# Agenda

# Meeting: Young People's Overview & Scrutiny Committee

# Venue: Grand Committee Room, County Hall, Northallerton DL7 8AD (see location plan overleaf)

# Date: Friday, 4 April 2014 at 10.30 am

## Business

**1. Minutes of the meeting held on 31 January 2014.** **(Pages 1 to 5)**

**2. Public Questions or Statements.**

Members of the public may ask questions or make statements at this meeting if they have given notice to Lorraine Laverton of Policy & Partnerships *(contact details below)* no later than midday on Tuesday 1 April 2014 three working days before the day of the meeting. Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

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

***Suggested timings***

**3. Executive Members Oral Briefing** ***10.35am- 10.50am***

Enquiries relating to this agenda please contact Lorraine Laverton **Tel: 01609 532108**
**Fax: 01609 780447 or email Lorraine.laverton@northyorks.gov.uk**
Website: www.northyorks.gov.uk

4. **2020 North Yorkshire Programme Update** – Oral Report of the Corporate Director – Strategic Resources. ***10.50am- 11.10am***

5. **Children & Young People's Plan** – Presentation by the Corporate Director – Children & Young People's Service. ***11.10am- 11.30am***

6. **Pupil Place Planning 2014-2017** – Report of the Corporate Director – Children & Young People's Service. ***11.30am – 11.50pm***

**(Pages 6 to 18)**

7. **Commissioning of the 5-19 Healthy Child Programme (HCP)** – Report of the Director of Public Health. ***11.50am - 12.10pm***

**(Pages 19 to 33)**

8. **Draft North Yorkshire Alcohol Strategy** – Report of the Director of Public Health. ***12:10pm-12:30pm***

**(Pages 34 to 61)**

9. **Work Programme** – Report of the Scrutiny Team Leader. ***12:30pm-12:40pm***

**(Pages 62 to 65)**

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

Carole Dunn
Assistant Chief Executive (Legal and Democratic Services)

County Hall
Northallerton

27 March 2014

**NOTES:**

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

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

(b) **Emergency Procedures For Meetings**

**Fire**

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First Aid treatment can be obtained by telephoning Extension 7575.

# Young People

# Overview and Scrutiny Committee

**1. Membership**

| **County Councillors (13 )** | | | | |
|---|---|---|---|---|
| | *Councillors Name* | *Chairman/Vice Chairman* | *Political Party* | *Electoral Division* |
| **1** | ARNOLD, Val | | Conservative | |
| **2** | BACKHOUSE, Andrew | | Conservative | |
| **3** | BASTIMAN, DEREK | | Conservative | |
| **4** | JEFFELS, David | | Conservative | |
| **5** | JEFFERSON, Janet | | NY Independent | |
| **6** | JONES, Anne | | Liberal Democrat | |
| **7** | LUNN, Cliff | | Conservative | |
| **8** | PLANT, Joe | Vice Chairman | Conservative | |
| **9** | RITCHIE, John | | Labour | |
| **10** | SANDERSON, Janet | | Conservative | |
| **11** | SHIELDS, Elizabeth | Chairman | Liberal Democrat | |
| **12** | SWALES, Tim | | Conservative | |
| **13** | TROTTER, Cliff | | Conservative | |

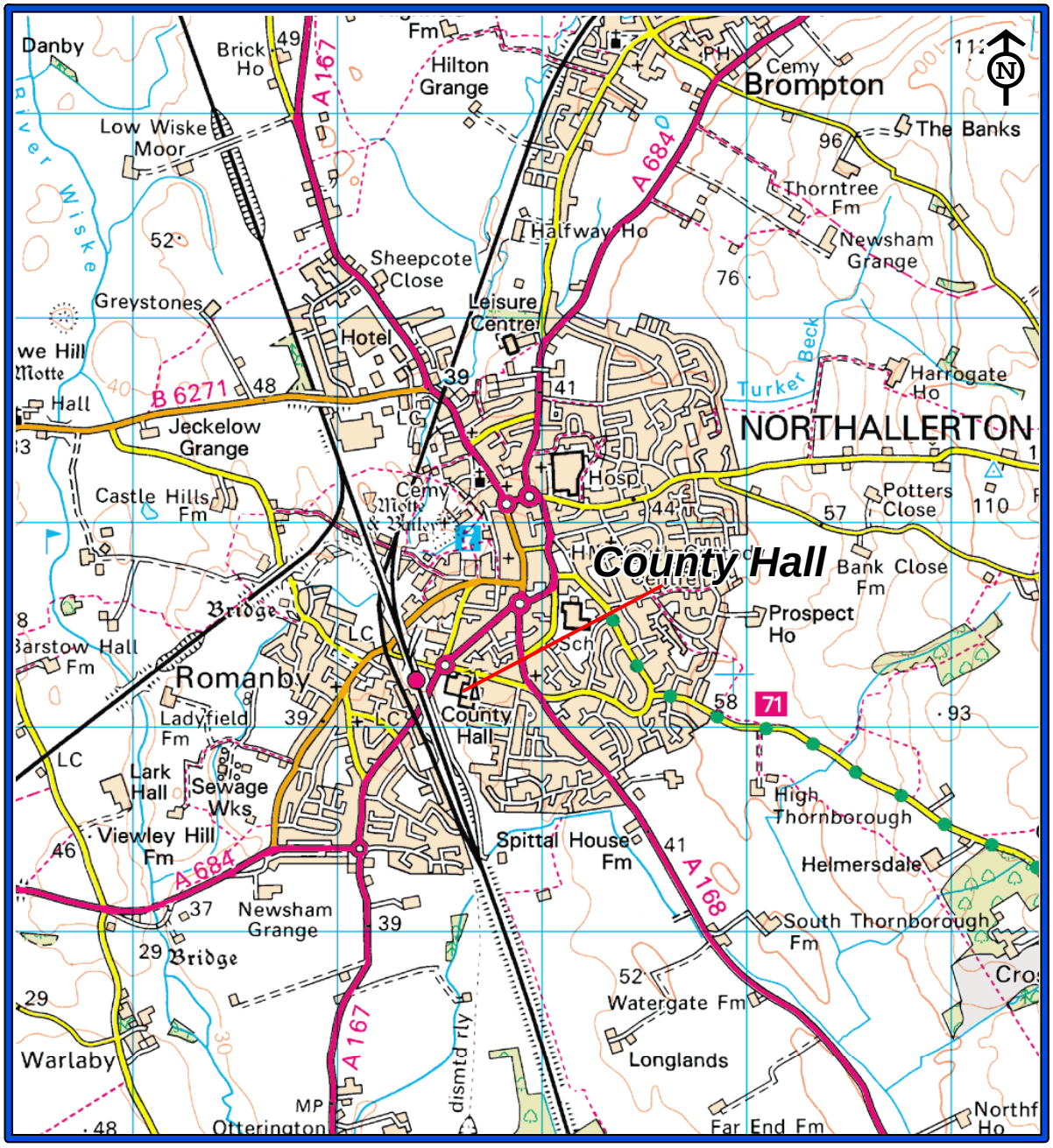
| **Members other than County Councillors – ( ) Voting** | | |
|---|---|---|
| | *Name of Member* | *Representation* |
| **1** | RICHARDS, Graham | Church of England |
| **2** | VACANCY | Non-Conformist Church |
| **3** | VACANCY | Roman Catholic Church |
| **4** | VACANCY | Parent Governor |
| **5** | VACANCY | Parent Governor |
| **6** | | |

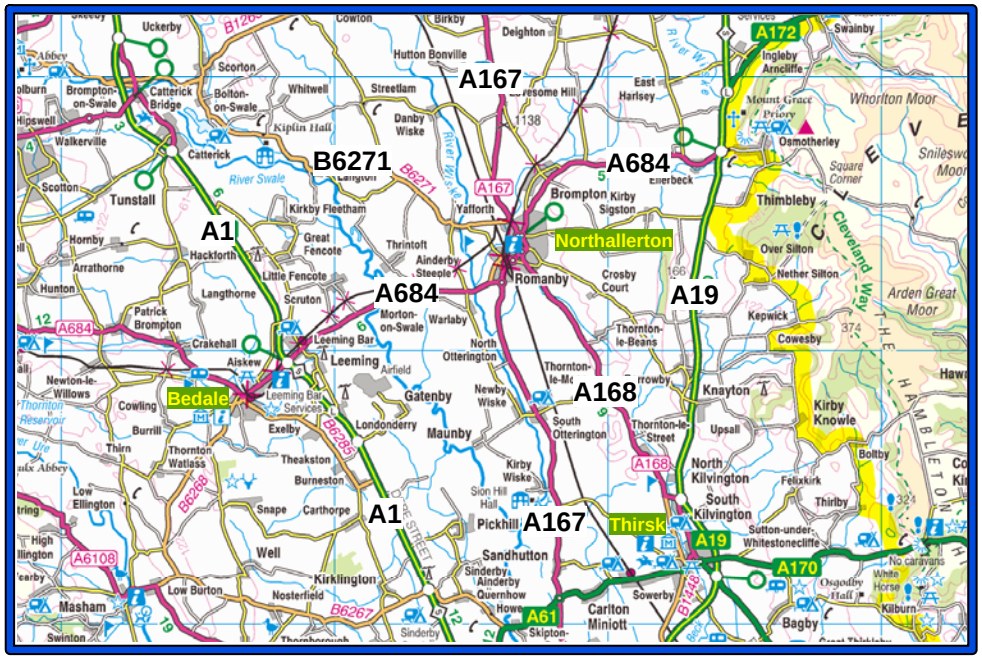
| **Non Voting** | | |
|---|---|---|
| **1** | VACANCY | Secondary Teacher Representative |
| **2** | CLARKSON, Michael | Primary Teacher Representative |
| **3** | CARLING, Jon | Voluntary Sector |
| **4** | ALLINSON, Kenneth | Voluntary Sector |
| **Total Membership – ( )** | | **Quorum – (4)** |

