatment they received and treatment outcomes (including information collected using a tool called the 'Sundial Outcomes Monitoring Tool' - this tool was a locally modified version of a validated outcomes tool). Researchers also used a number of different tools to look at how the service affected quality of life and mental health. The tools used were:

- The Alcohol Use Disorders Identification Test (AUDIT)
- The Generalized Anxiety Disorder (GAD-7) validated questionnaire
- The Patient Health (PHQ9) validated questionnaire
- The EuroQol five dimensions questionnaire (EQ-5D)
- The severity of alcohol dependence questionnaire (SADQ)

This information was collected by the people delivering the North Yorkshire Horizons services, and was sent to researchers at PHI in a safe and secure way.

Information about the cost of the service

Researchers carried out work to find out if the service was good value for money. Researchers used the information collected about the people who had used North Yorkshire Horizons to predict the costs and benefits of the service. The information used in this evaluation was the economic value of quality of life improvements (measured through the Treatment Outcome Profiles and the EQ-5D quality of life questionnaire). The evaluation specifically focussed on alcohol related hospital admissions, and on drug and alcohol-related crime and antisocial behaviour. The majority of the economic analysis is based only on these outcomes.

The cost effectiveness work did not include the Needle and Syringe Exchange (because there is a lot of evidence already which says they provide value for money), the Residential Detox and Rehabilitation part of the service (because only 1% of North Yorkshire Horizons clients used this service and we already know this type of service is very costly; it can take up to 12 years to see the value for money in this type of service) or the positive benefits of drug use.

Information from people who had delivered or worked with the service

To find out people's views and experiences of how the service was delivered, good and bad points, and ways it could be improved, researchers carried out 15 interviews with

- Managers and staff from North Yorkshire Horizons
- Professionals from North Yorkshire County Council who developed the service
- Staff from partner organisations (such as health, criminal justice and children's services

All staff involved in delivering the service were invited to take part in an interview. Professionals from North Yorkshire County Council identified key people to be included in the interview.

Information from people who had used the service

To find out people's experiences of using the service and the ways in which it had affected them, researchers carried out 27 interviews with people. It was important to make sure a range of people were included in the research, so people from different locations with different experiences were invited to take part. Key workers from within the services displayed posters and information about the research and provided the research team with the contact details of anyone who wanted to take part.

WHAT DID THEY FIND?

Who used North Yorkshire Horizons?

- Across an 18-month reporting period a total of **2,582** individuals accessed structured treatment interventions provided by North Yorkshire Horizons (or based in GP practices and supported by North Yorkshire Horizons).
- **532** individuals were engaged with criminal justice interventions provided by North Yorkshire Horizons.
- **878** individuals accessed needle exchange services, this included North Yorkshire Horizons hub based services and pharmacies.
- **1064** individuals engaged with the Recovery & Mentoring Service; **889** of these were individuals who had completed structured treatment within North Yorkshire Horizons.

2,582

Number of individuals who accessed structured treatment interventions provided by North Yorkshire Horizons

1,064

Number of individual engaged with the Recovery & Mentoring Service

A substance misuse profile of services is detailed here:

Drug profile 4 groups	Opiate		Non-opiate		Non-opiate and alcohol		Alcohol only		Total	
	n	%	n	%	N	%	n	%	n	%
Structured	1106	42.8	252	9.8	151	5.8	1073	41.6	2582	100
Criminal Justice	161	31.0	214	41.2	72	13.8	73	14.0	532	100
Needle exchange	722	82.2	153	17.4	3	0.3	0	0	878	100
R&M	319	30.0	89	8.4	67	6.3	589	55.4	1064	100

How many people were referred to North Yorkshire Horizons?

- North Yorkshire Horizons received **4,711** referrals during the first 18 months of service. This includes all referrals that were made through the Single Point of Contact.
- Self-referrals made up **40.1%** of all referrals; this number has increased since the service was introduced (the figure was 15.1%).
- Referrals from criminal justice also increased (from 4.4% to **11.2%**).

What treatment did people use?

- **2846** interventions were accessed by the **2582** individuals during the **18** month evaluation.
- For clients accessing structured treatment, most accessed psychosocial interventions (52%), pharmacological interventions (30.2%) and recovery support (17.8%).

What impact did the service have?

