Agenda

Meeting: Care and Independence Overview & Scrutiny Committee

Venue: Brierley Room, No 3 Racecourse Lane Northallerton DL7 8QZ

Date: Thursday 26 September 2019 at 10am

The Brierley Building (main County Hall building) is closed now until July 2020. All Committee meetings will be held in either No. 1 or No. 3 Racecourse Lane, Northallerton, DL7 8QZ. Please note the venue above for the location of this meeting. Please report to main reception which is located in No. 3 Racecourse Lane

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PLEASE NOTE START TIME OF MEETING

Business

1. **Minutes of the meeting held on 27 June 2019** **(Pages 5 to** 9**)**

2. **Any Declarations of Interest**

3. **Public Questions or Statements.**

Members of the public may ask questions or make statements at this meeting if they have delivered notice (to include the text of the question/statement) to Ray Busby of

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

Policy & Partnerships *(contact details below)* no later than midday on Monday 23 September 2019. 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.

PROVISIONAL TIMINGS

4. **Chairman's remarks - Any correspondence, communication or other business brought forward by the direction of the Chairman of the Committee. (FOR INFORMATION ONLY)** ***10-10.10am***

5. **Mental Health: Implementation and Pathway– Presentation** by Chris Jones-King Corporate Director of Health and Adult Services ***10.10-10.50am***

(Pages 10 to 29)

6. **Budget Position: Operational Actions overspend update –** Report by Corporate Director of Health and Adult Services ***10.50 – 11.15am***

(Pages 30 to 35)

7. **Living Well Evaluation–** Presentation by Corporate Director of Health and Adult Services ***11.15-11.50am***

(Pages 36 to 46)

8. **Assistive Technology: Independent Living –** Report by Corporate Director of Health and Adult Services ***11.50am-12.20pm***

(Pages 47 to 53)

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

(Pages 54 to 57)

10. **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.

18 September 2019

NOTES:

Emergency Procedures for Meetings

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

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

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

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

Care and Independence
Overview and Scrutiny Committee

Membership

County Councillors (13)				
	Councillors Name	*Chairman/Vice Chairman*	*Political Group*	*Electoral Division*
1	BROADBANK, Philip		Liberal Democrat	Harrogate Starbeck
2	BROADBENT, Eric		Labour	Northstead
3	CHAMBERS, Mike MBE		Conservative	Ripon North
4	ENNIS, John		Conservative	Harrogate Oatlands
5	GOODRICK, Caroline		Conservative	Hovingham and Sheriff Hutton
6	GRANT, Helen	Vice-Chairman	NY Independents	Central Richmondshire
7	JEFFELS, David		Conservative	Seamer and Derwent Valley
8	JENKINSON, Andrew		Conservative	Woodlands
9	LUMLEY, Stanley		Conservative	Pateley Bridge
10	MANN, John		Conservative	Harrogate Central
11	MARTIN, Stuart MBE		Conservative	Ripon South
12	SEDGWICK, Karin	Chairman	Conservative	Middle Dales
13	TROTTER, Cliff		Conservative	Pannal and Lower Wharfedale

Members other than County Councillors – (3)			
Non Voting			
	Name of Member	*Representative*	*Substitute Member*
1	QUINN, Jill	Dementia Forward	
2	PADGHAM, Mike	Independent Care Group	
3	VACANCY		

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

Con	**Lib Dem**	**NY Ind**	**Labour**	**Ind**	**Total**
10	1	1	1	0	13

2. Substitute Members

Conservative		**Liberal Democrat**	
	Councillors Names		*Councillors Names*
1	MOORHOUSE, Heather	**1**	GRIFFITHS, Bryn
2	PLANT, Joe	**2**	
3	PEARSON, Chris	**3**	
4	ARNOLD, Val	**4**	
5	LUNN, Cliff	**5**	
NY Independents		**Labour**	
	Councillors Names		*Councillors Names*
1		**1**	COLLING, Liz

`North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

Minutes of the meeting held on Thursday 27 June 2019 at 10.00am at County Hall, Northallerton.

Present:-

County Councillor Karin Sedgwick in the Chair.

County Councillors: Cllrs Philip Broadbank, Eric Broadbent, Mike Chambers MBE, Caroline Goodrick, Helen Grant, David Jeffels, Andrew Jenkinson, Stanley Lumley and Stuart Martin MBE and.

In attendance:
County Councillors Caroline Dickinson (Executive Member for Adult Social Care).

Officers: Toya Bastow (Direct Payments Support Service Manager, Care and Support (HAS)), Ray Busby (Scrutiny Support Officer), Joss Harbron (Head of Provider Services, Care and Support (HAS)), Chris Jones-King (Assistant Director Care and Support, Health and Adult Services), Cara Nimmo, Head of Craven Locality and Care and Support Portfolio (HAS), Cath Simms, Head of Targeted Prevention, Care and Support (HAS), Louise Wallace (AD Health and Integration, Commissioning (HAS)).

Apologies:
County Councillors John Ennis and John Mann
Voluntary and Community Sector: Independent Sector: Mike Padgham (Independent Care Group) and Jill Quinn (Dementia Forward)

Copies of all documents considered are in the Minute Book

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190. Minutes

Resolved –

That the Minutes of the meeting held on 4 April 2019 having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

191. Declarations of Interest

There were no declarations of interest to note.

192. 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.

193. Chairman's Remarks

Cllr Karin Sedgwick thanked her predecessor, John Ennis, for everything the committee accomplished, for handing over the committee's business in such good health, and for his guidance about the committee's work.

194. Supporting People with Learning Disabilities in North Yorkshire

Considered

Presentation by Cara Nimmo, Head of Craven Locality and Care and Support Portfolio (HAS)

Cara advised that In North Yorkshire it is estimated that there are 11,338 people with a learning disability aged 18-85. This is predicted to rise to 11,870 by 2030, Launched in June 2017, the Health and Well Being Boards "Live Well, Live Longer" strategy for people with Learning Disabilities was created in consultation with people who have a Learning Disability in North Yorkshire. It is grounded in a partnership approach between NYCC & NHS partners.

Since April 2017 assessment staff throughout the whole of Adult social care pathway work with and support adults with Learning Disability

Across the County there are around 200 Supported Living properties, housing over 500 people, so it is essential that we ensure services and properties are good quality and provide value for money. A programme of work was started in September 2018 to provide a strength based assessment for all adults with Learning Disability, residing in supported living accommodation. The aim is to focus on individuals strengths and promote maximum independence.

Cara highlighted the work of the Learning Disability Partnership Board as an effective user-led body. Members mentioned the previous work they had undertaken which highlighted the value and strength of our approach to user engagement and empowerment.

On the basis of what Members heard, they concluded that:

- Overall governance arrangements appear to be sound.
- The service is looking at people's strengths and skills to help them live in the community. Support is focussed on the person
- There is a good organisational culture and the directorate is determined to build on that and move forward.
- Services are being planned around people's skills and interests. We are supporting the person to have an ordinary and meaningful life

Resolved –

a) That the report be noted.
b) The Chairman report the committee's conclusions in her statement to council, emphasising the committee's view that the directorate's actions are consistent with the aims of the strategy that people with a learning disability should have the opportunity to live long and healthy lives.

195. Update on the All Age Autism Strategy and implementation within Health and Adult Services

Considered –

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

Members recognised the statement that Autism is much more common than many people think. When advised that 17% of children with Autism have been suspended from school; 48% of these had been suspended three or more times; 4% had been expelled from one or more schools, a member remarked that his was very much of concern to the Young Peoples Overview and Scrutiny Committee.

Members supported the key commitments of the directorate, especially the processes around improved Diagnosis and referrals, the investment in staff investment and training; and the improvements achieved as a result of the Self- Assessment Framework.

Resolved -

a) That the report be noted.
b) The committee expressed its appreciation and congratulations to all staff involved in ensuring that NYCC First Local Authority to have all of its Adult services accredited in the UK in 2016.

196. Direct Payments

Considered

Presentation by Toya Bastow, Direct Payments Support Service Manager, Care and Support (HAS)) supported by Cath Simms, Head of Targeted Prevention, Care and Support (HAS)

Toya explained that a direct payment is the amount of money that the local council pays to an individual who has been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local authority.

There is considerable evidence that many of those who have opted for Direct Payments have found it a positive change. The advantages include:

- They offer (and can increase) choice, control and flexibility.
- They can build confidence and gives power.
- It can cost the authority less.

However, 23 years after the introduction of direct payments – and despite successive governments' attempts to promote them – few people eligible to use them do so. Furthermore, there is great variation in the take-up in local authorities and between service user groups.

Statistically speaking, Toya conceded, NYCC's comparative performance appears disappointing. We found good reasons for this, most notably connected with social

care market conditions - for example the majority of direct payments money is, in practice, used to pay for personal assistants where the lack of provider availability is a significant problem. Some people eligible for support are simply uncomfortable about being an employer and the responsibilities that come with that. Some may lack confidence about keeping careful records and safely filing important documents such as receipts, although help to make these arrangements is available.

Members suggested that it may be the case that rurality and the demographic profile of the people we support makes it a challenge for the directorate to significantly increase take-up. That said, members were in agreement that from the evidence presented at the meeting:

- there was no lack of enthusiasm on the directorate's part for promoting direct payments to staff working with specific care groups;
- the indications were that direct payments are routinely offered as an option to people eligible to use them;
- efforts are being made to make staff more aware about what direct payments can be used for, who is eligible to use them, and how they can be accessed; and
- resources are well-placed to support people to help them manage their direct payments.

Members agreed that whilst the figures around take-up may not be where we would like them to be, there is convincing evidence that there is a supporting infrastructure within the directorate combined with a good understanding of the principles behind direct payments.

Resolved –

a) The Chairman report the committee's conclusions in her statement to council.
b) The Committee look again at NYCC performance on Direct Payments in a years' time.

197. Work Programme

Considered -

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

Ray Busby explained that it had not been possible to fit into the regular meeting cycle the intended session with Professor Sue Proctor, Chair of the Safeguarding Adults Board. Care and Independence Overview and Scrutiny members had met with the Board Chair at least once a year for a number of years now. This had usefully been timed to coincide with the publication of the Annual Report of the North Yorkshire Adults Safeguarding Board. That report would be available mid to late November. .

Members confirmed that they would want to meet with Professor Proctor, and if that meant a one off meeting with this as the sole item of business, then so be it.

Referring to discussion earlier at the meeting, Ray Busby reported that the Young Peoples Overview and Scrutiny Committee, is keen to do some exploratory joint scrutiny work on the new pathway that has been agreed between the HAS and CYPS

directorates for young people transitioning from children's social care to adult social care. A joint session had been suggested.

Resolved -

a) That the work programme be agreed.
b) An informal joint session with YPOSC committee members be arranged to review the new protocols and pathways for those children and young people who move from children's social care to adult social care – often referred to as “Transitions".

Health & Adult Services

Mental Health Pathway

North Yorkshire County Council

Journey so far…

- 2016 launch of the Mental Health Pathway Review – phase 1
- 2017/18 launch phase 2 - Service Configuration
- May 2019 Launch of the key pathway elements

Aim: To develop and implement a distinctive Social Care Mental Health offer across North Yorkshire for working age adults that supports the benefits of joint approaches with NHS partners.