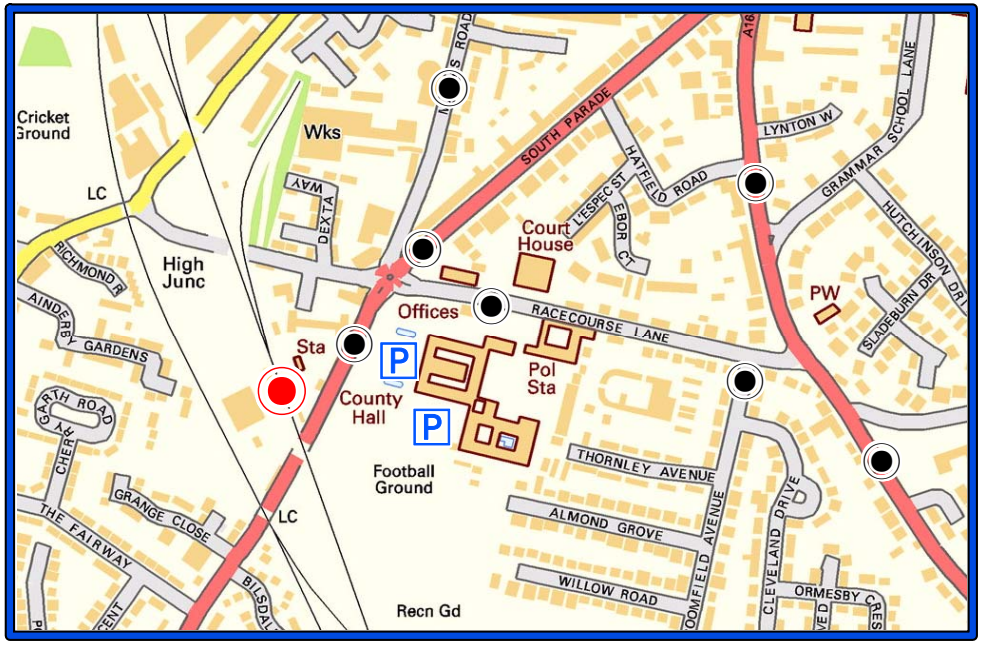
| **Con** | **Lib Dem** | **Ind** | **Labour** | **Liberal** | **UKIP** | **Ind** | **Total** |
|---|---|---|---|---|---|---|---|
| **9** | **2** | **1** | **1** | **0** | **0** | **0** | **13** |

**2. Substitute Members**

| **Conservative** | | **Liberal Democrat** | |
|---|---|---|---|
| | *Councillors Names* | | *Councillors Names* |
| **1** | ENNIS, John | **1** | GRIFFITHS, Bryn |
| **2** | MARSDEN, Penny | **2** | |
| **3** | BLADES, David | **3** | |
| **4** | WINDASS, Robert | **4** | |
| **5** | | **5** | |
| **NY Independent** | | **Labour** | |
| | *Councillors Names* | | *Councillors Names* |
| **1** | GRANT, Helen | **1** | RANDERSON, Tony |
| **2** | | **2** | |
| **3** | | **3** | |
| **4** | | **4** | |
| **5** | | **5** | |

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**County Hall**
Northallerton
North Yorkshire
DL7 8AD

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North Yorkshire County Council

# North Yorkshire County Council

# Young People Overview and Scrutiny Committee

Minutes of the meeting held on 31 January 2014 at 10.30 am at County Hall, Northallerton.

**Present**:- County Councillor Elizabeth Shields in the Chair

| | |
|---|---|
| County Councillors | Val Arnold, Derek Bastiman, John Ennis (as substitute for Cliff Trotter) David Jeffels, Janet Jefferson, Anne Jones, Cliff Lunn, Joe Plant, Janet Sanderson, Tim Swales |
| Co-opted members | Graham Richards (Church of England representative), Mr Paul Bircumshaw (Secondary Teacher representative and substitute for Mr Chris Head), Mr Michael Clarkson (Primary Teacher representative) |
| In attendance: | County Councillors Arthur Barker and Tony Hall (Executive Members) County Councillor Bernard Bateman |
| Officers: | Peter Dwyer (Corporate Director Children and Young Peoples Service (CYPS)), Anton Hodge (Assistant Director Strategic Resources, CYPS), Heather Newman (Adviser Quality & Improvement CYPS), Julie Firth (Head of Effective Practice and Quality Assurance, Children's Social Care), Lorraine Laverton (Corporate Development Officer) |

Apologies for absence were received from County Councillors Cliff Trotter, John Ritchie and co-opted member Jon Carling (Voluntary Sector representative)

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**Copies of all documents considered are in the Minute Book**

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**19. Minutes**

**Resolved –**

The Minutes of the meeting held on 18 October 2013 having been printed and circulated were taken as read and confirmed and signed by the Chairman as a correct record.

**20. Public Questions**

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

**21. Executive Members Oral Briefing**

The Chairman invited the Executive Members and the Corporate Director to update the Committee on the implications of the budget proposals for the Children and Young People's Service.

The Committee were advised that:

- An increase in post 16 home to school / college transport fees would be considered by the Executive in February 2014
- The proposals of the North Yorkshire Commission for School Improvement were included on the agenda but it is good to see schools themselves being involved in school improvement
- Savings from children's social care would be as a result of improvements to services and joined up working whilst further preventative work would reduce the numbers of children and young people requiring residential care.
- Questions would be asked to ensure that buildings are used to capacity and for community benefit
- In looking ahead to the savings for 2015/16 it is difficult to be specific but everything possible would be done to protect frontline delivery of services however in order to achieve the savings required difficult decisions will have to be taken.
- Areas to be reviewed include children's centres, how short breaks are provided, how partner agencies, schools and the County Council might pool resources, invest to save opportunities through an integrated transition team and further work on preventative services.

Members' questions and comments included:

- Reassurance that the needs and concerns of families would be taken into account when reviewing short breaks
- That Members are kept informed about the review of any children's centre in their Division

**22. 2013 Annual Report of the Looked After Children Members' Group**

Considered -

The report of County Councillor Janet Sanderson, Chairman of the Looked After Children Members' Group updating Members and the wider Council on the work of the Looked after Children Members Group.

County Councillor Janet Sanderson gave a full statement to the Committee in which she outlined the work undertaken by the LAC MG over the previous year. The Committee was unanimous in its support of the work of the Group and thanked Cllr Sanderson for her commitment and the dedication in which she has approached her work with the County Council's looked after children. Cllr Sanderson reiterated the need for all County Councillors to remember their role as a corporate parent and think how they might help the young people in our care. The Committee was particularly pleased to hear that future meetings of the LAC MG will receive an anonymous 'pen portrait' of a young person in the care of the County Council to help develop understanding around the circumstances that can lead to children and young people being 'looked after' and to recognise that each child has his or her own story.

Members' questions and comments included:

- That all County Councillors have responsibilities as corporate parents.
- Support for Regulation 33 inspections of children's residential homes by County Councillors.
- Suggestion to encourage local businesses with regard to employment and apprentice opportunities for looked after young people.

- Recognition for the 23 young people who have gone on to further education.

**Resolved -**

That the report be noted.

## 23. Sports Funding to Support Primary School Aged Children

Considered -

The report of the Corporate Director - Children and Young People's Service updating Members on the current funding arrangements to support primary aged children in Physical Education and Sport and outlining ways in which this funding can improve teaching and learning and extend sporting opportunities outside of the curriculum.

Ms Heather Newman informed Members about sports funding to support primary school children including that all schools with 17 or more primary pupils will receive a lump sum of £8000 plus a premium of £5 per pupil. Smaller schools will receive £500 per pupil for two years. In North Yorkshire this means that the smallest primary school will receive £7,500 and the largest £10,925 per annum. It represents over £5.5 million worth of funding across the County in the first two years.

Members' questions and comments included:

- In these austere times it is good to report on something positive for our young children. First of all it means that extra sport and physical education could in the long run help to reduce obesity in young people; secondly if this country is to achieve the highest rewards at not only at national, but also at international levels such as the Olympic Games and World Sports, then the training has to begin with the youngest.
- The possibility to broaden the scheme to include Parish Council and reassurance that links could be made.
- Recognition that each school is different and can use the funding appropriately to address their own needs.
- Clarification on how outcomes are monitored through the schools own website and OFSTED but that consideration is currently being given to the part the County Council plays in monitoring outcomes.

**Resolved -**

That the report be noted.

## 24. Proposals from the North Yorkshire Commission for School Improvement

Considered -

The report of the Corporate Director - Children and Young People's Service updating Members on the information provided in the North Yorkshire Commission for School Improvement report and seeking their comments.

The report informed the Committee that the Commission was established to address the question: '*How can we develop a collaborative system for effective school improvement that ensures that every school in North Yorkshire is good or outstanding?'*

In addressing this question Members felt it was important that the right people were sitting around the table and so they were pleased to see that those involved included leaders from primary, secondary and special schools, academies and federations together with local authority teams. The Committee agreed that the collaborative spirit in which this piece of work has been approached bodes well for the future and the proposals that the Commission has developed. The proposals include the development of a small number of school-led commissioning groups across the County. The Committee looks forward to a follow up report once the consultation on the proposals is completed and the results analysed.

**Resolved –**

a. That the report be noted.

b. That on conclusion of the consultation a follow up report be presented to a future meeting of the Committee.

## 25. Updating on Developing Stronger Families Programme

Considered -

Report of the Corporate Director - Children and Young People's providing Members with a general overview regarding the implementation and progress of the Troubled Families (locally known as 'Developing Stronger Families') initiative in North Yorkshire.

Ms Julie Firth advised the Committee about the work that continues to support those households who are defined by Central Government as 'troubled families'. The approach which the County Council has taken builds on the strengths of the family and the programme is therefore named 'Developing Stronger Families'. This ensures that they access the right support to address the needs for the whole family rather than responding to each problem, or person separately. Members continue to support the overarching aim of the programme to change the lives of these families for the better in the long term.

The Committee requested a further update on the programme in 12 months.

**Resolved –**

a. That the report be noted.

b. That the Committee receive a follow up report on the programme in twelve months.

## 26. Work Programme

Considered –

The report of the Corporate Development Officer inviting comments from Members on the content of the Committee's programme of work scheduled for future meetings.

The Chairman asked if Members had any additions, comments or changes to make on the Work Programme.

The Committee agreed to defer the final report of the Committee's Task Group looking at Online Safety for Children and Young People until the June 2014 meeting.

The Committee requested a report on the County Council's work on the prevention of child sexual exploitation and agreed that this should take place at the October 2014 meeting.

**Resolved –**

a. That the content of the Work Programme report and the Work Programme Schedule are noted.

b. That a report on the programme 'Developing Stronger Families' is scheduled in 12 months.

c. That the report on Online Safety for Children and Young people is deferred to the June 2014 meeting.

d. That a report on the County Council's work to prevent child sexual exploitation be presented to the October 2014 meeting of the Committee.