Using the information collected about the people using the services, **3,379** improved self-outcomes were recorded for 890 individuals whilst accessing treatment. These included:

- Improved coping skills (**19.5%**)
- Family relationships (**12.8%**)
- Life skills (**12.2%**)
- Physical health (**10.5%**)
- Mental health (**10.4%**)

Additional outcome measures showed a **reduction in substance use and injecting** between first and last assessments, and also showed an increase in quality of life and health and wellbeing scores. The SADQ tool showed a **reduction in the severity of alcohol dependence**.

The Sundial Outcomes Monitoring Tool also measured progress across six key outcomes including secure base, inclusion, supportive relationships, identity, coping strategies and goals. Additional outcomes were also monitored by the Recovery and Mentoring Service. Overall **446** positive/improved individual outcomes were reported during the evaluation period. This included **195** positive outcomes for clients engaged in education, and **251** reported as having 'no housing problem'.

Information gathered by interviewing people who used North Yorkshire Horizons talked in more depth about the positive outcomes they had experienced. Many highlighted improved relationships with family and friends.

> *"I've got my granddaughter back. I see her all the time. The kids come to the flat now." (Service User 10, Treatment and Recovery Mentoring Service Skipton)*

Others described how their physical and mental health had improved as a result of the service, either through helping them attend medical appointments, supporting them with welfare advice, or providing various group sessions for them to attend.

"They gave me not only a reason to live but they also helped show me what the reason was and helped me to get to where I am now." (Service User 1, Treatment Skipton)

DID THE SERVICE PROVIDE VALUE FOR MONEY?

Spend on substance misuse services is low in North Yorkshire compared to similar local authorities. Results from the cost effectiveness analysis suggest that North Yorkshire Horizons can be considered cost effective for all substance groups (e.g. opiates and alcohol), and for many substance groups would be cost saving to the public purse in the long-term.

The groups where the biggest gains are likely to be achieved are the two alcohol groups: alcohol only and non-opiate and alcohol; who on average gained the equivalent of 8 years of full health (QALYs) over their lifetime through having access to North Yorkshire Horizons, and having access to the services may produce healthcare and crime cost savings of around £50k-£60k per service user over their lifetime. The opiate user groups gained around the equivalent of 3 years of full health over their lifetime and had lifetime cost savings of around £72k.

Overall the results suggest that investment in adult drug and alcohol services in North Yorkshire is a cost effective use of resources and generates a high return on investment.

HOW EFFECTIVE IS THE MODEL OF A TREATMENT AND RECOVERY & MENTORING SERVICE?

North Yorkshire Horizons provides a cost-effective service which supports a reduction in substance use and injecting. The service also has a positive impact on wider outcomes, including mental wellbeing, physical health, relationships and life skills. Specific elements of the service that were found to be particularly important were:

- ***The flexibility of having a combined treatment and recovery service which could be adapted to suit the needs of the service users:*** *"The service is being commissioned to work with everything from alcohol to opiates, to cannabis, to your legal highs." (Stakeholder 15)*
- ***The referral process and Single Point of Contact allowed a wide range of pathways to people to get access to the service:*** *"You can phone up at any time and there is support there straight away for you, it's not a case of 'oh I can't fit you in till next week', it's a case of 'well can you get down within the next half hour and we will have a chat'." (Service User 12, Treatment and Recovery Mentoring Service Scarborough).*
- ***The staff and peer support element provided a friendly and supportive atmosphere:*** *"When they all merged into Horizons the difference was massive. There is more support there now. There are more activities to do, there is more group work… If somebody's feeling down, they can just drop in whereas before if you'd have dropped in, they'd have been saying 'you've not got an appointment'." (Peer Mentor 2, Recovery Mentoring Service Scarborough)*
- ***Increased visibility of people using substance misuse services within the community and overcoming stigma:*** *"Visible recovery and visible recovery communities will raise the profile of people who have stopped using… I think the recovery community has helped with the stigma if they are visible." (Stakeholder 14)*

COULD THE MODEL OF DELIVERY BE IMPROVED?

Although the evaluation showed North Yorkshire Horizons to be effective and cost-effective, the evaluation found that the numbers of service users who complete treatment and move from treatment into recovery could be improved. Addressing these recommendations may help:

Encourage service users to volunteer to become peer mentors and ensure that all those who are suitable and wish to volunteer receive appropriate support and training. Peer mentors need to be carefully managed and monitored.

Opportunities to work with new partners should be explored, to continue to enable the service to provide a wide range of support.

Continue to use community settings for meetings and continue to expand the number of locations. Providing meetings for specific groups should be explored.

The flexibility of the service was important and should be continued. Additional out of hours support and support for relatives should be considered.