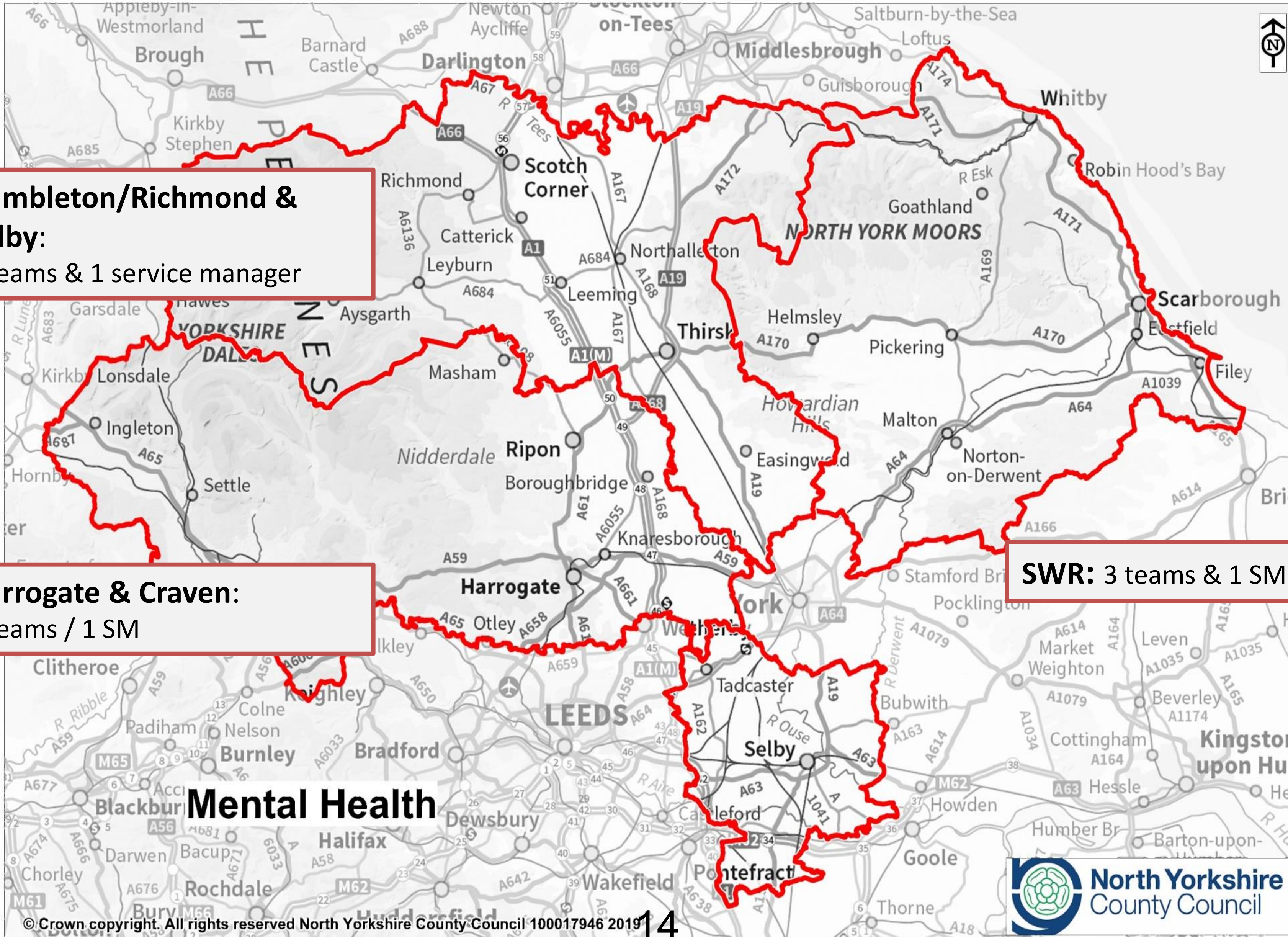
Scope of the challenge (non negotiable)

- ✓ Compliance with the Care Act 2014
- ✓ Strengthen the prevention offer and ensure a 'strengths based approach' (SBA) to assessment, care and support.
- ✓ Relinquish care coordination role (CPA approach)
- ✓ Change the primary electronic recording system to LLA
- ✓ Continue to co-locate with health colleagues
- ✓ Engagement in existing health processes for daily management of care & support
- ✓ Include over 65year functional illness.

Vision & Aims for Mental Health Services

- Confident, consistent practice, that is focussed on a strength-based approach
- Develop new opportunities to strengthen the prevention within mental health
- Deliver an all age specialist service
- Explore future use of technology and technology within the pathway
- Align to North Yorkshire County Council Health & Adult Services care pathway
- Build on relationships and continue to develop and work effectively with all external partners
- Be the employer of choice

New Mental Health Team Boundaries

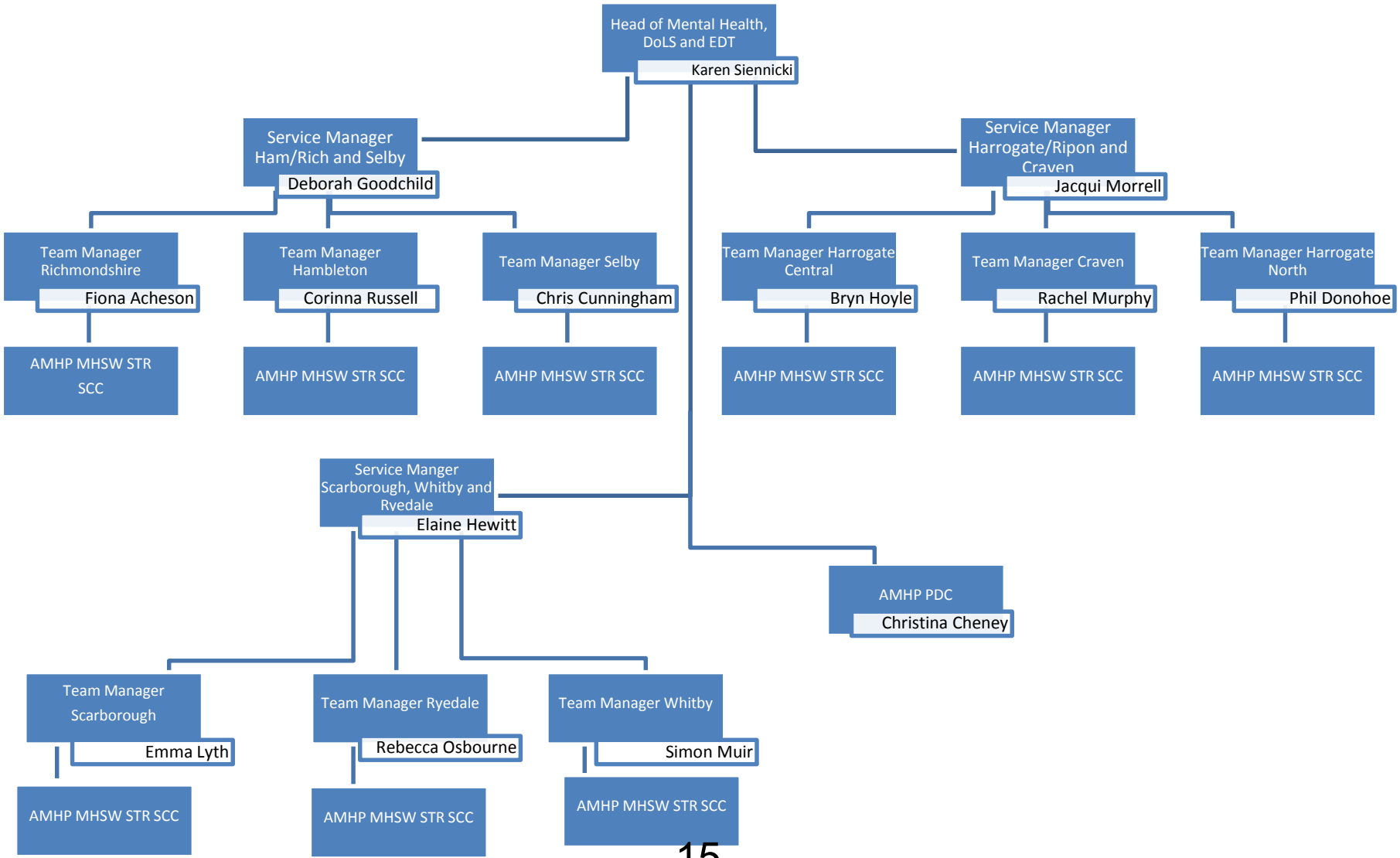


Hambleton/Richmond & Selby:
3 teams & 1 service manager

Harrogate & Craven:
3 teams / 1 SM

SWR: 3 teams & 1 SM

Mental Health Service Structure



April Pathway Development Event

- ✓ Established a shared understanding of the reason ***why*** mental health social care has to change, ***what*** needed to happen and by ***when***.
- ✓ Mapped a distinctive pathway for mental health within social care for North Yorkshire.
- ✓ Developed a clear action plan detailing next steps in preparation for a planned roll out from 1st May 2019.
- ✓ Mapped different customer journeys
- ✓ Clarified service criteria
- ✓ 147 unique actions identified across:

PROCESS

- Front door care & support team
- Referrals
- Safeguardings
- Over 65yrs
- Internal/external interface