The meeting concluded at 12:45

LL/JR

NORTH YORKSHIRE COUNTY COUNCIL

CHILDREN AND YOUNG PEOPLE'S SERVICE

CHILDREN AND YOUNG PEOPLE'S OVERVIEW AND SCRUTINY COMMITTEE

4 April 2014

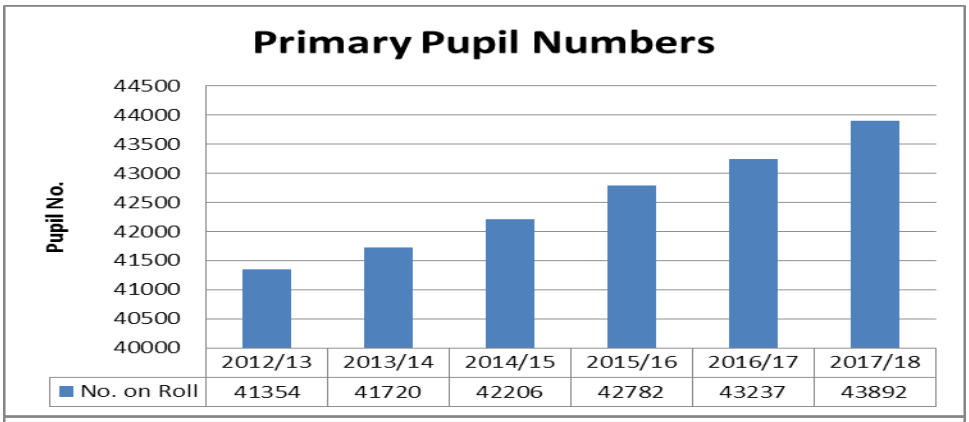
**PUPIL PLACE PLANNING**
**2014 to 2017**

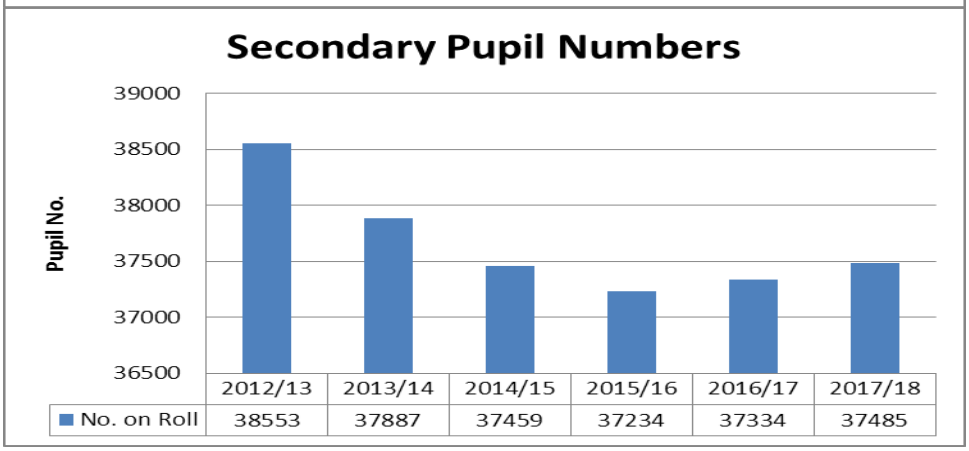
1.0 PURPOSE OF REPORT

To brief Overview and Scrutiny Committee on the need for additional primary pupil places up to September 2017 and the actions being taken to meet this demand.

2.0 BACKGROUND

2.1 Local authorities have a statutory duty to ensure an adequate supply of school places for children in their area. After many years of falling pupil rolls primary pupil numbers are now growing due to increased birth rates. Primary numbers are predicted to increase by 6% over the next five years on average across North Yorkshire. At secondary phase and Post 16 numbers will continue to fall until 2015/16 beyond which initial growth will be slow and uneven and will only start to gather pace towards the end of this period if significant housing comes forward.

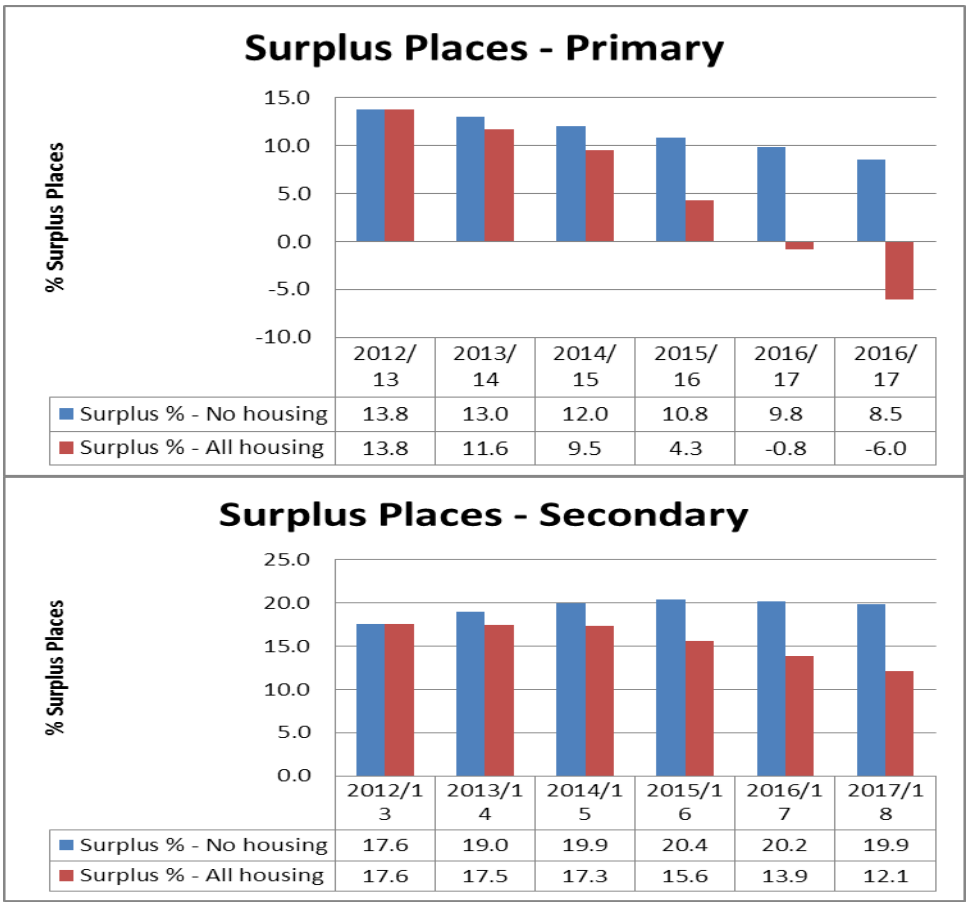


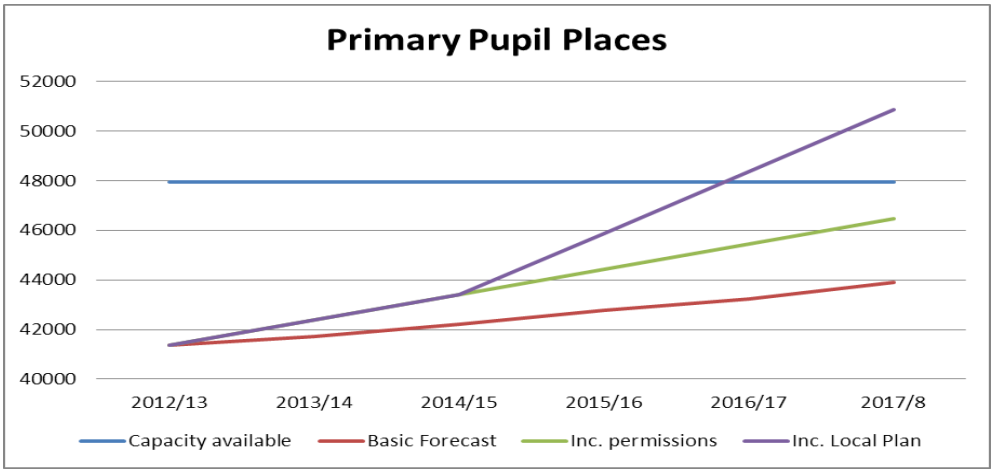



2.2 Currently at primary phase an average of 13.8% of all primary places are unfilled and at secondary phase 17.6%. Based on population growth alone this County wide surplus is forecast to reduce over the next five years to 8.5% at primary but to increase to 19.9% at secondary. These figures are county-wide and do not reflect actual need in individual communities. (see 2.5 below)

2.3 This position is very sensitive to housing growth at a local level. If all current planning approvals come forward in the next five years surplus places at primary schools will reduce much more quickly to only 3% which will create shortfalls in some places. The impact of this at secondary is less significant.

2.4 In addition to housing developments which have already achieved planning approval there are significant new site allocations being included to increase the supply of housing in the longer term. If additional housing allocations from Local Plans are factored in and start to come forward in the next few years the position becomes very different, with an emerging shortfall of 6% of primary places and surplus places at secondary reducing to 12.1%. This means that at an aggregated County level some 2,889 additional primary places may be needed by September 2017. At secondary phase 5,674 places will still available.






2.5 Surplus places in some parts of a locality may mask shortfalls in other parts of the wider area**. If no new places were provided, the total extent of oversubscription at an individual school level would total 7,256 primary places (the equivalent of 34 1FE primary schools) and 1,446 secondary places by September 2017. This represents the total extent to which individual schools might exceed their net capacity if no action were taken and all housing came forward. It is a theoretical worst case scenario.** The report will discuss the extent to which this is likely to translate into the need for additional physical capacity in schools.

2.6 It is clear that in some places significant numbers of additional primary places will be needed. The scale and timing will be determined by the speed at which housing comes forward. This is unpredictable and largely uncontrollable particularly as some Districts are moving away from a phased approach to housing delivery towards a more market driven approach. In some cases planning applications are being submitted ahead of inclusion of sites in local plans. This will create a challenge in terms of strategic planning and potentially the requirement for significant capital resources in the medium to long term.

3.0 MEDIUM TO LONG TERM IMPACT OF HOUSING GROWTH

The headline impacts of existing permissions combined with proposed Local Plan site allocations for new housing up to 2026 is as follows:

**Selby Town** –It has been established that an additional 1FE primary school will be required by September 2016 to serve the Staynor Hall development. It was agreed following consultation last year that this would be a new Academy. Some temporary expansion of Barwic Parade Community Primary School has already been undertaken in the short term.

Barlby Bridge Community Primary School will need to be relocated onto a new site and enlarged to accommodate the Olympia Park development which recently obtained planning approval. Significant additional housing which may be located in the Crosshills Lane area in the Selby CP catchment would require a significant expansion or an additional primary school if agreed. A planning application is expected for expansion of housing in Barlby which would impact on primary provision. It will be difficult to accommodate on existing sites. Expansion of some rural Selby primary schools will also be needed.

**Harrogate town** – If all current permissions come forward additional capacity will be needed in Harrogate town in the next five years. Housing in West Harrogate at Pennypot and Cardale Park (Bluecoates Site) will potentially create the need for two additional primary schools at the end of this period. Discussions are underway with developers to secure financial contributions. A number of other primary schools will need to be expanded in the short term and discussions are taking place with local schools. There may be an impact on secondary provision in the longer term as a result of a planned reduction to the capacity of Harrogate High School arising out of the rebuilding programmed by DfE after 2015. Additional capacity may be needed at secondary phase in some schools.

**Scarborough town** – Although it will not result in the requirement for additional pupil places, the Middle Deepdale development may create the opportunity to relocate Overdale Primary School. The timing of this remains unclear but the aspiration is for this to be delivered by September 2015. A number of other Scarborough town primary schools are likely to need additional capacity in the short and medium term based on current permissions. The Local Plan has yet to firm up longer term housing allocations but it is likely that local plan housing will be concentrated in Scarborough town.

**Knaresborough** – Housing at Manse Farm which already has planning approval will create the need for an additional primary school site and/or the significant expansion of existing primary schools. It is intended to consult on options during 2014. Additional capacity has already been put into two schools in recent years to ensure adequate places in the short term.

**Northallerton** – An additional primary school site will be needed to serve the North Northallerton Development Area for which a planning application will be made in the next few months. Some expansion of existing primary schools has been undertaken to provide capacity until the new school is developed. It is intended to consult on options during 2014.

**Thirsk** – An additional primary school or the significant expansion of existing primary schools will be needed to serve the Sowerby Gateway development. It is intended to consult on this during 2014. Feasibility work has already been undertaken to establish whether existing schools are capable of expansion.

**Catterick** – Significant planned expansion around the Garrison in the Local Plan will create the need for at least one additional primary school and/or expansion of existing provision. MOD rebasing plans may create temporary bulges in demand for primary places and impact on secondary provision. An officer working group is looking at how this can best be managed.

**Gatherley Road, Richmond** –If housing comes forward on this site it would be necessary to develop a small new school site due to the constraints of existing school sites. This may be managed as a satellite of an existing school.

**Pickering** – Significant housing will have an impact on Infant and Junior Schools on constrained sites which may require a wider review of primary provision in Pickering town once Ryedale housing allocations are clear.

**Malton and Norton** – Existing permissions will create a significant shortfall of places in the next five years. An additional primary school site is likely to be needed in both communities in the long term based on likely Local Plan allocations. Proposals have been drafted to expand two schools in Malton and a site is being sought for an expansion of primary provision in Norton.

**Sherburn** – It is likely that there will be a requirement for the significant expansion of one primary school and some expansion of other primary schools in the area to accommodate current permissions and likely Local Plan allocations. A site has been acquired to enlarge Sherburn Athelstan Primary School and one other primary school is currently being expanded.

**Other areas -**There are a number of places in addition to the above where planned growth will potentially create the need to expand existing primary provision e.g.

- Bedale
- Central Ryedale, particularly Kirkbymoorside
- Easingwold
- Ripon
- Richmond.
- Leyburn

Most Local Plan housing is concentrated in urban areas or market towns although there are some individual village primary schools which will need additional capacity to deal with localised growth.

At secondary phase pupils rolls are generally still falling and will continue to do so until 2016/17. However, there are forecast shortfalls in some places during that period which will need to be managed e.g.

- Knaresborough
- Boroughbridge

4.0 NEED FOR ADDITIONAL PLACES 2014-2015

4.1 Pupil place planning is now based on 22 secondary and 54 primary planning areas. The primary planning areas subdivide the town and rural areas. This ensures that growing urban demand is not masked by surplus places in surrounding rural areas which may not be realistic alternatives for parents due to geography or travelling distances.

4.2 Knaresborough is the only locality which has so far experienced a shortfall of places. This is being addressed through the expansion of existing schools. Other isolated shortfalls have been successfully addressed through capital investment and other measures. In other localities there are varying degrees of surplus still remaining.

4.3 A level of surplus places between 5% and 10% is historically considered to be a reasonable level to ensure an adequate buffer against fluctuating numbers and to maintain some element of parental choice. Ripon, Easingwold and North Ryedale now have surpluses which have dropped below that level. In contrast, in some rural areas the surplus exceeds 25%. For example,

Wensleydale has 29.8% surplus places, spread across a number of rural primary schools.

4.4 At secondary level Boroughbridge, Knaresborough, South Craven, Swaledale and Wensleydale all have less than 10% surplus, largely as a result of individual popular secondary schools. Catterick has 50% surplus at Risedale but this is an area where surplus capacity has been purposely retained due to troop movements.

4.5 So, the picture is a mixed one across the County but the general theme is one of surplus places quickly being absorbed by population and housing growth and an emerging build-up of demand for primary places in the urban areas compared with lower growth or continuing decline in rural areas.

4.6 **Based on the underlying population trend plus housing already with planning approval, there are around 40 primary schools which will be 30 or more places short (i.e. a full class) by September 2017 and others with varying degrees of shortfall below 30 places where additional capacity <u>may</u> be needed to ensure schools do not become excessively overcrowded.** This is a snap shot and forecasts do vary year on year.

4.7 **If an additional classroom were to be provided only for every multiple of 30 places this would be equivalent to 94 additional primary classrooms, the equivalent of 13 or 14 new 1 form entry primary schools. To give some impression of the scale of capital funding potentially required to address this shortfall, using the current multiplier (2008/9) for providing permanent additional primary places of £13,596 per place this would equate to more than £38m. The same proposition for secondary schools would indicate demand for 26 additional classrooms at an estimated cost of £15m**.

| Phase | Places per classroom | No. of classes potentially needed (multiples of 30) | Total number of places needed | Cost per place | Total cost |
|---|---|---|---|---|---|
| Primary | 30 | 94 | 2820 | £13,596 | £38,340,720 |
| Secondary | 30 | 26 | 780 | £20,293 | £15,828,540 |
| Total | | | | | £54,169,260 |

4.8 So, the developing demand for additional places over the next five years could theoretically cost in excess of £54m to deliver. The costs would be significantly higher where wholly new schools on new sites need to be provided as there are additional costs for site acquisition, external site development and ancillary accommodation. Also, some existing sites are constrained meaning that split site schools may need to be created to deliver additional places.

4.9 900 additional places have already been provided or will have been provided by September 2014 funded through the School's Capital Programme and developer contributions – 720 in primary schools and 180 in secondary.

## 5.0 NEED FOR ADDITIONAL PHYSICAL CAPACITY

5.1 The net capacity of each school, which is the baseline for assessing whether a school is full or not, reflects both the physical space in the building plus the number of funded places available in terms of classes being run and teachers employed.

5.2 In some cases, it will not be necessary to provide all of these extra places through the provision of additional physical classrooms. Where schools reach their Published Admission Number (PAN) it is possible for small numbers of additional pupils to be accepted above the PAN. Admissions staff will continue to work with schools to agree this. This scenario also may occur as a result of successful appeals at popular schools.

5.3 In some schools the net capacity of the school as it is currently organised is lower than the actual physical capacity of the building and it may be possible to increase the PAN to allow the school to grow without needing further physical space. This will involve discussions with schools about how they organise themselves. In some cases it may mean asking schools to change their class structure from single to mixed year groups. Care must be taken not to allow schools to become too overcrowded or classes too large. Class size legislation still constrains infant classes to 30 pupils. Where such expansion is agreed by governing bodies it is no longer necessary to undertake formal statutory processes to enlarge schools.

5.4 Some schools are popular and have attracted children from outside their catchment area in significant numbers. Over time as numbers grow within the catchment pupils will be displaced back to their 'normal' schools or to others with space available. This may mean that other schools in the area become fuller rather than needing to expand accommodation. This may have an impact on the extent to which it is possible in future to meet parental choice for places in popular schools. It may also mean on rare occasions being unable to offer a place at the normal school serving the child's home address and having to transport children to other nearby schools with places rather than providing additional physical capacity. This is something which North Yorkshire County Council has tried to avoid in the past.

5.5 In some schools there are spaces which, as numbers have fallen, have been taken into use as specialist spaces like art or music rooms or leased to third parties. Consideration will need to be given on a school by school basis as to whether it is possible to bring these spaces back into use as classrooms to avoid the capital cost of expansion. There may be concerns expressed by schools about the impact on the curriculum of doing so. Some of these spaces may be occupied by early year's providers or Children's Centre where there may be an impact on other children's service delivery. In some cases, though, the return of children's centre accommodation for school use may be of mutual benefit as the Council seeks to meet MTFS savings targets, which include an element covered by reducing the numbers of buildings used for the delivery of children's centre services.

5.6 In some cases housing with planning permission may not come forward to the full extent. There is considerable additional housing identified in the District Council's Local Plans and if any of that receives planning approval and begins to come forward the numbers may build up more quickly. Historically it has advanced more slowly than anticipated. The position on housing

completions is monitored with Districts annually and forecasts updated termly. Indications are that housing growth is now starting to accelerate but the actual rate of completion will be driven by market conditions.

5.7 The need to prioritise the provision of additional places in particular locations or at specific schools is under continuous review taking account of the above factors. A review of the impact of the current round of capital investments in addressing basic need has been undertaken as part of the annual capacity return to DfE and officers are now analysing the most recent set of pupil forecasts to determine the next set of priorities. There are proposals for the provision of a further 240 primary places in the 2014/15 capital programme to address pupil place need up to September 2015 (and the start of work on the new Staynor Hall primary school). A further report will be made to the Executive in September 2014 to agree additional places up to September 2017.

5.8 For the first time in many years it has been necessary for the County Council to consider how it can deliver whole new school sites and find significant blocks of capital funding amounting to several million pounds to bridge the gap between the building of a new school to serve a new development and the developer contribution being made, whilst continuing to address smaller scale growth needs and the maintenance of the existing estate.

## 6.0 CREATION OF NEW SCHOOLS

6.1 Where it is necessary to create wholly new schools there is a legal presumption that they will be Academies. This means that the Count Council is unlikely to be able to create new community schools. The local authority has the statutory responsibility to provide both capital funding and the pre and post opening revenue funding until such time as the school is at full capacity. This makes the decision about when and how to bring new schools on stream financially very significant. Revenue funding is provided through the retained Growth element of the Dedicated Schools Grant. If a number of new schools are opened at the same time this could be a significant level of expenditure.

6.2 There are various processes involved in opening an Academy including the appointment of an Academy sponsor. Once the school is built the site is transferred to the Academy sponsor on a 125 year lease and is no longer the responsibility of the local authority to run or maintain.