ORGANISATION & WORKFORCE

- Role clarification
- AMHP model

TECHNOLOGY

- Use of equipment
- LLA

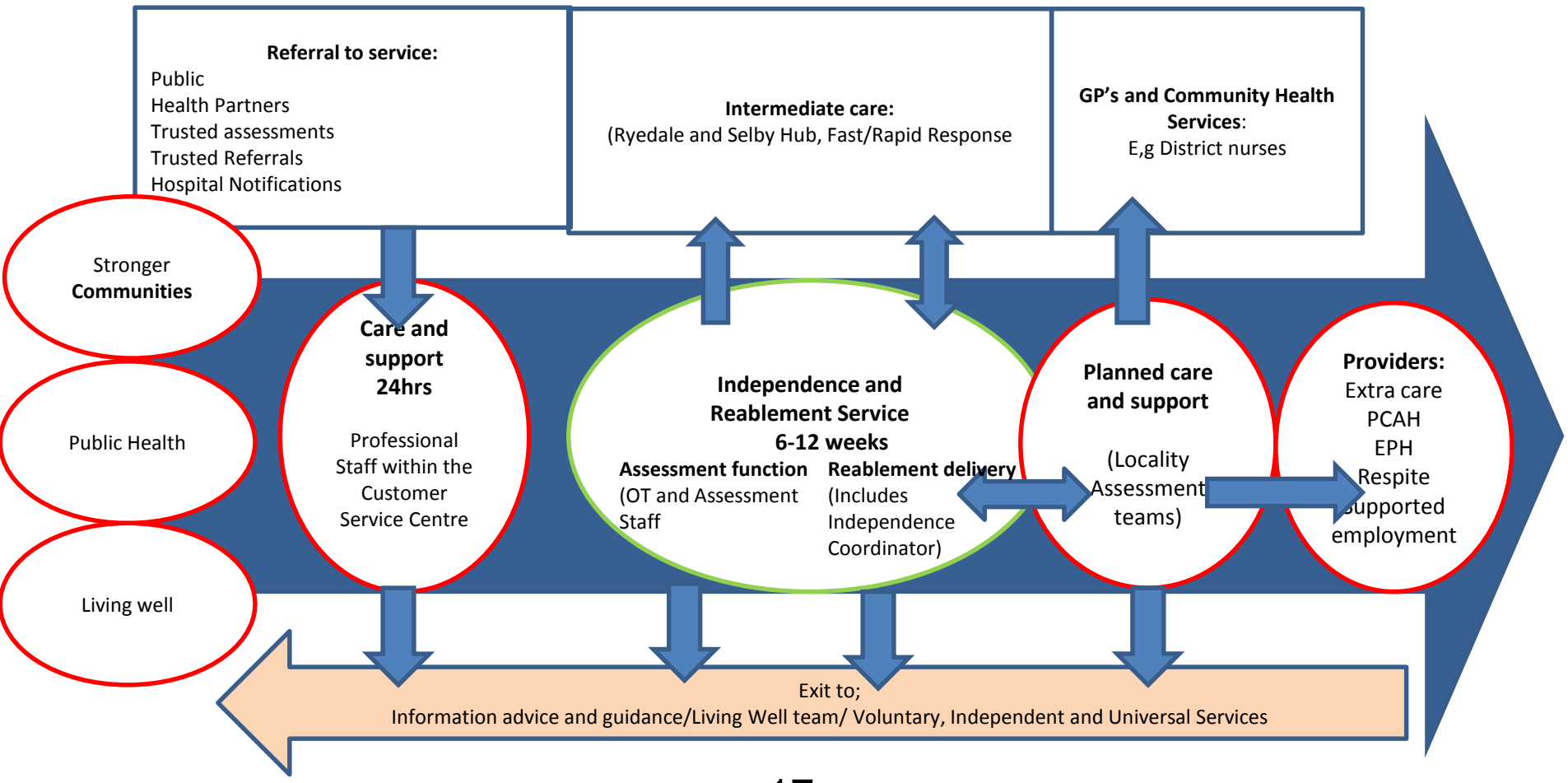
INFORMATION

- Development of KPIs/Dashboard
- Comms strategy

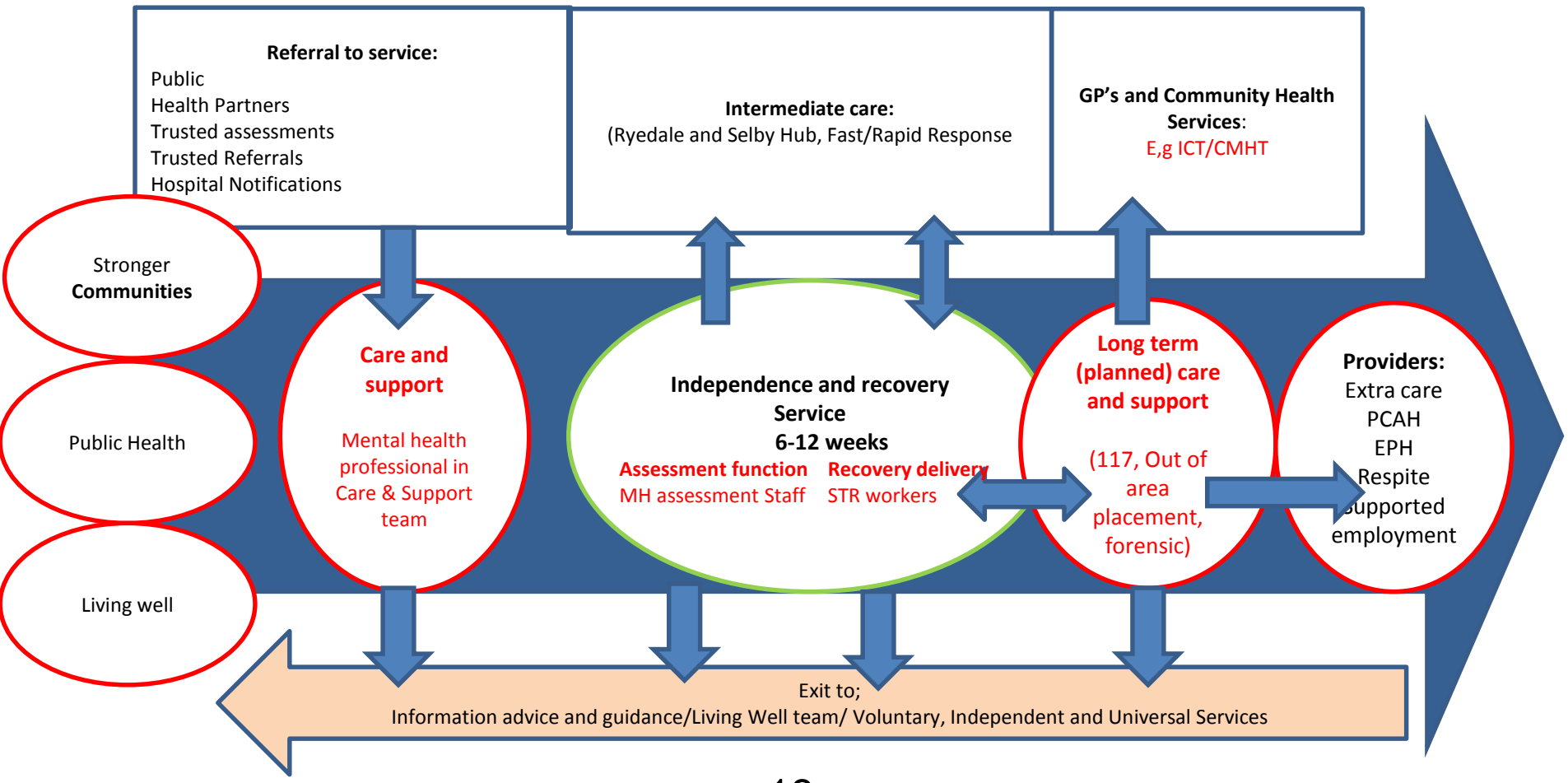
Service Criteria:

- 18+ - To include those over the age of 65 open to MHSOP with a functional diagnosis
- Referred into local mental health services within the last 3 months (integrated Triage, First Response, Access Team)
- Who are currently experiencing mental distress that is impacting on mental wellbeing resulting in social care need

Care Pathway – Health and Adult Services 2017



Mental Health Pathway – Health and Adult Services 2019



Referral into Service: Triage & Prevention

MH within the Care & support team to support triage of closed or not known/new referrals

Signposting

Information, advice, guidance

Safeguarding

Stronger communities

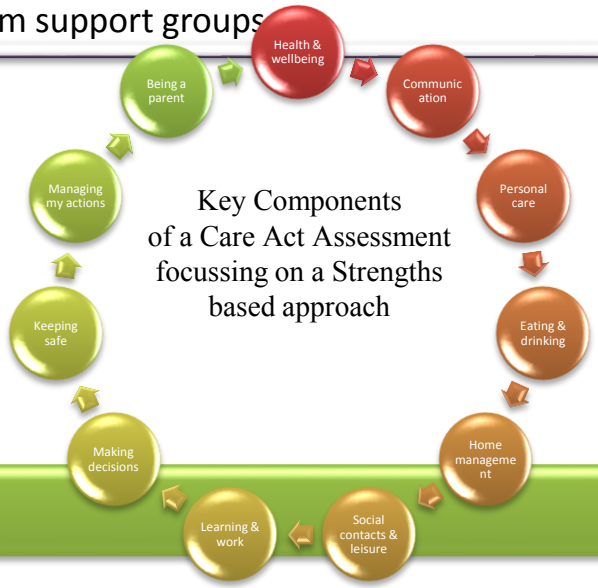
Living Well

VCS

Public Health

Carers

Referrals to GP, Advocacy, Self help groups & victim support groups



Independence & Recovery : 6-12 weeks

(Assessment to be completed with 28 days)

Recovery orientated services

Independent / daily living skills

Confidence/skills development

Group work

Social inclusion/integration

Supported housing

Measured outcomes

Maximise independence

Supported employment Service

Income maximisation team

Family group work

Access to commissioned services

Crisis intervention (non MHA)

Reablement support

Professional support through low level therapeutic interventions

Long term (planned) care

DToC

Hospital in-reach

Safeguarding

MHA work (ie:117)

Court of protection

Guardianships

Personalisation

Direct payments/ personal budgets

Out of area placements

Transitions

Complex needs

CHC

Specialist placement review

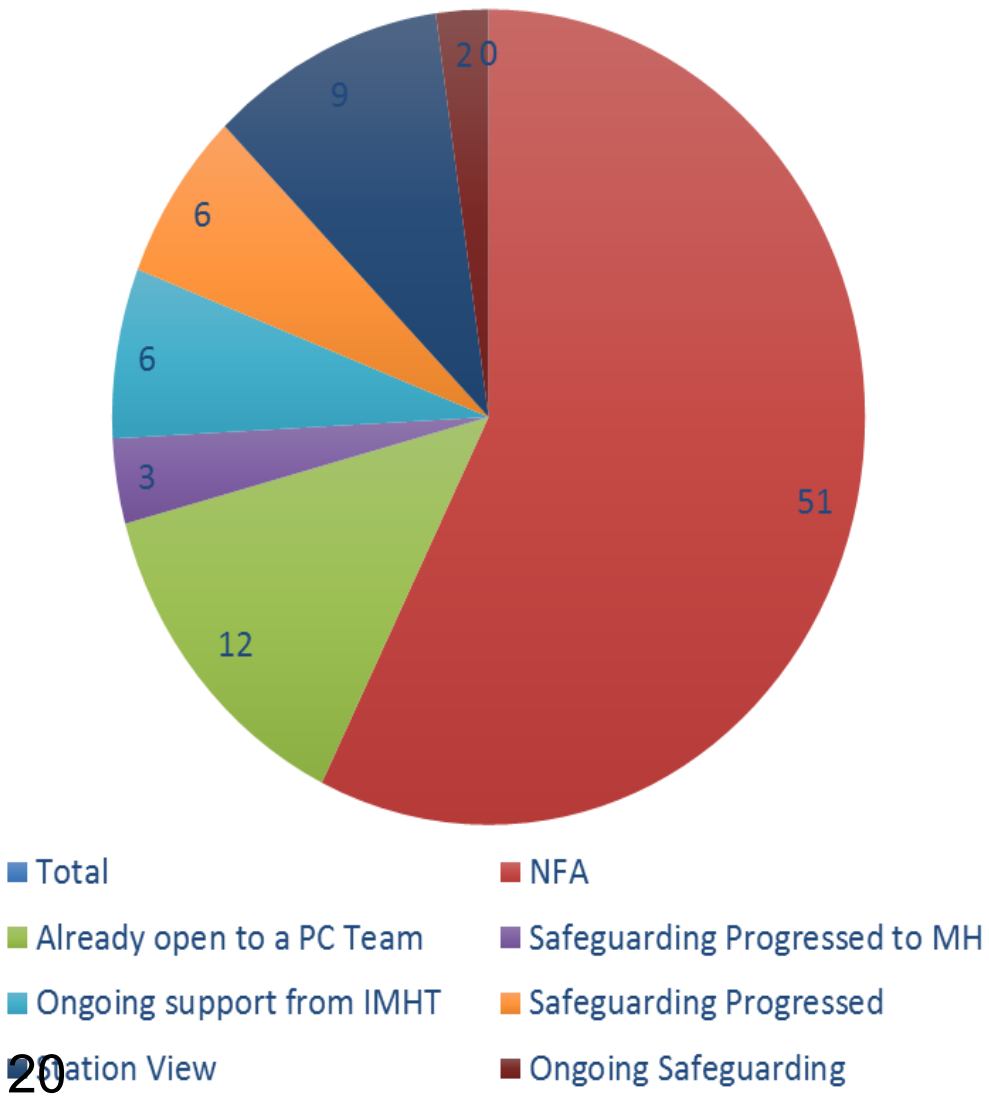
Prevent, reduce, delay

Integrated Mental Health Team

Pilot

- 5 staff seconded from TEWV
  - 1 ANP (Advanced Nurse Practitioner) Team Lead
  - 1 Physio
  - 3 Specialist mental health nurses
- Previously involved in Harrogate Vanguard and instrumental in testing the IRS model.
- 29th April 2019 pilot the team sat within Care & Support Front Doors services (4 days per week)
- So far 89 people/cases reviewed with 57% prevented from going any further into HAS services.
- Feedback so far :
  - Reduced the delay in receiving the necessary information to make the right decision
  - 'reduced the generalist opinion' when triaging and putting meaning to mental health terminology in referrals
  - Reduced number of complaints from locality teams because of point 2
  - LLA limited with information. Access to PARIS informs and supports the triage process and SALT returns

Outcome



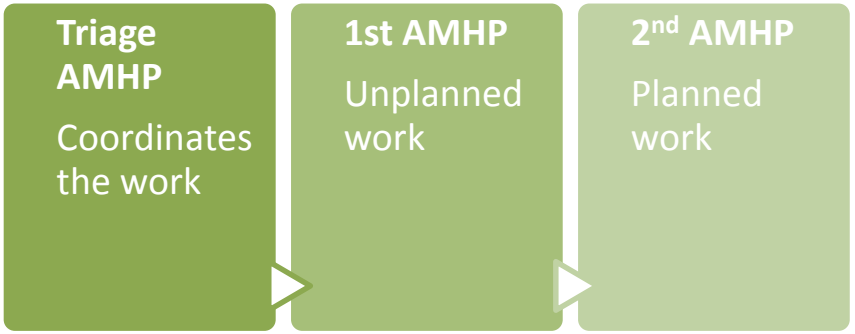
Duty Work Role:
AMHP/MHSW/SCC

5 Duty Workers across the County:
Harrogate N&C/ Craven/ Selby / SWR / Ham & Rich

Introduction of internal governance reporting framework for mental health teams

To offer assurance and monitoring of quality, risks and mitigation

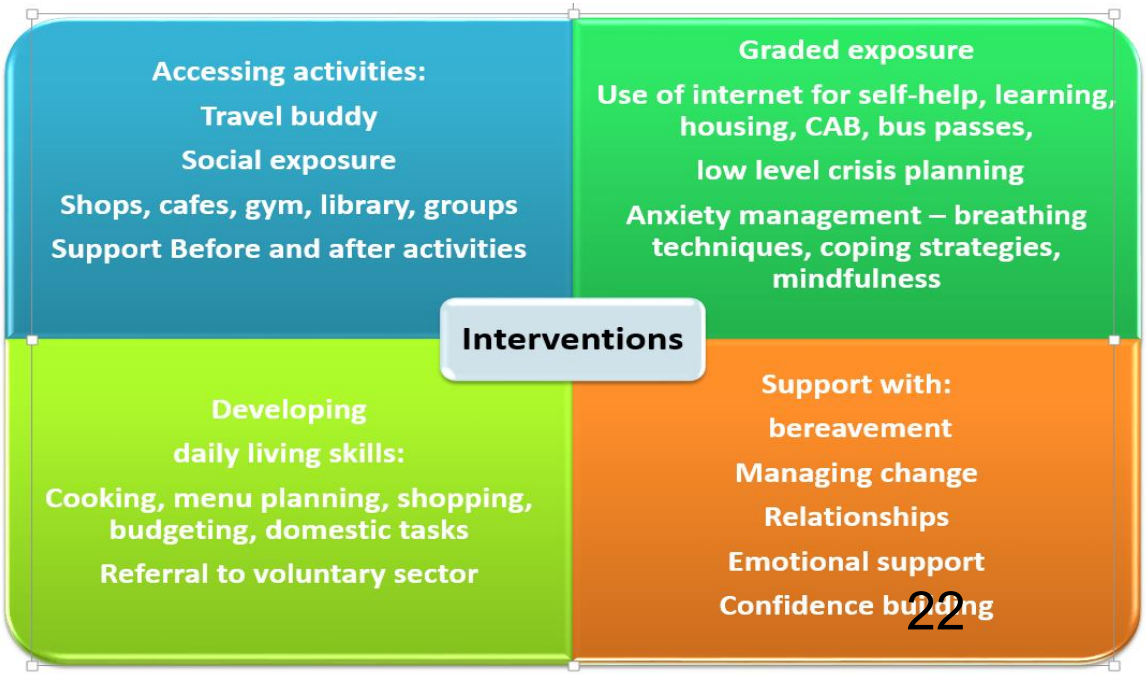
County Wide AMHP model pilot



- Each locality to adopt the above model
- If required triage AMHP can cover other localities
- Cross locality working according to need (ie: out of locality assessment/placement)
- Closer working relationship with EDT

Support Time & Recovery Workers (STR)

- Redefined the role and returned to the original Sainsbury's model
- Referrals now directed from SCC/MHSW/AMHP following a social care needs assessment identifying a person has eligible needs under the care act.
- Agreed outcome measure tool (7 domains)
- Developed recovery plans that can be recorded on LLA and reported on monthly



Managing mental health

Physical wellbeing

Connecting with the community

Relationships

Independence, choice and control

Meaning & purpose

Trust, identity, hope & self esteem

Visual Control Tool

	Scarborough	Whitby	Ryedale	Harrogate north	Harrogate Central	Craven	Hambleton	Richmond	Selby
Preparation									
Case loads analysed and action plans developed									
transfer of all care coordination cases									
Re-allocation of cases in LLA to the correct team									
Workforce									
All new positions recruited to									
all staff moved to new teams									
implementation of modern council working and changes to bases									
Practice									
Delivery of SBA training									
use of REM process for practice development									
introduction of case file audits									

KEY FOR PATHWAY IMPLEMENTATION PROGRESS	
	not yet implemented
	started but under 50%
	started and over 50% implemented
	In place
	Embedded / Complete

GUIDANCE	
1	On a monthly basis, the Team Manager is responsible for rating the current status of their team against each step prior to AMT. detailed narrative to be added in the team progress sheet.
2	Mitigating actions required for those steps rated yellow/amber and red.
3	Report to be given to the Service Manager who will includen as part of the locality assurance report

Scarborough

	COMMENTS
Preparation	
Case loads analysed and action plans developed	
transfer of all care coordination cases	
Re-allocation of cases in LLA to the correct team	

Key Performance Indicators – KPI

Process

- Timescale for referral to reach correct MH team/worker
- Number of assessments by type – fit into Assessments Dashboard (in progress min 4 weeks)
- Timescale from referral date to assessment start date (to measure timeliness in work being carried out)
- Timescale from referral date to assessment end date (to measure time for assessment to be carried out from contact with client)
- Timescale from assessment start to assessment end date (to measure how long assessments are taking)
- Overdue reviews
- Timescale from referral start to referral end
- Number of cases with involvements from others on LLA but not reported
  - Internal – measure 'involvements' in LLA – and TEWV involvement
  - External – mechanism to record Eg. TEWV involvement
- MH Act : How many
  - Admission – voluntary/ not voluntary
  - Not admitted

Inputs

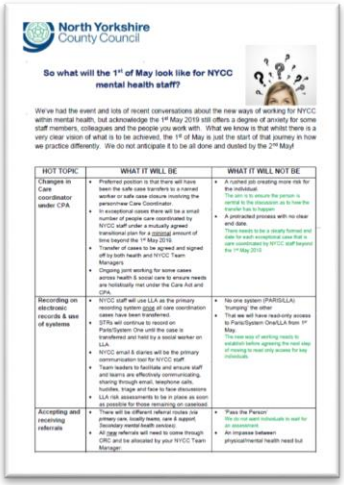
- Number & source of referrals into MH teams
- Timescale between referral date & caseworker start date (to measure if referrals are being sent to correct teams & worker allocated in a timely manner)
- Number of referrals being dealt with by C&S team (potentially require new options on C&S form in LLA) – measure how many are sent to triage team
- Breakdown of triage outcomes by type (currently recorded on a spreadsheet) AMHP MH Act Assessments (recorded on spreadsheets)

Outputs

- Number of referrals that don't result in an assessment
  - Number by referral and reason
- Assessment outcomes
  - Number of assessments resulting in each outcome
- Recovery star scores/ chime scores – compare score at start of process to end, to measure impact of interventions
- Return rate of clients and timescale

Progress so far…

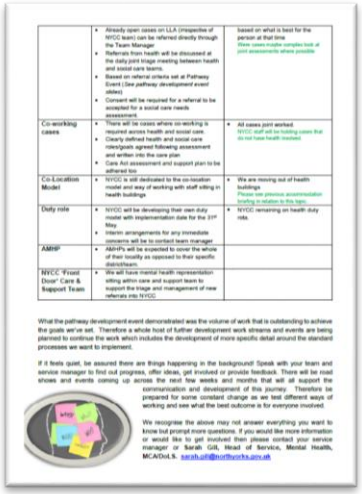
Communication bulletins:


North Yorkshire County Council

So what will the 1st of May look like for NYCC mental health staff?

We've had the event and lots of recent conversations about the new ways of working for NYCC within mental health, but acknowledge the 1st May 2019 still offers a degree of anxiety for some staff members, colleagues and the people you work with. What we know is that whilst there is a very clear vision of what is to be achieved, the 1st of May is just the start of that journey in how we practice differently. We do not anticipate it to be all done and dusted by the 2nd May!

HOT TOPIC	WHAT IT WILL BE	WHAT IT WILL NOT BE
Changes in Care coordinator under CPA	• Preferred position is that there will have been the safe care transfers to a named worker or safe case closure involving the person/new Care Coordinator. • In exceptional cases there will be a small number of people care coordinated by NYCC staff under a mutually agreed transitional plan for a minimal amount of time beyond the 1st May 2019. • Transfer of cases to be agreed and signed off by both health and NYCC Team Manager's • Ongoing joint working for some cases across health & social care to ensure needs are holistically met under the Care Act and CPA.	• A rushed job creating more risk for the individual. The aim is to ensure the person is central to the discussion as to how the transfer has to happen • A protracted process with no clear end date. There needs to be a clearly formed end date for each exceptional case that is care coordinated by NYCC staff beyond the 1st May 2019
Recording on electronic records & use of systems	• NYCC staff will use LLA as the primary recording system once all care coordination cases have been transferred. • STRs will continue to record on Paris/System One until the case is transferred and held by a social worker on LLA. • NYCC email & diaries will be the primary communication tool for NYCC staff. • Team leaders to facilitate and ensure staff and teams are effectively communicating, sharing through email, telephone calls, huddles, triage and face to face discussions • LLA risk assessments to be in place as soon as possible for those remaining on caseload.	• No one system (PARIS/LLA) 'trumping' the other • That we will have read-only access to Paris/System One/LLA from 1st May. The new way of working needs to establish before agreeing the next step of moving to read only access for key individuals
Accepting and receiving referrals	• There will be different referral routes (via primary care, locality teams, care & support, Secondary mental health services). • All new referrals will need to come through CRC and be allocated by your NYCC Team Manager.	• 'Pass the Person' We do not want individuals to wait for an assessment • An impasse between physical/mental health need but


	• Already open cases on LLA (irrespective of NYCC team) can be referred directly through the Team Manager • Referrals from health will be discussed at the daily joint triage meeting between health and social care teams. • Based on referral criteria set at Pathway Event (See pathway development event slides) • Consent will be required for a referral to be accepted for a social care needs assessment	based on what is best for the person at that time There cases maybe complex look at joint assessments where possible
Co-working cases	• There will be cases where co-working is required across health and social care. • Clearly defined health and social care roles/goals agreed following assessment and written into the care plan. • Care Act assessment and support plan to be adhered too	• All cases joint worked. NYCC staff will be holding cases that do not have health involved
Co-Location Model	• NYCC is still dedicated to the co-location model and way of working with staff sitting in health buildings	• We are moving out of health buildings Please see previous accommodation briefing in relation to this topic.
Duty role	• NYCC will be developing their own duty model with implementation date for the 31st May. • Interim arrangements for any immediate concerns will be to contact team manager	• NYCC remaining on health duty rota.
AMHP	• AMHPs will be expected to cover the whole of their locality as opposed to their specific district/team	
NYCC 'Front Door' Care & Support Team	• We will have mental health representation sitting within care and support team to support the triage and management of new referrals into NYCC	

What the pathway development event demonstrated was the volume of work that is outstanding to achieve the goals we've set. Therefore a whole host of further development work streams and events are being planned to continue the work which includes the development of more specific detail around the standard processes we want to implement.

If it feels quiet, be assured there are things happening in the background! Speak with your team and service manager to find out progress, offer ideas, get involved or provide feedback. There will be road shows and events coming up across the next few weeks and months that will all support the communication and development of this journey. Therefore be prepared for some constant change as we test different ways of working and see what the best outcome is for everyone involved.

We recognise the above may not answer everything you want to know but prompt more questions. If you would like more information or would like to get involved then please contact your service manager or Sarah Gill, Head of Service, Mental Health, MCA/DoLS. sarah.gill@northyorks.gov.uk


North Yorkshire County Council

2020 MODERN COUNCIL & COMMUNITY MENTAL HEALTH SERVICES

April 2019

As part of the service changes from 1st May 2019, I am in the process of agreeing formal arrangen
with TEWV and BDCT in respect of the accommodation arrangements for NYCC staff co-located
mental health bases. The detail is still being discussed and will be communicated as so

North Yorkshire County Council

COMMUNITY MENTAL HEALTH SERVICES CO-LOCATION UPDATE

May 2019

I felt it would be useful to update you all in terms of the current situation with agreeing formal arrangements with TEWV and BDCT in respect of the accommodation arrangements for NYCC staff co-located in the community mental health bases.

North Yorkshire County Council

Mental Health Pathway Development Event Briefing:

April 2019

What was this about?

Following the agreed restructure of Mental Health Social Care, a four day event was held on the 2nd -5th April 2019 to co-develop the Mental Health Pathway and new service offer.

The ambition for the new pathway is have a distinctive service that enhances prevention through implementing a strengths based approach when assessing and offering care and support.

The event was focused on sharing ideas and expertise in order to produce real practical outputs by the end of the week, which could be implemented and tested in the near future.

Who came together?

- Service Users
- Carers
- Tees, Esk and Wear Valley NHS FT
- Bradford District Care Trust
- Public Health
- Representatives from across Health and Adult Services
- CCG Commissioning

What did we do?

We explored the customer journey for people in different circumstances who may require a mental health service.

By ensuring the customer was central to the process, we were able to identify the impact on our customers and partners around the following four areas:

- Process
- Organisation
- Technology
- Information and communication

What was the outcome?

A pathway that reflects the existing care & support Health and Adult services pathway was designed, with 147 unique actions identified. These have been themed and prioritised to form a clear action plan.

Mental Health Pathway – Health and Adult Services: 2019

Next steps?

While the focus was on producing plans and proposals at the end of the week, it is recognised that some areas will need further work and resources. The aim of this is to maintain the momentum by having a series of further, inclusive events as soon as possible.