## 7.0 CAPITAL FUNDING

7.1 There are a limited number of sources of capital to resource additional pupil places:

<u>LA Capital Allocations – Basic Need</u>

7.2 Local authorities receive funding for additional places in the form of Basic Need grant. It is calculated on the basis of an annual return on capacity but weighted nationally to address relative need. It is not expected to meet the full costs of providing additional places. The allocations in recent years have been volatile:

| Financial Year | Basic Need Capital allocation |
|---|---|
| 2011/2012 | £3,262,822 |
| 2012/2013 | £5,099,199 |
| 2013/2014 | £1,563,312 |
| 2014/2015 | £1,563,312 |

7.3 In 2013 and 2014 the government made available further capital for additional places in the form of Targeted Basic Need which was a funding pot into which local authorities could bid. This was for places needing to be provided up to September 2015. It was not possible to demonstrate that the criteria for additional basic need funding could be met in North Yorkshire in 2012 when bids were submitted. Half of all that funding was subsequently allocated to London, the remainder mainly to large urban local authorities. This funding stream has been discontinued from April 2015. Instead DfE have made capital announcements for Basic Need in 2015/16 and 2016/17.

| Financial Year | Basic Need Capital allocation |
|---|---|
| 2015/2016 | £19,168,081 |
| 2016/2017 | £20,126,485 |

The allocations to North Yorkshire are significantly larger than in previous years and reflect the work that was undertaken in 2013 to adjust North Yorkshire planning areas to expose the true level of demand for places. This allocation will make a significant contribution towards the need for additional places up to September 2017 and will allow a full three year Basic Need programme for 2014 to 2017 to be approved in September 2014.

LA Capital Allocations – Other Funding

7.4 The remaining element of capital funding for schools which comes to local authorities is Capital Maintenance which may be used to meet any local priority including the provision of new places.

7.5 Other local authorities faced with mounting need for new places have needed to use elements of capital maintenance funding to support their growth programmes – in some cases up to 100%. To date it has not been necessary to do that in North Yorkshire but this may need to be considered. The annual allocation of Capital Maintenance has also been reducing:

| Financial Year | Capital Maintenance allocation |
|---|---|
| 2011/12 | £14,073,091 |
| 2012/13 | £11,803,443 |
| 2013/14 | £11,363,467 |
| 2014/15 | £11,048,236 |

7.6 The funding level beyond April 2015 will be unpredictable due to a change in the way it is being calculated by central government.

7.7 Other capital funding streams such as LCVAP (for VA schools only) and Devolved Formula Capital can be used to support Basic Need.

7.8 There are implications for the on-going maintenance of the school estate if insufficient investment is made in maintaining the physical condition of buildings. It may also constrain other investment needs such as the need to reconfigure accommodation around changing patterns of provision or curriculum delivery. The capital maintenance backlog currently exceeds £33m and if expenditure is reduced the County Council's efforts to keep pace with this growing need are likely to be compromised.

7.9 The risks of reducing expenditure on capital maintenance could be an increase in building failure leading to disruption of children's education, increased risk of non- compliance with building related regulations, increased risk of health and safety issues on school sites including safeguarding issues and the ensuing reputational damage. For these reasons it has not been proposed to use any element of Capital Maintenance funding in 2014/15 to support the delivery of new places.

7.10 It is proposed to bring forward a revision to the Local Investment Priority statement which lays out the County Council's priorities for investment in schools to take account of this changed context. This document forms part of the County Council's policy framework and would be agreed by the Executive following consultation with schools.

Developer Contributions

7.11 Where there are major housing developments under consideration agreement will be sought to the provision of land and financial contributions towards additional places through Section 106 or Community Infrastructure Levy. This helps to support the capital allocations received by the local authority. There are already agreements in place which would provide approximately £5 in terms of contributions which may help to address need in the next five years. The majority of this relates to the Staynor Hall, Selby Development and Sowerby Gateway where new schools or major expansions will be required if housing advances.

Other sources of funding

7.12 Other potential sources of funding are:

- Capital receipts
- County Council borrowings
- County Council reserves
- PFI
- Free School applications

Given the depressed state of the housing market and general economy in recent years, capital receipts have been hard to come by. There are a number of former schools already on the market with little interest shown from developers.

Other local authorities have found it necessary to allocate corporate resources to support the provision of additional educational places. This may be something which may need to be considered in North Yorkshire in future. This may be a significant challenge in the face of reducing budgets over the coming years.

## 8.0 CONCLUSIONS

8.1 There is a growing demand for pupil places. Initially this will predominantly be in primary schools but later on this will be seen in the secondary sector. The demand is volatile and sensitive to housing growth. Officers will continue to work closely with District colleagues and developers to monitor the scale and speed of housing growth.

8.2 There are a range of measures which local authorities can take in conjunction with schools to minimise the extent to which this demand needs to be met through additional buildings. There are some risks and potentially some difficult decisions that may need to be taken as a result. Officers will continue to have these conversations with individual schools. In some cases this will be to seek agreement to expansion. In others it will be to agree the alternative use of existing physical capacity, the increase in admission numbers or to discuss the potential for new school sites.

8.3 Where appropriate, consultation will be undertaken with local stakeholders particularly parents to agree future patterns of educational provision in an area. Where wholly new schools are needed officers will be responsible for working with DfE to secure an appropriate Academy sponsor.

8.4 The capital funding available to meet the demand for places is limited and not likely to be adequate to meet the full need, particularly where whole new school sites need to be provided. Officers will continue to seek developer contributions and to maximise the availability of funding from central government.

8.4 Members may need to take decisions about reprioritising other aspects of capital funding or allocating funding from other sources to support the provision of school places in the future in order to meet its statutory duty to ensure sufficient school places.

## 9.0 RECOMMENDATION

That members of Overview and Scrutiny Committee note the current position.

CORPORATE DIRECTOR – CHILDREN AND YOUNG PEOPLE'S SERVICE.

Report prepared by Suzanne Firth, Strategic Planning Manager

# Appendix 1: Summary of Capacity, Pupil Roll and Forecast Data – Primary

| Planning Area | Capacity | Roll Sept 2013 | Current Surplus/ Shortfall | Forecast Sept 2017 | Forecast Surplus/ Shortfall | Notes |
|---|---|---|---|---|---|---|
| Barlby | 454 | 480 | -26 | 568 | -114 | Plan to relocate and enlarge Barlby Bridge CP |
| Bedale | 330 | 328 | 2 | 393 | -63 | Exploring feasibility of expansion - some surplus in village schools |
| Bedale Outer | 943 | 640 | 303 | 675 | 268 | |
| Boroughbridge | 413 | 423 | -10 | 472 | -59 | Exploring feasibility of expansion - some surplus in village schools |
| Boroughbridge Outer | 705 | 504 | 201 | 515 | 190 | |
| Catterick Garrison | 1079 | 1031 | 48 | 1228 | -149 | Feasibility undertaken on potential expansion. Rebasing plan creates complexity |
| Catterick Outer | 729 | 633 | 96 | 663 | 66 | |
| Easingwold | 315 | 317 | -2 | 387 | -72 | Exploring feasibility of expansion - some surplus in village schools |
| Easingwold Outer | 962 | 915 | 47 | 999 | -37 | |
| Filey | 551 | 470 | 81 | 554 | -3 | |
| Filey Outer | 391 | 333 | 58 | 357 | 34 | |
| Harrogate Outer | 1440 | 1173 | 267 | 1241 | 199 | |
| Harrogate Urban Central | 2397 | 2013 | 384 | 2288 | 109 | |
| Harrogate Urban East | 1040 | 1058 | -18 | 1111 | -71 | Exploring feasibility of expansion with a number of schools |
| Harrogate Urban West | 1883 | 2025 | -142 | 2135 | -252 | Proposal for significant enlargement of one school and potential for smaller enlargement of others |
| Knaresborough | 1142 | 1197 | -55 | 1261 | -119 | Adding capacity to two schools. Will consult on new site in 2014 |
| Knaresborough Outer | 420 | 388 | 32 | 416 | 4 | |
| Malton and Norton | 1066 | 1066 | 0 | 1253 | -187 | Proposal for enlargement of two schools in Malton. Exploring potential sites in Norton. |
| Malton and Norton Outer | 939 | 774 | 165 | 829 | 110 | |
| Masham Area | 119 | 155 | -36 | 193 | -74 | |
| Nidderdale Outer | 266 | 258 | 8 | 288 | -22 | |
| North Craven Outer | 870 | 580 | 290 | 592 | 278 | |
| North Ryedale | 972 | 990 | -18 | 1072 | -100 | Some capacity being added to two schools and further planned. Additional site area acquired. |
| North Ryedale Outer | 566 | 455 | 111 | 501 | 65 | |
| Northallerton | 1330 | 1268 | 62 | 1467 | -137 | Adding capacity to one school. New school site will be needed by 2017. |
| Northallerton Outer | 714 | 632 | 82 | 714 | 0 | |
| Pateley Bridge Area | 120 | 113 | 7 | 122 | -2 | |
| Ripon | 1364 | 1337 | 27 | 1436 | -72 | Exploring feasibility of expansion. |
| Ripon Outer | 658 | 569 | 89 | 601 | 57 | |
| Scarborough Central | 2500 | 2180 | 320 | 2435 | 65 | |
| Scarborough North | 1239 | 1319 | -80 | 1472 | -233 | Undertaking feasibiilty of expansion. Housing has stalled. |
| Scarborough Outer | 1064 | 999 | 65 | 1048 | 16 | |
| Scarborough South | 1053 | 784 | 269 | 950 | 103 | |
| Selby | 1297 | 1163 | 134 | 1458 | -161 | Capacity added to one school. Planning a new 1FE school for 2016. |
| Selby Outer North | 948 | 950 | -2 | 1052 | -104 | Adding capacity to three schools in 2014 |
| Selby Outer South | 2093 | 1843 | 250 | 2009 | 84 | |
| Settle | 210 | 196 | 14 | 219 | -9 | |
| Sherburn | 629 | 609 | 20 | 781 | -152 | Adding capacity at two schools. Additional site area acquired for future significant enlargement. |
| Sherburn Outer | 908 | 837 | 71 | 925 | -17 | Additional capacity planned at one school |
| Skipton | 1130 | 1019 | 111 | 1080 | 50 | |
| Skipton Outer | 1226 | 1013 | 213 | 1049 | 177 | |
| South Craven | 617 | 548 | 69 | 617 | 0 | |
| South Craven Outer | 508 | 488 | 20 | 508 | 0 | |
| Stokesley | 447 | 355 | 92 | 368 | 79 | |
| Stokesley Outer | 984 | 776 | 208 | 812 | 172 | |
| Swaledale | 1196 | 1127 | 69 | 1149 | 47 | |
| Swaledale Outer | 599 | 450 | 149 | 461 | 138 | |
| Tadcaster | 649 | 554 | 95 | 625 | 24 | |
| Tadcaster Outer | 223 | 210 | 13 | 226 | -3 | |
| Thirsk | 663 | 608 | 55 | 773 | -110 | Consulting on major expansion or new school site in 2014 |
| Thirsk Outer | 862 | 768 | 94 | 855 | 7 | |
| Wensleydale | 210 | 179 | 31 | 159 | 51 | |
| Wensleydale Outer | 457 | 307 | 150 | 279 | 178 | |
| Whitby | 1183 | 945 | 238 | 1027 | 156 | |
| Whitby Outer | 953 | 691 | 262 | 693 | 260 | |
| | | | | | | |
| Totals | 48026 | 43043 | 4983 | 47361 | 665 | Surplus capacity reduces from 10% to 1% |