If you would like to get involved or would like more information then please contact Sarah Gill, Head of Service, Mental Health, MCA/DoLS. sarah.gill@northyorks.gov.uk

Item 5

Internal Workshops:

- Governance and reporting structures with the team/locality & AMT
- Duty worker role / STR work Role / AMHP triage model
- Pilot to strengthen the mental health triage at the front door of NYCC/Care & Support

Roadshows:

- One in each of the localities for all key stakeholders

Team work:

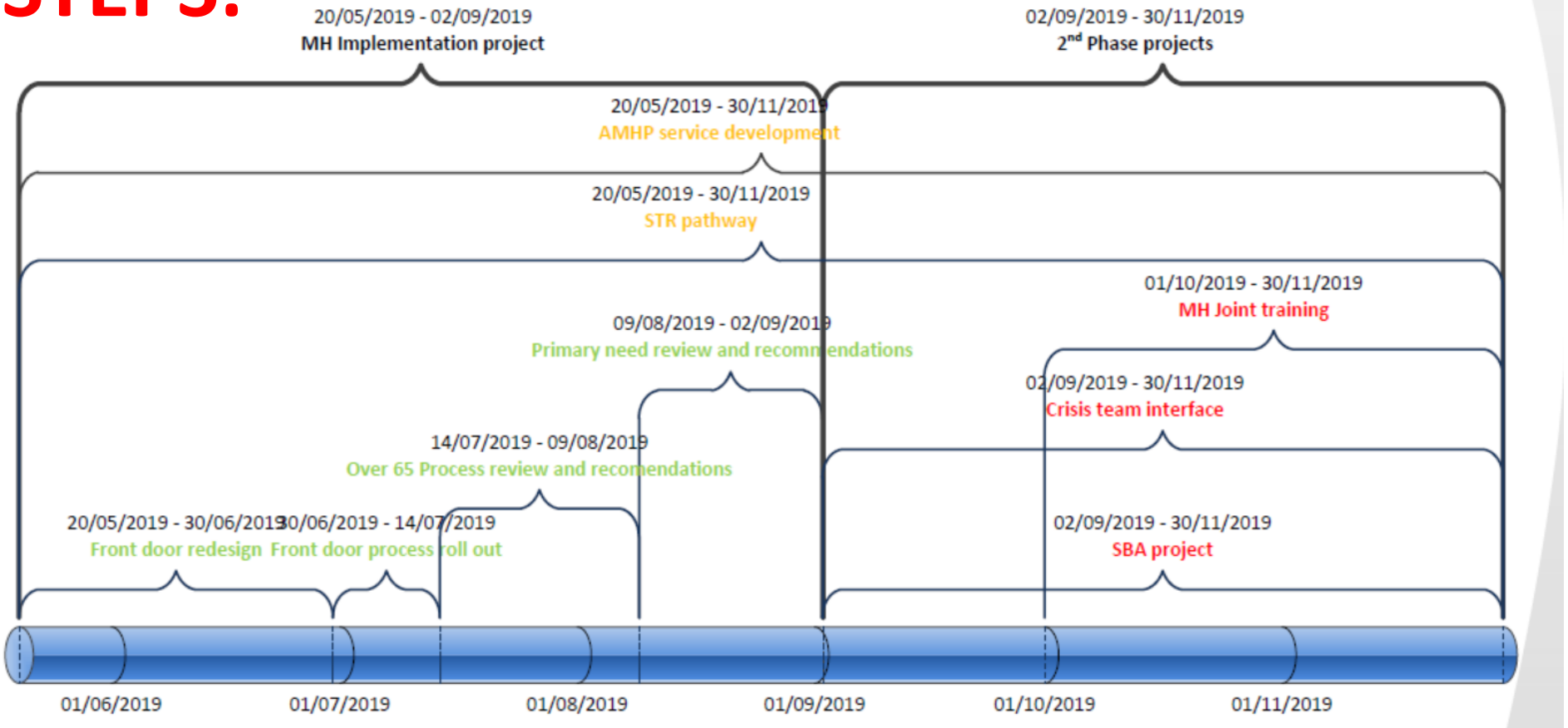
- Transition of cases to health
- Changes to team structures

Tools to support delivery:

- Thematic action plan and visual control for implementation across teams

NEXT STEPS:

Mental Health Service Redesign Road Map



Ongoing in house workshops

Care act practice, LLA usage, Data intelligence work, Duty worker, Ward liaison, Locality team interface

Expected Benefits

- Ability to meet the statutory obligation under the Care Act
- Reduction in people requiring mental health services through offering a stronger prevention offer at the front door.
- Specialist advice, support and input for people with comorbidities and are over 65years of age
- Continued Co-location with health colleagues providing a holistic response to need
- Minimise the impact of a crisis for an individual where there is a social care need identified
- Increase in number of assessment staff
- Clarity of role, expectations and job satisfaction
- Aligned pathway with care and support (HAS)
- County wide AMHP model leading to a consistent approach through having a clearly identified pathway
- Clearly defined and distinctive social care pathway for North Yorkshire that is outcome focussed, strength based and responsive to the needs of the local population.

Customer feedback

Group of 8 customers participated Across the workshops & one focus group Discussed 5 key themes;

1. Raising awareness & communication

"need greater communication"

2. Information sharing

"I want to hear about the status of my referral regularly and a timely fashion and I want to know who to ring directly that best knows what is going on with my care"

3. Social care crisis response – what could the offer look like?

"What would it look like?"

4. Ongoing future involvement

"MH carer and service user consistent offer across county in terms of strategy, support groups, involvement (i.e. involvement in recruitment, access to leadership, service design/change)"

5. Carer specific Mental Health

"SU in their own right re: prevention & key to co-production in their role as carers"

A question for the Committee- are they further areas of development you would like to see moving forward?

NORTH YORKSHIRE COUNTY COUNCIL

YOUNG PEOPLE'S OVERVIEW AND SCRUTINY COMMITTEE

26 SEPTEMBER 2019

HAS FINANCIAL POSITION

1.0 PURPOSE OF REPORT

1.1 This paper highlights the areas presenting with the most significant financial pressures facing HAS as at September 2019 and the management action that is being taken in response to the pressures.

2.0 HAS FINANCIAL PRESSURES

2.1 At its meeting on 13 August 2019, the Executive received the Quarterly Performance and Budget Monitoring Report for Q1, 2019-20. The report highlighted a projected overspend in Health and Adult Services which, at Q1, was forecasting that IBCF (Improved Better Care Fund) grant of £2.7m and £2.4m of Winter Funding will be required to ensure a break-even bottom line position. Therefore without this money, there would be an overspend of £5.1m – or approx. 3% of the net budget.

2.2 This IBCF is temporary funding - £19.6m over the period 2017-20, of which around £6.9m was originally earmarked to support financial pressures in adult social care. This has now increased to £7.9m – in addition to £4.8m of additional funding "Winter Pressures) allocated by central government for 2018-19 and 2019-20.

2.3 The main area of overspend is within Care and Support, the service area which accounts for £133m of a net £157m directorate budget. The predicted overspend in this area is £4.9m. A summary of the main Care and Support variances as at Q2 are shown in the table below and the full directorate position is shown in Appendix 1:

BUDGET HEAD	REVISED BUDGET	FORECAST	VARIANCE
Care & Support			
Area Budgets			
Care & Support - Hambleton & Richmond	27,344	27,280	-64
Care & Support - Selby	14,907	15,532	624
Care & Support - Scarborough, Whitby & Ryedale	42,274	43,842	1,568
Care & Support - Harrogate	38,940	41,254	2,314
Care & Support - Craven	9,461	11,486	2,025
CHC Income and Other Budgets		-1,534	-1,534
	132,926	137,860	4,934

2.4 Within these areas financial pressures are greatest in budgets which support Older People and Adults with Learning Disabilities. This continues a pattern of pressures in recent years which have been offset to an extent by growth allocated to the budget until now.

2.5 In addition, Mental Health budgets are currently overspending by approx. £400k on a budget of £8.5m. This is mainly the result of additional costs incurred in Mental Capacity Act budgets linked to preparation for Liberty Protection Safeguards and cost pressures on residential and nursing budgets.

2.6 The following sections highlight some of the key areas of financial pressure and management action which is being undertaken to mitigate against these. At the same time we continue to lobby for changes in funding which will take account of the pressures we currently face and provide more certainty of resources available in future.

3.0 BACKGROUND

3.1 Adult Social Care accounts for over 41% of County Council spend and this share has increased since 2010 due to the relative protection of these budgets. £18.5m savings have been made countywide in the service since 2015, with a further £7.5m to be delivered by 2022 – at this stage. Voluntary sector budgets have been protected overall, as has mental health spend, although funding has been re-allocated to address areas of greater need.

3.2 Our transformation and savings agenda has included spending more on prevention which will have an overall positive impact both on people's lives and on the budget for long term support. Benchmarking shows that we would need to spend £11m more on long-term support to mirror the Shire authority average and this has helped us deliver the savings referred to above.

Funding

3.3 Approximately 16% of the net local social care budget depends on funding being passported from the NHS. Part of this funding (the Improved Better Care Fund), plus other grants for Winter Pressures were originally due to cease in March 2020, although we understand that it will continue for one further year If this funding ends, then there will need to be significant cuts to social care services, and, in particular, to the additional support to hospitals for rapid patient discharge, as this is where the passported funding is targeted.

3.4 Overall, adult social care is increasingly reliant on a fragmented mix of funding sources: government grants (reducing), council tax, social care precept (which, in part, covers the national living wage costs), charges and funding passported from the NHS. People who use services often have to pay for some or all of their care costs, with limited ability to plan for the future. Providers we commission who accept the County Council's rates usually have different charging arrangements for self-funders in order to ensure they have the income to remain sustainable. This risks a public perception that self-funders subsidise people funded by the State.

The Care Market

3.5 The care market nationally is facing an existential challenge. Locally, the situation is better but still under significant pressure.

3.6 Increasing demands (such as the ageing population profile and increased care needs) place more pressure on local care systems and help to drive up costs. The proportion of placements for older people (65+) above NYCC rates (42%) is rising. It is a key driver of budget pressures, particularly in Harrogate & Craven where the levels rises to 68%.

3.7 We have undertaken work that shows that key ASC workers in the county spend 45 minutes on average as "downtime" – for each visit in rural areas. This compares with 20 minutes in urban areas. This "rural premium" costs us over £2.5m per annum for domiciliary costs and a similar amount for residential services. We also pay £2.8m in transporting users to day centres and other services. Transport is not part of the means-tested assessment and users currently contribute a small amount to this – approx. £100k in 2018-19 although this will increase over time.

Other Growth and Pressures

3.8 The volume of HAS-related contacts into the Customer Resolution Centre (CRC) was up by 6% year on year for Quarter 1, and the actual number of referrals passed to HAS for assessment were up by 5%, representing real growth in demand for assessment activity against reduced staff numbers in operational teams. Referrals to mental health teams were up by 10%.

3.9 The flow of increased demand through the Care & Support Team based in the CRC experienced a 41% increase in the number of contacts it handled during Quarter 1. The team processes a significant volume of simple equipment and minor adaptations cases and begins safeguarding processes for approximately 50% of new safeguarding concerns, reducing the burden on frontline teams. In the second half of 2018/19, the team also took on a role in completing initial assessment work for new cases, which is the key driver for the recorded increase in activity levels.

3.10 The 'prevent, reduce, delay' agenda aims to mitigate growing demand for social care support by diverting referrals away from the formal assessment route where other interventions may be able to provide appropriate levels of support. The additional resources allocated to Living Well through the Improved Better Care Fund (IBCF) continue to facilitate increased activity levels, with referrals up 90% year on year whilst the service's high satisfaction levels have been maintained. The other key strand of the prevention agenda, reablement, recorded a 2% increase in the number of interventions delivered year on year.

Savings

3.11 Despite these pressures, the Directorate has contributed significantly to the Council's savings requirement as set out above.

4.0 ACTION PLAN

4.1 We have an action plan which aims to reduce the financial pressures in Care and Support, while continuing to look for other savings to support the Council's overall budget position.

This plan focuses on three key areas. One of these – the **Market** – is highlighted above. The other areas are **Practice** and **Productivity.**

4.2 In terms of **Practice**, we are on a ten-year journey to ensure our practice is confident and consistent. We have made a good start in introducing a Strength-Based Assessment (SBA). SBA is about making an assessment on the basis of what the individual can do, what support they can get from their family, friends and community and, only then, looking at how that can be enhanced by a care package - a radically different type of practice from the social care provided since the 1990 NHS & community care act took effect in April 1993.

4.3 We will also ensure that standards of **Productivity** are high right across the entire Council. We will make best use of technology. To minimise the number of assessments which end before completion (one in four), we will strengthen our so-called “front door” arrangements. This is where we can quickly make decisions about which route to take with different social care contacts and referrals and therefore reduce unproductive effort.

4.4 Work on our Action Plan has begun and includes:

- Building on the work we already do such as auditing case files and setting up Risk Enablement Meeting (REM) panels.
- Developing and delivering a Confident and Consistent Practice Organisational Development programme for all managers and practitioners
- Enhancing Practice team scrutiny of individual care plans
- Scrutiny of all in-month Residential Care Home and Nursing Home placements by the Care and Support Leadership Team
- Providing CHC, S117 and Transforming Care Partnership practice support to increase rigour around defining Health and Social Care needs and assertion / challenge. We are also working better with Health partners to ensure that the split of costs for individual packages has better gatekeeping and is fair.
- Implement process to review monitoring spreadsheets in a timely manner with business support and Budget Managers to ensure effective budget monitoring practice, following a fundamental review of the budget last year and building on the progress already made to ensure that service managers are now far more involved in forecasting. The additional review is required as we move all of our records onto the online CONTROCC system.
- Review of HAS screening tool: questions; consistency of usage and practice in the CRC; outcomes
- Continued delivery of Quality Improvement Team work leading to reduced closures / emergency placements at higher rates (IBCF)
- Money spent on where people live (especially Physical Learning
- Disabilities and Mental Health accommodation, covered by Strength-based Approach (SBA) Phase to improve VFM and quality
- Increase rigour and scrutiny around REM to ensure consistent approach to high cost packages / placements and review budget approval and authorisation levels
- Continue working with local communities to develop micro-enterprise solutions to delivery of care in rural areas
- Introduce category management in commissioning teams to ensure best value
- Consider reduced focus on Delayed Transfers of Care (DTOC) to release operational capacity in other areas however this would impact on performance and may incur fines

5.0 FUNDING

5.1 As set out last year, we continue to lobby central government for a fairer funding settlement for Adult Social Care.

5.2 In all of these discussions, our message has been that in future any funding settlement must be comprehensive, enduring and fair settlement for social care. It should also be less complex than the current system which is a mixture of one-off and recurrent funding, ring-fenced and non-ringfenced grants, local ability to raise additional Council Tax and contributions from service users.