Appendix 2: Summary of Capacity, Pupil Roll and Forecast Data – Secondary

| Planning Area | Capacity | Roll Sept 2013 | Current Surplus/ Shortfall | Forecast Sept 2017 | Forecast Surplus/ Shortfall | Notes |
|---|---|---|---|---|---|---|
| Bedale and Rural | 937 | 760 | 177 | 871 | 66 | |
| Boroughbridge | 769 | 776 | -7 | 911 | -142 | 120 places added in 2013 |
| Catterick | 900 | 454 | 446 | 514 | 386 | Surplus for troup movement |
| Central Ryedale | 1894 | 1561 | 333 | 1466 | 428 | |
| Easingwold and Rural | 1441 | 1276 | 165 | 1208 | 233 | |
| Filey | 840 | 613 | 227 | 645 | 195 | |
| Harrogate and Rural | 8745 | 7386 | 1359 | 7309 | 1436 | Capacity to be reduced at HHS in 2015 |
| Knaresborough | 1673 | 1680 | -7 | 1762 | -89 | A third of the cohort are Harrogate children with places available at HHS |
| Mid Craven | 2782 | 2462 | 320 | 2408 | 374 | |
| North Craven | 881 | 687 | 194 | 666 | 215 | |
| North Ryedale | 1726 | 1460 | 266 | 1476 | 250 | |
| Northallerton | 2112 | 1441 | 671 | 1409 | 703 | |
| Ripon and Rural | 1689 | 1313 | 376 | 1398 | 291 | |
| Scarborough | 4534 | 3584 | 950 | 3596 | 938 | |
| Selby Secondary | 3621 | 2643 | 978 | 2743 | 878 | |
| Sherburn and Tadcaster | 2825 | 2353 | 472 | 2480 | 345 | |
| South Craven | 1769 | 1732 | 37 | 1773 | -4 | |
| Stokesley and Rural | 1412 | 1216 | 196 | 1227 | 185 | |
| Swaledale | 2246 | 2122 | 124 | 2099 | 147 | |
| Thirsk and Rural | 1277 | 1010 | 267 | 955 | 322 | |
| Wensleydale | 523 | 470 | 53 | 402 | 121 | |
| Whitby and Rural | 1984 | 1426 | 558 | 1380 | 604 | |
| | | | | | | |
| Totals | 46580 | 38425 | 8155 | 38698 | 7882 | Surplus capacity falls from 18% to 17% |

**NORTH YORKSHIRE COUNTY COUNCIL**

**YOUNG PEOPLE OVERVIEW AND SCRUTINY COMMITTEE**

**4 April 2014**

# Commissioning of the 5-19 Healthy Child Programme (HCP)

## 1. Purpose of the report.

To provide the Young People's Overview and Scrutiny Committee with information about the Healthy Child Programme and the commissioning arrangements.

Reference: Healthy Child Programme. From 5-19 years old.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

## 2. General Information

2.1 The HCP was established by the Department of Health in October 2009 and is separated into two programmes, one focusing on pregnancy to 5 years and the other on 5 to 19 year olds. The main contract associated with the 0-5 programme relates to the Health Visitor workforce and this is contract managed by NHS England through the area team. This responsibility will transfer to Public Health in the Local Authority from October 2015. The responsibility for the 5-19 HCP transferred along with other Public Health functions to the Local Authority in April 2013.

2.2 The HCP is defined as good practice guidance for prevention and early intervention services for children and young people. Delivering the HCP is the responsibility of many partners and is not restricted to the contracted services referred to in this report. It is however important that there is effective coordination between the contracted HCP service and the range of other early intervention and prevention services that impact on health and wellbeing of children and young people.

## 3. Current arrangements.

3.1 The contract for the School Nursing Service which includes the delivery of the National Child Measurement Programme currently represents the contracted element of the HCP. Harrogate and Rural District NHS Trust manage this service across all of North Yorkshire except in Easingwold and Selby District. The service in these localities is delivered by York Teaching Hospital NHS Foundation Trust and Public Health in the City of York Council manage this element of the contract on behalf of North Yorkshire.

3.2 The contracted services for the delivery of the HCP were transferred under the waiver to contract procedure as referred to above and these will end on the 31st March 2015. The main reason for commissioning a new service is that the current arrangements have evolved over a number of years out of different commissioning and contractual processes. This has resulted in a fragmented delivery model which has made managing the contract difficult.

## 4. Progress

4.1 The commissioning timetable is on schedule and the engagement and information exchange phase has been completed and a report produced (Appendix A). The project team had been established and the scoping of the service specification has commenced.

4.2 The authorisation and accountability for the procurement process are slightly more challenging than normal due to the responsibility and budget for this work sitting within Public Health which is managed within Health and Adult Services with the commissioning process being led by CYPS. All the necessary authorisations have been received for the procurement of a new service to progress. The aim is to have this in place and ready to commence on the 1st April 2015.

## 5. Summary of gaps in provision and emerging priorities. (Refer to Appendix)

5.1 The most frequently mentioned areas of concern and identified gaps were:

- The importance and increasing demand for help with issues related to emotional wellbeing and mental health(section 8.1)
- Lack of provision for young people aged 16 and over (section 8.2)
- Insufficient focus on the needs of children and young people who are at higher risk of poor health outcomes and those least likely to seek help with regards to their health (section 8.3)
- Lack of clarity and publicity about what the service provides (section 8.4)
- Inconsistency of practice in the type and standard of the services being offered in different geographical areas and settings (section 8.5)
- Lack of advice and practical help after children have been weighed and measured as part of the National Child Measurement Programme (section 8.6)
- The importance of having effective screening and health checks to identify problems that may be impacting on the child's development (section 8.7)

## 6. Challenges that the service specification and delivery model will need to address.

6.1 Establishing a seamless 0-19 HCP

The most recent government announcement is that this responsibility for the 0-5 HCP will transfer to Local Authorities in October 2015. When defining the support pathways within the 5-19 HCP due regard has been given to the key transition points and this includes that from the pre 5 age as well as transition to adult provision. The goal of having an integrated 0-19 HCP for North Yorkshire can still be realised but within a longer timeframe than anticipated and developed as part of an incremental process.

6.2 Highlighting unmet need.

The commissioning process for the 5-19 HCP has inevitably highlighted some gaps in provision which are not within the scope of a HCP. Where these are being uncovered further discussions are being had with the respective commissioners or service areas to clarify who has responsibility for which element of care.

6.3 Opportunities for creating efficiencies.

The commissioning process provides an opportunity to create efficiencies across different aspects of the CYPS. This might be in terms of financial efficiencies and/or in terms of contributing to the reduction in pressures on other parts of the service or minimising the demand being placed on tier 3 provision. The option for increasing the capacity at tier 2 to support young people with emotional and mental health needs through the HCP service is being considered.

6.4 Provision for those living outside of North Yorkshire.
There is no easy answer to the question as to how best to provide a service for children and young people who live outside of North Yorkshire but who may receive education on a daily or residential basis in the county. The project group are addressing this and will ensure that there is clarity prior to finalising the specification for the contract. Legal advice will be sought to ensure that whatever is proposed does not contravene any discrimination legislation or contracting rules.

## 7. Proposed delivery model.

7.1 The proposal is to tender for a Core HCP Service, a community child and young person's weight management service and if additional resources are found, a Targeted HCP service that will include some additional support for those with emotional and mental health. These different elements of the service will be identified under the umbrella of the HCP and contribute to achieving the outcomes identified as a priority within the Children and Young People's Plan and the Health and Wellbeing Board.

## 8. Recommendations

8.1 The Young People's Overview and Scrutiny Committee is recommended to note the information on the Healthy Child Programme in this report

Appendices Appendix A Findings of stakeholder engagement

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21st March 2014.

**APPENDIX A**

**Commissioning a service**
**to contribute to achieving the outcomes of the 5-19 Healthy Child Programme.**
**A report on the findings from the stakeholder engagement exercise.**

## 1. General information about the changes to the commissioning responsibilities

1.1 The Health and Social Care Act 2012 gave new statutory responsibilities to local authorities for the health of their populations. From the 1st April 2013 North Yorkshire County Council assumed key responsibilities across the three domains of public health – health improvement, health protection and healthcare public health. The new responsibilities for public health are intended to complement the existing roles of local authorities to promote health and wellbeing and include such things as transportation, community safety, housing, education and environmental health.

1.2 Included within these responsibilities was the local co-ordination and planning to deliver elements of the Healthy Child Programme (HCP). The main contracted service delivering the HCP is that of school health service which also includes additional requirements as part of the National Child Measurement Programme. Contracts transferred under a 'lift and shift' arrangement and allowed no flexibility to amend current practice . The current contract will end on the 31st March 2015 and the aim is to commission a new service from the 1st April 2015.

## 2. The Healthy Child Programme

2.1 The HCP was established by the Department of Health in October 2009 and is separated into two programmes, one focusing on pregnancy to 5 years *(Healthy Child Programme. Pregnancy and the first five years of life. Dept of Health October 2009)* and the other on 5 to 19 year olds. *(Healthy Child Programme. From 5-19 years old. Dept of Health October 2009)* The main contract associated with the 0-5 programme relates to the Health Visitor workforce and this is contract managed by NHS England through the area team. This responsibility will transfer to Public Health in the Local Authority from October 2015.

2.2 The HCP is defined as good practice guidance for prevention and early intervention services for children and young people. Health and wellbeing is not restricted to physical health needs and there is frequent reference within the HCP to the importance of the emotional and mental health of children and young people. There is an expectation that there will be structured and clearly understood integrated pathways to identify and provide preventative services to those at risk of having poor health outcomes. Delivering the HCP is the responsibility of many partners and is not restricted to the contracted services referred to in this report. It is however important that there is effective coordination between the contracted HCP service and the range of other early intervention and prevention services that impact on health and wellbeing of children and young people.

## 3 The reasons for commissioning a new service.

3.1 The main reason for commissioning a new service is that the current arrangements have evolved over a number of years out of different commissioning and contractual processes. This has resulted in a fragmented delivery model which has made managing the contract difficult. For example the Selby district and Easingwold town (which is part of Hambleton district) receive their school nursing service from York NHS Trust with the remaining areas of North Yorkshire receiving their service from Harrogate and Rural District NHS Trust.

3.2 The contract specification had been modified in the past by NHS NYY to reflect changing commissioning priorities but this 'ad hoc' and reactive response to changing needs has produced a service which lacks coherency and integration with other provision for children and young people and their families.

3.3 The current contract has the potential to exacerbate inequalities in health because of the gaps in service that have resulted from the contractual requirements. For example the focus is on school aged children and those who attend school. As such those at risk of poorer health outcomes, for example families that are dis-engaged from mainstream services, children not in education etc. are not prioritised and may not receive any provision.

3.4 The activities delivered as part of the contract are historically based and do not reflect the changing physical development or societal and technological influences that impact on children and young people. The organisational structures, most noticeable of which is the governance and management of schools, within which the service needs to operate are now significantly different to when the original school nursing contract was established.

3.5 There are increasing financial pressures on all services therefore the need to coordinate the commissioning priorities and delivery of services is important. As the responsibility for the commissioning of children's services rests with different bodies this is made more complex but shouldn't prevent commissioners from seeking ways to integrate their plans and/or co-commission services to ensure that pathways of support are appropriate and meet the needs of children, young people and their families.

## 4. The commissioning timetable.

| Phase | Timeframe | Activity |
|---|---|---|
| 1 | August – September 2013 | Preparation, information gathering and research |
| 2 | September – October 2013 | Awareness raising, information giving.<br>Reports to Children's Trust Board, Health & Wellbeing Board, Executive members. |
| 3 | October 2013 – February 2014 | Engagement and information exchange with:<br>Stakeholders that are recipients of the service |

| | | |
|---|---|---|
| | | (children, young people, families)<br>Stakeholders who have a vested interest in the decisions taken (schools, youth settings, children's centres, GPs)<br>Stakeholders who will be directly affected by the decisions taken (current and potential providers, practitioners and managers)<br>Other commissioners (CCGs, PCU, NHS England Area team) and colleagues within CYPS/NYCC |
| 4 | Feb - March 2014 | Scoping of the service and production of draft specification. |
| 5 | April – May 2014 | Consultation on the draft service specification.<br>Production of final specification by end of May. |
| 6 | June 2014 | Gateway 1 of procurement process<br>Required authorisations attained from Public Health, CYPS, CTB<br>Key decision attained from Executive |
| 7 | July 2014 – October 2014 | Procurement - through relevant Gateway stages |
| 7 | By end of Nov 2014 | Contract awarded |
| 7 | December 2014 – March 2015 | Standstill period / appeals |
| 8 | January – March 2015 | Transition and transfer arrangements of workforce (if necessary) |
| | 1st April 2015 | New contract commences. |

**5. Stakeholder engagement.**

5.1 This report is the conclusion of phase 3. Information was exchanged and gathered from 319 individual stakeholders via questionnaires, individual conversations, group meetings and workshops and included children, young people, parents, and a wide range of other partners. A full list of acknowledgements is included in Appendix A.

5.2 One of the challenges in engaging with different stakeholders, many of whom had no previous knowledge about the HCP was to provide relevant information in sufficient detail to enable them to engage effectively.

5.3 Many people use the term 'health' broadly to encompass the many varied and different organisational structures that now exist under the health services' umbrella. For the purposes of this commissioning exercise the following descriptions and explanations were used to help participants to understand what the HCP related to.

## 6. Identifying age and development related needs.

6.1 The HCP uses traditional age bandings when describing the services and support that it envisages being delivered within the programme. These age bandings of 5-10 (primary school, 11-16 (secondary school) and post 16 do not reflect the age bandings that might be more appropriate in defining the commissioning priorities for the 5-19 age range.

6.2 Every child will mature physically and emotionally at a different rate and therefore it is not possible to describe exactly an age range that would receive a specific intervention it is possible to cluster features that are associated with an age range which would affect commissioning decisions. Feedback from stakeholders was useful in illuminating what these features might be and the benefits of describing the HCP in different age bandings to those described in the published document.

6.3 Features associated with the 5-8 age range

- Transition from early years and nursery settings to school.
- Decisions about health and control over health behaviours determined by parent(s).
- Parents/carers largely engaged and interested in child's education and lifestyle.

6.4 Features associated with the 9-12 age range

- Transition to secondary school.
- Physical changes and puberty.
- Increased control over decision making about certain aspects of their lifestyle and increased peer pressure.
- Greater exposure to external influences through media and peers.
- Relaxed parental control and/or influence may impact on a child's health and wellbeing.

6.5 Features associated with the 13 – 19 age range

- Increased control over decision making with regards to lifestyle and health behaviours.
- Decreased involvement of some parents in the education / development needs of their child.
- Transition from mainstream education into post 16 learning
- Transition into employment or unemployment
- Increased potential risks associated with some behaviours.
- Transfer of consent from parent to young person.

6.6 The service provided as part of the 5-19 HCP will also be applicable to those young people with additional needs up to the age of 25 and there will also be an overlap with other commissioned services that encompass teenage/young adult age range such as specialist sexual health services.

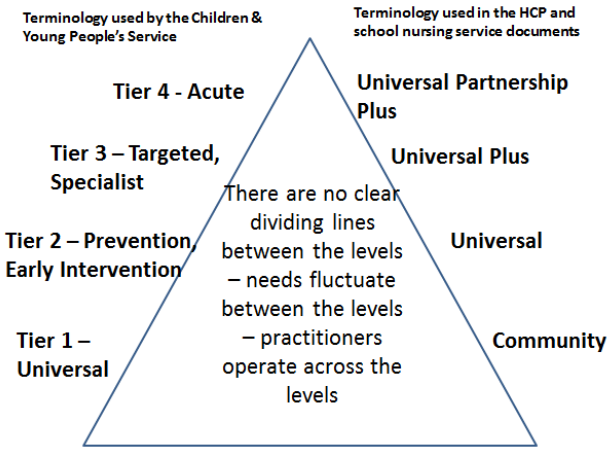
6.7 Although this programme does not directly relate to the 0-5 age range, the services delivered to that age range will have implications for the consistency of support and provision that families and children receive.

Features associated with the 0-5 age range

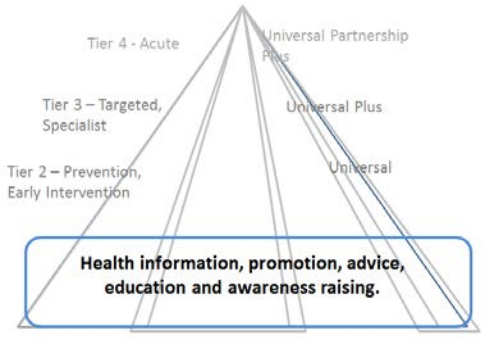
- Maternal health and social wellbeing (including maternal mental health) during pregnancy and its impact on the health of the baby
- Significant changes in brain development
- Rapid physical and sensory development
- The importance of attachment and parenting on future outcomes
- Attendance at early years and nursery settings
- A recognition that services delivered as part of the 0-5 Healthy Child Programme relate not just to mother and baby but also to paternal and family health and their involvement in the child's development.

## 7. Tiers of intervention.

7.1 The terminology used by children and young people's services when describing different levels of help differs slightly to that used in the HCP and other documents familiar to the school health service.

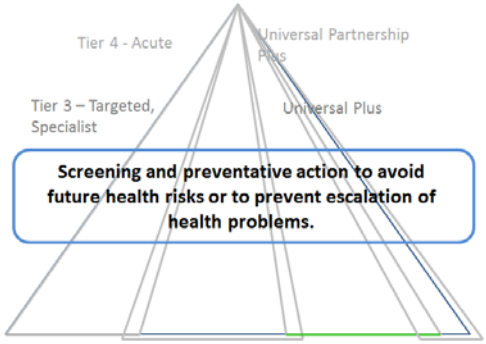



7.2 To ensure consistency throughout the engagement process the different levels were described by the type of health activity that might take place at each level.



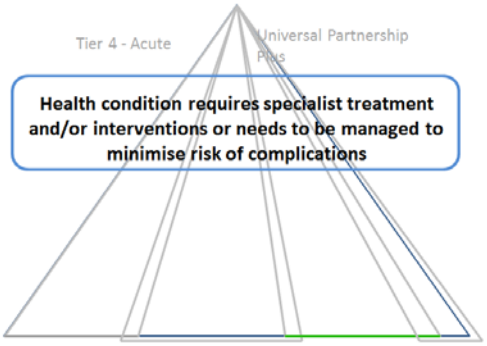

Tier 1: Children and young people receive most of the interventions at this level from parents, exposure to national health campaigns, publicity or other promotional materials, information obtained from watching TV programmes which are focusing on a health topic or through structured classes as in school based PSHE programmes or health sessions in youth settings.

The source and accuracy of the information cannot always be assured and therefore the HCP would seek to ensure that information being provided at this level was from a reliable source and accurate.

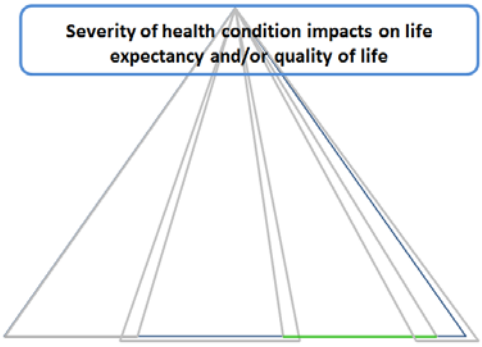



Tier 2: This will be the main focus for the commissioned HCP service. It will seek to add value and where pertinent signpost to the services provided by other health professionals who also provide some services at this tier, for example those available from GPs.

Although these are tier 2 interventions and may be focused on specific issues, individual children/ young people or families the delivery of the interventions will primarily be in tier 1 settings such as schools, homes and local communities.




Tier 3: Some elements of the HCP contracted service will operate at this level. There are currently services commissioned by the Children and Young People's Service which deliver services at this level and which contribute to the delivery of the HCP, for example with the Risk Taking Behaviour service which includes young people's drugs and alcohol treatment services.
Settings and interventions at this tier will include vulnerable children and young people, for example those subject to Child Protection orders or Looked After Children or those within the Youth Justice Service.
It will be important to have in place effective care pathways from tier 2 to enable timely and appropriate referrals to be made into specialist services.




Tier 4: The HCP will not deliver services at this tier but will be required to understand the services and referal routes that are available at this level and where necessary support children and young people with this level of need who may be being supported in a universal setting.

7.3 The discussions with stakeholders therefore focused on what they expected from a service that operated within the universal setting (homes, community, schools) but which could provide tier 2/early help and support to prevent health problems occurring or escalating.

## 8. Gaps in current provision and emerging priorities.

### 8.1 The importance and increasing demand for help with issues related to emotional wellbeing and mental health.

8.1.1 This subject was raised by all participants as a high priority. Feedback from young people always placed this as a high priority. Practitioners including school staff expressed concerns about the consequences that such things as anxiety and stress, poor body image and peer pressure are having on children and young people.