5.3 We have also said that there needs to be a review of the funding allocations formula, with Adult Social Care funding based on ageing and disabled population and Public Health Grant funding based on indices of multiple deprivation.

5.4 Consideration should be given of additional cost pressures facing local government and the NHS in remote rural and coastal communities. Any funding formula should take into account the different costs of delivery incurred by geography and supply, for example higher transport costs and an older population. We also endorse the LGA and PHE report from 2017 (https://www.local.gov.uk/health-and-wellbeing-rural-areas) which notes, amongst other conclusions, that:

- Both sparsity and rurality appear to affect poverty levels and consequently the health of people in rural areas. Sparse areas on the fringes of towns and urban settlements have the highest proportions of poor households, although no area type is poverty free.

- Changing population patterns, including outward migration of young people and inward migration of older people, are leading to a rural population that is increasingly older than the urban population, with accompanying health and care needs.

- Sparsity and the increasing scarcity of public transport links have a significant impact both on daily living costs of rural households and on access to services.

- Rural areas have worse access in terms of distance to health, public health and care services. Longer distances to GPs, dentists, hospitals and other health facilities mean that rural residents can experience ‘distance decay’ where service use decreases with increasing distance. Different models of service delivery may be needed for rural areas, including new models of workforce development. These also include the development of rural hubs providing a range of services, and more services provided on and through the internet.

5.5 We have also advised that we need to review and decide what is the responsibility and resulting costs of the state and what we agree should fall on individuals and families. In this we need to reflect on charges to people and revisit means test and needs test thresholds. We should be cautious about the unintended consequences of including people’s homes in financial assessments for home care.

5.6 Finally, there needs to be clarity – not least for the general population – about the respective roles of the health and social care sectors and how much people will have to pay to access these. Expectations are understandably confused when some health care is free without means-testing while this is not currently the case in social care provision.

6.0 RECOMMENDATION

6.1 Overview and Scrutiny Committee is asked to note the contents of the report.

RICHARD WEBB
Corporate Director, Health and
Adult Services

Report Prepared by Health and Adult Services Leadership Team

LIVING WELL NORTH YORKSHIRE

October 2018

Key findings

- 4,507 referrals up until the 31st March 2018, similar volume and client profiles in year 1 and 2
- More one-off support and fewer full Living Well agreements in year 2 vs year 1
- Primary reason for referral to Living Well - more face-to-face IAG in year 2
- 91% of clients across the two years said the support received from Living Well was successful
- 72% of clients recorded a meaningful increase in well being scores (mean +8 points)
- Main short-term outcomes focus on information, advice and guidance, but there are longer term impacts on social, emotional and practical support
- Segmentation analysis suggests there may be more benefits for certain groups, but the evidence is not strong enough to suggest a more targeted service
- £1.7m saving due to delayed entry to social care
- £8.9m net social impact (ROI £3.84)

Similar referral volumes and demographics in year 2

4,507 referrals up until the 31st March 2018.

- 2,176 referrals in year 1
- 2,331 referrals in year 2

➢ 495 received more than one referral over the two years

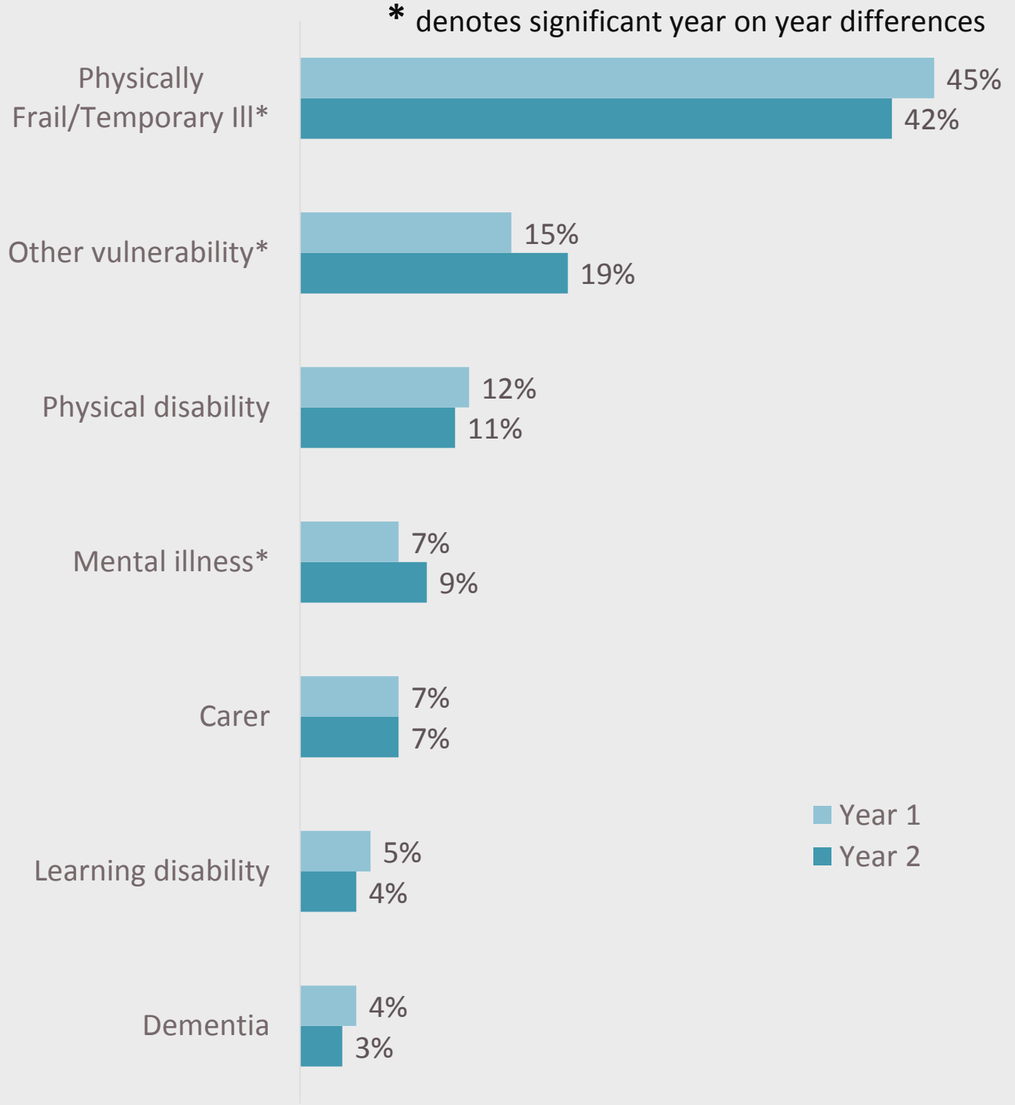
Demographic profile similar to year 1

- 60% female
- 44% aged 75 or older
- 31% single, 28% widowed, 28% married, co-habiting or partnered, 13% divorced or separated

The source of referral changed between years 1 and 2

- fewer referrals from planned care (13% vs 29% year 1)
- more from primary care (22% vs 14%) and independence (23% vs 8%)

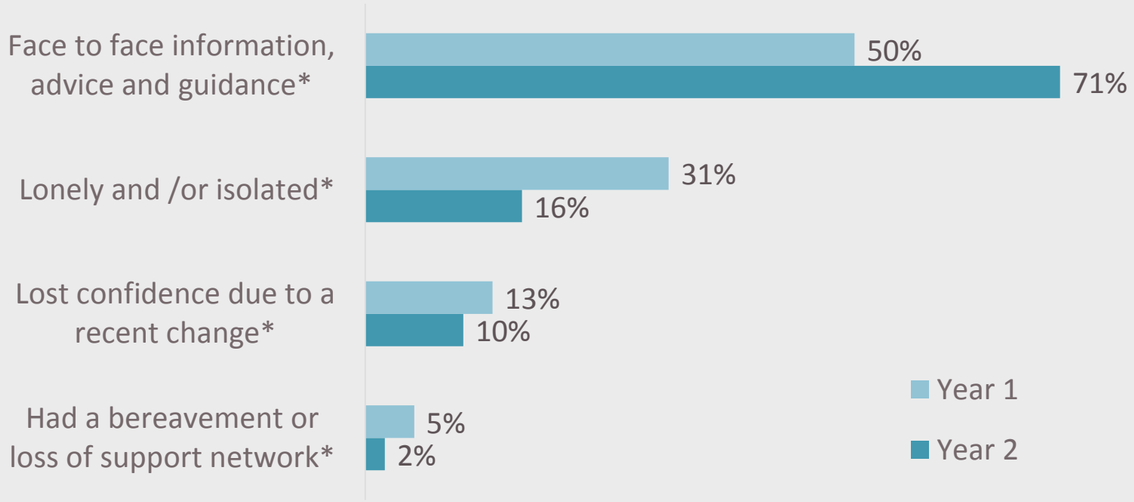
Health profile of clients referred to Living Well (base = 4,507)



More face to face and fewer full Living Well agreements

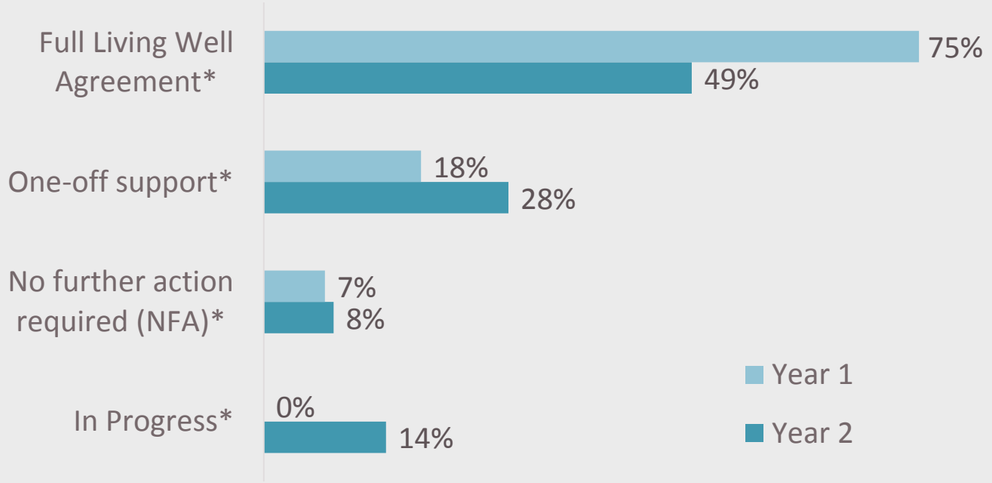
Primary reason for referral to Living Well (base = 4,004)

* denotes significant year on year differences



Type of Living Well support received (base = 4,507)

* denotes significant year on year differences



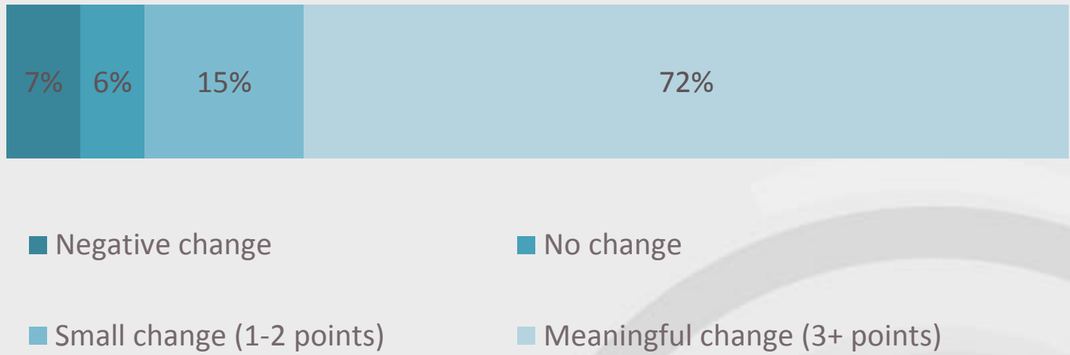
More face-to-face IAG in year 2, perhaps because other categories are much more tightly defined and the changes in the source of referral.

One-off support was more common in year 2: acknowledgement that one-off support is still a beneficial intervention and a full Living Well agreement not necessary for everyone.

Success of the Living Well programme

- 93% in year 2, 87% in year 1
- A further 8% said ‘partially’ successful
- But low response (n=1,920) means it’s possible that non-responders had a different view

Change in WEMWBS scores
(base, all those with complete data = 1,224



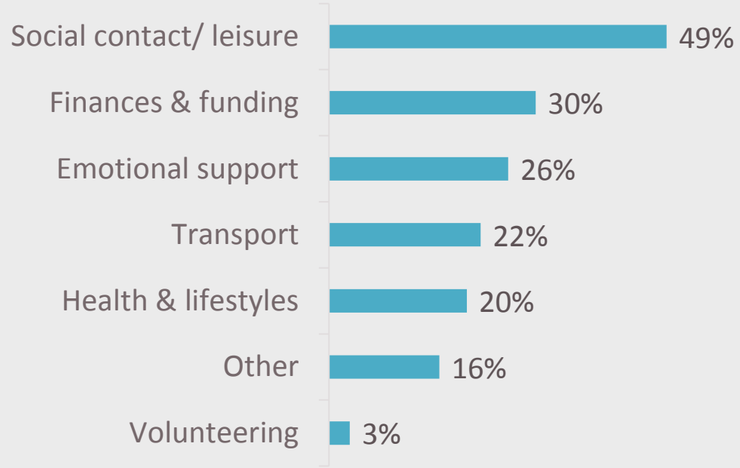
- The mean change in wellbeing before and after Living Well was 8 points
- No significant changes in well-being data between year 1 and 2
- Based on full WEMWBS data from around quarter of the total referrals

Main outcomes

Outcomes of Living Well for those that received a full Living Well agreement (base = 2,758)

* denotes significant year on year differences

Outcomes of Living Well (base = 240, all those that received one-off support since December 2017)



Year 1 outcomes from client research

- Becoming connected with local community through engagement with support groups for socialising, managing health issues, pursuing leisure interests, developing work skills
- Taking on a volunteering role either within or outside the home
- Finding the confidence or ability to leave the house with someone or go out independently
- Improving financial wellbeing through access to income support via the income maximization team
- Receiving practical support to help better manage day to day activities, such as housing, banking or managing household expenses

Evidence does not suggest a targeted approach is needed for LW

- Segmentation was used to see whether the population could be broken down into smaller groups showing whether some groups had benefitted more than others.
- Four segments were identified and follow up interviews were held with Living Well Coordinators to find out why.
- Co-ordinators found it hard to say why LW works better for some than for others: most concluded that individual's motivation and readiness to accept help are important in them engaging in Living Well and experiencing a positive outcome
- Mental illness a possible factor influencing the poorer WEMWBS outcomes – possibly less likely to seek help from a service such as Living Well
- Client expectations may be a factor if they are too high

> *We can support, and we can hold hands, so to speak, but at the end of the day it's down to that person. And if that person decides for whatever reason not to continue with Living Well, then we've got to stop.*
>
> **Living Well coordinator**

> *It really is very individual. However, you can see the people who are ready to accept that support and ready to access further services, and then people who aren't quite there yet, and do need more of a friend, more of a long- term support than Living Well can offer. And it's getting to those people at the right time...it's not a specific age group or gender, I would say, it's when they're ready.*
>
> **Living Well coordinator**

Overview of analysis methods

Two main indicators used to assess the direct economic value of the Living Well service:

- savings associated with delays to the entry of service users to social care → Comparing the outcomes of Living Well service users, with those of a historical comparator cohort of similar individuals.
- the economic value assigned of improved wellbeing amongst service users → assigning an economic value to changes to user WEMWBS scores

Further measures:

- whether there has been a reduction in the proportion of older people within North Yorkshire open to social care over the lifetime of Living Well
- whether there has been a reduction in the proportion of people contacting the CSC being referred to social care within North Yorkshire, over the lifetime of Living Well

→ Monitoring data from HAS and CSC

Living Well delivers improved well being worth £3.84 per £1 spent

Assumption	WEMWBS gain	Deadweight	SROI ratio
Impact is only for cohort with 2 WEMWBS scores (1,244 clients)	£6,649,180	0	£1.84
		27%	£1.07
		65%	-£0.01
Impact applies to only half of those with no second score	£15,297,390	0	£5.63
		27%	£3.84
		65%	£1.32
Impact is same for full cohort as those with 2 observed WEMWBS scores	£24,052,500	0	£9.43
		27%	£6.61
		65%	£2.65

Based on

4,500 Living Well clients

- Individual gain per person £5,345
- Total costs of LW £2,306,000 up to March 2018

Evaluation evidence demonstrates a positive impact of Living Well for service users and North Yorkshire Country Council

Positive impacts continue into year 2, despite changes to source of referral and changing profile of client needs

Net savings for health and social care services

- £1.7m saving due to delayed entry to social care
- £8.9m net social impact (ROI £3.84)

Success of Living Well for an individual depends on a combination of factors:

- Motivated clients and those in need of practical support appear to benefit most
- Possible that those with mental health issues are less likely to benefit as much

➢ However, the evidence is not clear and we would not recommend a targeted approach without substantial further evidence

➢ Consider introducing a follow up call or contact for the most vulnerable clients

Low proportion of re-referrals to the service, often reflect greater needs or change in circumstances and not a failure of the service

➢ Need to monitor re-referrals in terms of volume, need and outcomes

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NORTH YORKSHIRE COUNTY COUNCIL

Care and Independence Overview and Scrutiny Committee

26th September 2019

Assistive Technology Service Update

1. Purpose of Report

1.1 To provide background and information on how NYCC uses Assistive Technology to enable people to live more independent lives for longer.

2. Current Delivery Model

2.1 Since April 2018 NYCC has commissioned Assistive Technology services (AT) through Nottingham Rehab Services (NRS) following a competitive procurement process. NRS deliver AT services across the county to both Adults and Children.

2.2 NRS assess for and supply Assistive Technology products and work in partnership with Apello who operate a monitoring centre which connects to devices such as alarm call pendants, and also with Yorkshire Ambulance Service (YAS) who provide an emergency response.

2.3 At present approximately 800 people have some form of AT assessed through the current contract with NRS. The range of equipment being used is extensive, ranging from simple lifelines to complex AT equipment such as GPS trackers, epilepsy sensors, property exit sensors and many more. At present an average of 140 new referrals are made to NRS from NYCC assessment staff each month.

2.4 The service commissioned in 2018 differs greatly from the previous iteration. Rather than specifying certain pieces of equipment and relying on NYCC Occupational Therapists (OTs) to understand and assess for this, the new contract operates as a more direct partnership between NRS and NYCC. NRS directly employ their own OTs, who receive referrals from NYCC assessment staff. These OTs are supported by NRS' technical experts who are able to identify the most appropriate piece of equipment to support a person's assessed needs and outcomes. This allows people to be supported with a far wider range of equipment and allows the contract to stay up to date with new and emerging technologies.

3. Nature of support offered and AT available

3.1 The AT contract allows for a wide range of products and solutions to be supplied to individuals to meet assessed needs, including:

- Fall Detectors
- Epilepsy (seizure) sensors
- GPS trackers
- Property exit sensor
- Carbon monoxide detector
- Smoke detector
- Bed / chair sensors
- Lifeline Pendants
- Door sensor
- Heat Detector
- Fob door systems

3.2 Depending on the level of support required by individuals, sensors can be connected to NRS' emergency response centre via Apello or to family or friends who are able to respond.

3.3 Where people require physical support Yorkshire Ambulance Service provide an emergency response service to people's homes if friends and family are not in a position to support.

4. Assessment and Eligibility

4.1 Assistive Technology for Adults is a chargeable service although costs are included within a person's financial assessment. Only people with an assessed eligible care and support need can be funded for AT by NYCC.

4.2 There are currently four AT service levels determined by assessment as shown below:

- Extra care schemes, NYCC Elderly Persons Homes and Resource Centres – Pendant not connected to monitoring centre at £2.00 per week
- Standard - base unit, pendant and friend and family response at £3.40pw
- Standard plus - base unit, pendant, mobile response - up to 2 add-ons at £6.00pw
- Standard extra - base unit, pendant, mobile response with 3 or more add-ons at £7.00

4.3 Consideration of AT forms a core part of the needs assessment completed by HAS Care and Support staff, with access to the AT referral embedded within Liquid Logic. Where cases are escalated for review consideration of AT support is always a priority.

4.4 NYCC provides a free of charge period of AT for reablement of up to 10 weeks, where the person may or may not have other eligible needs, to date approximately 120 people have accessed AT as part of their reablement package. This enables an assessment to be made of whether people would benefit in the long term from any sort of assistive technology.

4.5 Where people complete a period of reablement but not have assessed eligible needs, they are able to access AT through NRS' private pay offer.

4.6 As a service for people with assessed eligible needs, the AT service is focussed on ensuring that technology is used to maximise people's outcomes and to:

- Enable people to live healthier, independent lives for longer
- Enable people to live in their own homes for longer
- Reduce demand on social care services
- Reduce demand on health services
- Prevent or delay unnecessary hospital or care home admissions
- Facilitate early hospital discharges
- Enable market innovation
- Provide solutions that complement our existing services
- Support our strength based assessment processes
- Deliver services that provide value for money for the customer and the County Council
- Provide Assistive Technology solutions that changes lives, that enhances and compliments personal contact
- Improve access to Assistive Technology services

4.7 And providing a service that;

- is focused on prevention and early intervention
- has a clear process pathway, with a simple access to services for professionals through a self-referral route or information and advice on products to private paying customers

- Works with the private paying market which has a huge potential for expanding the service, offering more people more choices before the necessity to access statutory services
- Provides improvements in value for money, quality and efficiency
- Targets the reduction in the cost of care with a technology first culture
- Delivers increased opportunities for complex installations, delaying escalation in care and/or support needs
- Ensures there is a place for all types of technology to meet all types of needs
- Has clear and accessible information and promotes the use of Assistive Technology through social media and other methods of Marketing.

5. Long Term Support through Assistive Technology

5.1 The service is focussed on meeting a person's individual outcomes. To achieve this referrers no longer assess for specific equipment, instead they identify what outcomes a person is wanting to achieve i.e. reducing falls, keeping safe etc. By working together, NYCC assessment staff and NRS OTs and specialists are able to identify which piece of equipment or technology will best enable people to meet their outcomes and remain independent. NRS hold a catalogue of commonly used items but are able to special order more specialist items based on assessments. Where items such as this come into more general use they can be added to the catalogue.

5.2 As a service for people with assessed eligible needs, AT is very much focussed on augmenting existing care packages. Items such as fall detectors and epilepsy sensors give peace of mind to the person as well as friends and family and often allow a reduction in the need for direct care visits. In many cases people prefer this non-invasive approach, preferring a small piece of equipment to unnecessary visits from care workers who are 'just checking'.

5.3 People receiving ongoing care and support either through NYCC or a commissioned provider will have an annual review of the services they receive. This will include a review of their AT needs, assessing whether existing equipment still supports outcomes of if new or additional equipment is required due to a change in circumstances.

6. Case Study – Tim

6.1 Tim moved into The Cuttings, an Extra Care scheme in Harrogate earlier this year.

6.2 Tim likes to get out and about with his dog, Daisy, but he can be affected by short-term memory loss following a serious accident several years ago. This has caused him to be lost on a couple of occasions resulting in the police being called. To improve his confidence and independence, he now wears a GPS tracker on his wrist, which looks like a conventional watch.

6.3 The GPS tracker can be monitored by staff in The Cuttings, which means Tim and Daisy can be easily contacted when they are out, if need be. The tracker has a 'Geo Fence' which was agreed with Tim and will alert staff at The Cuttings if Tim and Daisy move beyond their usual routes. The two way communicator in the tracker means Tim and the staff at The Cuttings can easily communicate and can arrange to pick Tim up if he becomes lost or disoriented. This simple piece of AT has greatly restored Tim's confidence and his ability to go out walking, shopping and to the local pub to enjoy a quiz night with friends he has made.

6.4 This example highlights how the combination of a strong assessment by NYCC to understand what matters to a person – in this case the ability independently walk Daisy –

followed by the technical expertise of NRS has allowed an innovative approach that allows a person to maintain their independence and live the life they want to live.

6.5 Tim lives with the impact of an acquired brain injury, however this example could just as easily apply to people with other cognitive impairments such as dementia. Given the rising prevalence of dementia and the importance of delivering on the ambition of the North Yorkshire Dementia Strategy the AT service is focussed on supporting people and their carers.

6.6 AT can be particularly beneficial to people living with dementia and their carers - GPS trackers allow people the freedom to wander safely and offer peace of mind to carers and family who are able to unobtrusively ensure people are safe. Basic smart watches or phones with alerts and reminders can support people to comply with medication regimes and act as a prompt for daily tasks such as washing and dressing. More standard pieces of equipment such as fall detectors and smoke alarms linked either to a family member or response centre can offer safety and peace of mind.

6.7 Products such as property exit sensors are being used both out in the community and within our extra care housing schemes. These sensors are connected to a person front door and alert family, friends or staff, that a person has left their home. The person can be guided back safely or supported to go where they want to, but accompanied. Bed occupancy sensors are also regularly used, which alert family/staff if someone has left their bed and not returned. This could be due to a fall or confusion about the time – a time delay can be set on the equipment, to allow the person time to return to bed themselves, before someone responds, so it is less intrusive for the person.

7. Management of the Service

7.1 The Assistive Technology service is managed by the Housing Market Development Team (HMDT) as this team has a wider remit around Digital and online service development within HAS. Rebecca Dukes, HAS Housing Market Development Manager is the lead officer for the day to day operations of the contract.

7.2 HMDT work closely with Jon Tilley, Senior Occupational Therapist and operational staff to ensure that appropriate referrals are made and that equipment supplied to individuals supports the achievement of their desired outcomes.

7.3 Monthly service development meetings are held with NRS to ensure the contract is functioning effectively and meeting the needs of NYCC and individuals. These meetings allow individual instances to be discussed where a particular bespoke piece of equipment may be required but also wider strategic discussions around the direction of the contract such as how the digital telephony switchover can be handled. There is a strong working relationship between NRS and HMDT and where issues are more urgent these are raised and dealt with immediately. NRS have a dedicated contract manager who is in regular contact with the team, with national and strategic leads joining meetings and discussions as appropriate.

7.4 Throughout the contract so far NYCC officers have found NRS to forward thinking and proactive in addressing issues as they arise, the partnership ethos of the contract is well understood in these meetings and this allows for open discussions and innovative thinking.

8. Evaluation

8.1 To enable close monitoring of the AT service, NRS provide NYCC with monthly Management Information reports through a secure portal. These reports contain valuable

information that has not previously been collected in this format, allowing an overview of all the different aspects of the service delivered by NRS. The data from the monitoring service also enables the monitoring of call types i.e. people who have fallen, frequent callers, emergency service response, types of equipment being used, numbers of referrals for reablement etc. Receiving this type of data means that for certain aspects of the service, such as frequent callers, we are able to be more proactive, feeding data back to Care and Support teams who can then work with people to ensure their care package and AT support is appropriate and investigating any other issues.

8.2 Following the initial transition and implementation phases, work has begun with NRS on a full Benefits Realisation process. This process will enable NRS to report back to NYCC as to where potential savings or efficiencies could be made around reducing or delaying the need for more formal care, which pieces of AT are most effective and any gaps in the existing offer. NRS will use data from North Yorkshire as well as their experience from working with other local authorities across the country. This information will inform future service development as well as care and support practice and decision making.

9. Future Development of Assistive Technology / Digital Transformation.

9.2 The current service is designed to encourage and facilitate innovation and person-centred solutions. The specification was specifically written so that a provider could demonstrate innovation through their assessments, giving the autonomy to consider equipment outside of the standard catalogue for people with more complex or specific needs.

9.3 The technology sector is moving very quickly and the contract allows NYCC to stay at the forefront of any change. This development is true of both traditional AT products and consumer technology. We have reached a stage where many people have more powerful technology in their own homes than we are able to provide. In these instances it is important to link in to what people already have wherever possible. Increased use of products such as Amazon Alexa and Google Home offers tremendous opportunities as evidenced by the ongoing work by Stronger Communities in Sleights.

9.4 All equipment supplied to NYCC clients from April 2020 onwards will be fully compliant with the digital telephony switchover, meaning that we are able to gradually transition to these new products rather than having to replace all existing equipment in one go.

9.5 In the coming years we are likely to see an increase in wearable tech with a range of sensors and alerts to monitor people's health and predict events such as falls and UTIs which can have a major detrimental effect on outcomes. Smart Home technology is advancing rapidly with automated heat, light and security features, the benefits of these products need to be assessed and understood to ensure positive outcomes and value for money but there is much potential.

9.6 HAS are aware of the need to balance the use of technology with human contact. Social Isolation and loneliness are key factors in health and wellbeing and we are well aware that it is neither possible nor desirable to replace all human interventions with AT. Assistive Technology acts as a bridge between traditional hands on care and self-care, allowing people to remain independent with a safety net if the worst should happen.

9.7 From a HAS perspective AT also allows us to focus our workforce in the places that they are most needed rather than using valuable time on tasks that can be completed in other ways. This may mean completing what have been traditionally face to face visits with AT reminders or video calls whilst always being cognisant of the need for human contact and interaction. Where an individual has a strong social circle we can consider using AT in this

way, in cases where the carer may be the only visitor a person receives then we must consider the impact of removing that interaction.

9.8 More complex pieces of bespoke AT are also becoming available. We are also in the process of working with NRS and Dementia Forward to trial Yorkie, our first Robot colleague. Yorkie is a PARO Seal, first developed in Japan around 15 years ago and successfully used to support people living with dementia and other conditions all over the world ever since.

9.9 Whilst he may look like child's toy, Yorkie is a highly complex piece of equipment. He has five kinds of sensors: touch, light, audio, temperature, and posture, which he uses to perceive people and the environment. With the light sensor, he can recognize light and dark, he feels being stroked by tactile sensor, or being held by the posture sensor. Yorkie can also recognize the direction of voice and words such as its name, greetings, and praise with its audio sensor.

9.10 More importantly Yorkie seems to have a great impact on people's outcomes, trials across the world have been found to reduce stress, stimulate interaction between people and carers, and has been shown to have a Psychological effect on people, improving their relaxation and motivation and reducing challenging behaviour.

9.11 Yorkie will be spending three months with Dementia Forward where he will work with a range of people and groups so we can evaluate his impact on wellbeing. In addition to Yorkie we have also acquired a number of robotic cats which will be spending time in a range of services across the county over the next few months working in a similar way to Yorkie.

10. Regional and Collaborative Working

10.1 NYCC are full members of the TSA (Technology enabled care Services Association) giving full access to a wide range of resources, information and access to both regional and national events. The TSA has some initial involvement in supporting NYCC to shape our service specification.

10.2 The TSA the professional body that determines quality standards by which all AT and telecare services must achieve. For the purpose of NYCC's contract, NRS have achieved the TSA accreditation as outlined by the TSA.

10.3 A representative from the AT group also regularly attends both local and national AT/TEC forums for service development purposes. Good practice ideas from these forums are fed back into the monthly meeting with NRS.

11. Summary

11.1 The current Assistive Technology contract with NRS is considered to be a highly effective, outcomes and partnership led approach to supporting people. By moving away from a focus on products and instead concentrating on the outcomes people want to achieve, HAS is able to most effectively utilise existing and emerging technologies. The partnership with NRS is highly beneficial and allows access to innovative products such as PARO as well as access to deep knowledge of effective products and practice. This approach will allow HAS

to stay up to date as technology changes over the life of the contract and the demands and expectations of people receiving our services increase.

12.0 Recommendations

12.1 The Care and Independence Overview and Scrutiny Committee is recommended to note the information in this report.

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17 September 2019
Background Documents: None

NORTH YORKSHIRE COUNTY COUNCIL

Care and Independence Overview and Scrutiny Committee

26 September 2019

Work Programme 2019

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 Scheduled Committee dates/Mid-Cycle Briefing dates

3.1 Committee Meetings

- Thursday 28 November 2019 at 10am
- Thursday 5 March 2020 at 10am

3.2 Mid Cycle Briefing Dates

- Thursday 31 October 2019 at 10am.
- Thursday 13 February 2020 at 10am

3.3 It is expected that the new calendar of meetings will be available for the November council meeting.

4.0 Changes to the Work Programme

4.1 At the Mid Cycle Briefing, Group Spokespersons discussed the following topics and made a number of minor changes to the scheduling of some others.

5.0 Support for Carers

5.1 The committee had agreed to some overview work at this September meeting to assess the support provided to adult carers of adults in North Yorkshire. Recognising that the directorate was working on changes to the Respite/Short Breaks approach and the planned consultation on this would start after this meeting, group spokespersons agreed it made sense to defer both to the November committee meeting.

6.0 Section 75 HARA Consultation

6.1 Group Spokespersons welcomed the NYCC's joint work with NHS partners, to be covered by a Section 75 Agreement, towards an integrated approach to commissioning and provision of health care, public health and social care services in Harrogate and Rural District.

6.2 The focus for the briefing was the report considered by the Executive meeting on Tuesday 16 July 2019 and the consultation documents available here. https://www.northyorks.gov.uk/section-75-hara-consultation. Members agreed to receive periodic reports on progress.

7.0 Suicide Prevention and Audit

7.1 The Chairman and Group Spokespersons have agreed to follow up the briefing they received on Suicide Prevention and Audit at their mid cycle briefing with an interactive session for all the committee members. The intention is to close the 28 November committee meeting off early - it's a short agenda - and go straight into informal session for about an hour, starting around 11.30am

8.0 Young People with additional needs transitioning to Adulthood

8.1 The total number of young people with a learning disability aged 14-18 in North Yorkshire is approximately 500. On average just over 100 young people will "move" from Children's Services to Adult Social Care, of whom a third will have an array of complex needs.

8.2 Transition at all stages, whether from birth to home, home to nursery, primary to secondary, to a new home or residential situation or transition into a new specialist service, is a key issue for children, young people and families. Members were pleased to hear at the last meeting that HAS and CYPS have worked hard at improving the sharing of information and the planning and budgeting for services. A new pathway has been agreed between the HAS and CYPS directorates for young people transitioning from children's social care to adult social care. Clear protocols are consolidating better integration of services in appropriate areas to ensure appropriate support is in place as children move to adulthood.

8.3 As scrutiny members it is important that you assess how well we are supporting and responding to need during this very important stage in a young person's life. This committee's interest in this topic is shared by the Care and Independence Overview Scrutiny Committee. It was suggested that a joint session with that committee's membership be arranged. This has been agreed for the 6 December on the rising of the YPOSC meeting.

9.0 Recommendations

9.1 The 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

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4 September 2019

APPENDIX 1

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 26 September 2019 at 10am
	Thursday 28 November 2019 at 10am
	Thursday 5 March 2020 at 10am

Programme

BUSINESS FOR THURSDAY 26 September 2019			
TOPIC	**CONTENT**	**APPROACH**	**LEAD**
Health and Adult Services Financial Pressures	Operational Actions overspend update. A review of the actions undertaken aimed at reducing the financial pressures, while continuing to look for other savings to support the Council's overall budget position.	Assurance item. Report and Briefing	Anton Hodge
Mental Health – implementation and pathway	implementation and pathway	Presentation	Chris Jones-King
Living Well	Evaluation, current service and looking ahead	Presentation	Chris Jones-King/Cath Simms
Assistive Technology - Independent Living. To include reference to procurement	How NYCC uses Assistive Technology	Understanding and evaluation. Breifng Report	Dale Owens/Mike Rudd
BUSINESS FOR THURSDAY 28 November 2019			
TOPIC	**CONTENT**	**APPROACH**	**LEAD**
Short Breaks/Respite care	review – possible news on engagement sessions	Review consultation proposals	Dale Owens

Support for Carers	in particular how we respond to pressures upon families		
Health and Social Care Integration	Task Group Report - Final		Ray Busby
Transfers of Care Annual update	Performance item		
BUSINESS FOR THURSDAY	5 March 2020		
TOPIC	**CONTENT**	**APPROACH**	**LEAD**
Commissioned Services: The Provider perspective	Series managed dialogue/conversation with providers:	eg Wellbeing, Prevention and mental health contracts, Advocacy, Dementia Support	

Mid Cycle Briefings Dates –10am start

31 October 2019 DPH Annual Report Public Health grant review - priorities Public Health Campaigns briefing Reablement Prevent Reduce Delay current situation informal briefing Local Account Meeting Substance Misuse Providers (possible only)	**13 February 2020** Market Intervention and Residential Care/Domiciliary trade Review in-house residential provision Extra Care Programme Update and overview

Other arranged meetings

Monday 18 November 2019 at 2pm
Annual Safeguarding Board Report – Professor Sue Proctor

28 November (on rising of committee that day)
Suicide prevention and audit

Friday 6 December at (probably) 12.30pm
Transitions: Joint meeting with YPOSC members