8.1.2 In the primary school age range these pressures mainly stem from tensions within the family environment. The impact is generally behaviour related which impacts on the learning of the individual child and those around them. Although problems are

usually addressed by the school directly with parents there was a sense that teachers were struggling to afford the time or give the necessary attention to individual children to help them deal with these issues. There were many references to the perceived benefits that having access to talking therapies (often referred to as counselling) would bring.

8.1.3 In the secondary school age range stress and anxiety tended to be related to educational attainment and the pressure to achieve high grades. Young people reported this as almost a constant stress throughout their secondary school life.

8.1.4 Participants felt that the incidence of self-harm and extreme dieting resulting in eating disorders such as bulimia were increasing. Practitioners working with young people described situations where they were offering support to young people with what they considered to be 'mental health' problems and some practitioners expressed frustration in the current referral pathways into Child and Adolescent Mental Health (CAMH) services. There were also examples of excellent joint working with CAMHS colleagues with support being provided to tier 2 workers and referral routes operating effectively.

8.1.5 Generally the feeling was that gaining help from a qualified mental health practitioner was challenging because of the increased demand on the tier 3 CAMHS. Not all practitioners wanted to transfer the support for cases into CAMHS but they wanted reassurance from a mental health qualified colleague that the support they were giving to a child/young person was appropriate.

8.1.6 From the responses gathered there appears to be a gap in provision at the prevention/early intervention tier of support. Because of the pressures of demand on the CAMHS some children and young people are being held at this tier by practitioners who feel ill-equipped to deal with the mental health problems that are being presented to them.

**8.2 Lack of provision for young people aged 16 and over.**

8.2.1 Responses from young people in this age range tended to report that they would be comfortable seeking advice from their GP for ill health problems. They would be less likely to seek advice for exploratory behaviours that may affect their health and wellbeing, for example when they are or intend to become sexually active, or for alcohol or drug use. They may not recognise the need to seek advice or may delay accessing this until they or others, encourage them to seek help.

8.2.2 Services in Further Education colleges were well organised under Student Services (or similar) but this type of service is not always replicated in school settings for Year 12/13 students. Partnership working in FE settings has evolved differently depending on the institution with evidence of some good interagency work and effective referral pathways. There is no service provision delivered to these settings under the current contract.

8.2.3 Those young people who do not access an education setting do not currently receive a service but it can be assumed that the needs of these young people would be the same as that described by the post 16 aged respondents. These requirements mainly related to emotional health and the behaviours that resulted from anxiety and stress and relationship problems. As this age range felt that they would not be proactive in seeking help until the problem had escalated further consideration needs to be given to how best to encourage earlier engagement and/or to encourage young people to heed the health information that they are already aware of.

**8.3 Insufficient focus on the needs of children and young people who are at higher risk of poor health outcomes and those least likely to seek help with regards to their health.**

8.3.1 Many children and young people fall into this category but the main ones referred to in the engagement process were children and young people who are poor school attenders and/or low attainers, Looked After Children, young offenders, those with additional sensory, medical or physical needs and those with special educational needs.

8.3.2 There are many more children and young people who may fall into this category, for example those who witness or experience domestic violence, those who have parents with mental health and/or alcohol or drug abuse, young carers etc.

8.3.3 For many of these children/young people there are services including those provided by health services specifically addressing their needs. It is not the remit of the HCP to deliver a dedicated service for these children/young people but to identify how it can provide early help and interventions more effectively to add value to the services that already exist.

8.3.4 Some of the young people who provided feedback had direct experience of health services and unfortunately not all of their accounts were positive. However the purpose of the information exchange was not to judge existing provision but to try to identify what might be done in the future to improve services.

8.3.5 Because of the reluctance of these young people to voluntarily engage with what they considered to be judgemental or authoritarian services the options for improving their perceptions were explored. Some interesting suggestions were generated but the main responses related to the importance of having a trusted adult, someone who was non-judgemental and the importance of continuity of support. The young people didn't just want a 'brief intervention' but wanted on-going help.

8.3.6 Whilst they acknowledged that they disliked being 'forced' to engage with services they also recognised that the voluntary nature of the engagement meant that not engaging was the easy option for them. They also did not want anything that stigmatised them because of their circumstances although they did acknowledge

that by attending, for example, a Pupil Referral Unit they were already different to their peers.

8.3.7 The health support provided to Looked After Children (LAC) appeared to be well organised and feedback was positive including that provided by the specialist LAC nurses. There were some concerns raised in relation to the statutory requirement to provide annual reviews for all LAC and the need to ensure that these are conducted on all those from 5-19.

8.3.8 Residential homes had established good working relationships with health services in their locality and residential home staff were delivering advice and guidance where pertinent. Staff identified that if additional interventions were available from the HCP those most needed would be to for the emotional and mental health needs of young people and health factors related to risk taking behaviours, in particular in relation to sexual activity and drugs and alcohol.

8.3.9 Children with additional sensory, medical and physical needs and those with learning difficulties have a wide range of needs many of which cannot be met through the HCP. Because of their additional needs maintaining positive health will be made more challenging and access to universal services may be limited. For others their stage of emotional maturity may not match their physical maturity making them vulnerable when engaging in exploratory behaviours that are normal for young people as they move into adulthood. The interventions for these young people will need to be differentiated to reflect the specific need and level of vulnerability of each child/young person.

8.3.10 Practitioners working with these children/young people were frustrated by the inconsistencies in service provision and this is something that the different commissioning bodies for health will need to address.

**8.4 Lack of clarity and publicity about what the service provides.**

8.4.1 These responses reflect the findings from national research into what parents, children and young people want from a school nursing service*. (Ref: School Nurses Survey Results. National Children's Bureau 2011. Our School Nurse. Young people's views on the role of the school nurse. British Youth Council 2011. Online survey of parents organised by Netmums Dept of Health 2011)* Both parents and children/young people wanted practitioners in the service to be approachable and ideally for there to be someone who is known to the family and remains constant throughout the life of the child.

8.4.2 Understanding about what the HCP service can provide will be important as there remains a lot of confusion about the different health provision that is available. Some respondents queried how the HCP service would differ from what they received from their GP and some assumed that the service would just be located within schools.

8.4.3 The message that the HCP is about providing a service for children and young people was reiterated throughout the information exchange process. This was useful when discussing with schools what the new service might look like as they were able to differentiate between what they required as a school (in relation to curriculum support or policy development) and what their children/young people might need.

8.4.5 As the majority of children and young people attend school these will be key settings through which the contracted service can access children/young people and families. Although there were no strong opinions about the name of the practitioners it was felt that calling them 'school nurses' may no longer be apt. Young people in particular felt that this title implied a requirement on the nurse to share all information with their school. For other respondents there was the suggestion that the term carried with it a historical image of what the school nurse's role was and if there was a desire to change that perception the title will need to change.

**8.5 Inconsistency of practice in the type and standard of the services being offered in different geographical areas and settings.**

8.5.1 Historical arrangements, local working practices and local relationships that have developed between practitioners all play a part in creating inconsistent practice. This coupled with the geography of the county has resulted in variations in service. Without listing the specific examples it was evident through the information exchange that inequalities did exist and that these need to be addressed as part of the commissioning process for a new service. The aim will be to ensure that irrespective of where in the county a child lives they will receive the same standard and level of care.

8.5.2 It will also be necessary to unpick some of the queries that were raised related to the inconsistencies that result from cross border issues such as with children who live in one Local Authority area but who attend school in another Local Authority area. Likewise for those children registered with a GP and who receive their medical care from outside of North Yorkshire but who live within the county (or visa-versa).

**8.6 Lack of advice and practical help after children have been weighed and measured as part of the National Child Measurement Programme.**

8.6.1 Measuring the weight and height of all children when they reach reception and year 6 of school age is a national requirement. There is no requirement regarding what to do if a child is assessed as being overweight.

8.6.2 The main feedback on the impact of this came from parents. For many the communication about what the purpose of the weight and height measurement was unsatisfactory and some parents either could not recall their child having this or

were not informed. Of greater concern is the impact that notification that a child is overweight can have on the child and the family.

8.6.3 There was little evidence of any additional advice or communication being provided to the parent to help them understand the implications of the measurement or to investigate what other factors might indirectly be affecting the child's weight gain. Some of the responses clearly indicated that parents would have welcomed the opportunity to have a discussion or meet with a nurse or better still, a nutritionist to find practical ways to improve their child's weight problem.

**8.7 The importance of having effective screening and health checks to identify problems that may be impacting on the child's development (physically and academically).**

8.7.1 It is difficult to persuade people of the evidence base for certain practices when it relates to topics which they may have a particular interest in or which directly affected their child. This was particularly pertinent when discussing the benefits of some population screening. .

8.7.2 One of the topics which generated several strong opinions was in relation to hearing and sight screening. There are connections between impaired hearing/sight and the speech, language and communication development of a child. This in turn can have significant impact on their social, emotional and educational development so the need to identify problems early would be advantageous. Whether this is the role of the HCP needs further consideration.

8.7.3 Advice on the management of common childhood problems such as nits still emerged as a problem that parents and schools had to deal with. Whilst there was no indication that people wanted a return to mass hair checks there was a call for better advice and consistent practice in dealing with outbreaks. Several respondents believed that having a HCP nurse who could provide more targeted advice to parents/families where there was a recurring problem would be of value.

8.7.4 There was also reference to bed wetting and the impact that this can have on a child's confidence. The need for accurate preventative advice was seen as essential as was the targeted support for problems such as bedwetting through a discrete enuresis clinic.

## 9. Additional considerations when scoping the service specification.

9.1 During the engagement process there were queries and issues raised that will require further consideration and clarification as part of the scoping for the service specification.

9.2 There are areas of work which the HCP would be well placed to deliver but which may be the responsibility of different commissioners including the administration of

immunisations and vaccinations and the services provided for children with additional physical, sensory or medical needs or disabilities.

9.2 There are practical arrangements in delivering the HCP contracted service which will need addressing as a result of the cross border challenges, including where these differ for residency, education, GP registration and other healthcare provision.

9.3 There are number of private schools providing residential education in North Yorkshire. It will be important to define what is or is not being made available to these children and young people whilst resident in the county and what options there are in offering a bought HCP service to these institutions.

## 10. Conclusion

10.1 The engagement process has highlighted the key issues which the majority of respondents felt were important. The observations and suggestions that were gathered as part of this exercise along with reference to the specific requirements that are outlined in the 5-19 Healthy Child Programme guidelines will be used to inform the scoping of the service specification.

Report produced by:
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18th February 2014

**NORTH YORKSHIRE COUNTY COUNCIL**

**YOUNG PEOPLE OVERVIEW AND SCRUTINY COMMITTEE**

**4 April 2014**

# Draft North Yorkshire Alcohol Strategy

**1.0 Purpose of Report**

1.1 This report asks the Committee to:

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

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

## 2.0 Purpose

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

## 3.0 Background

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

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

## 4.0 Proposals

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

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

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

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

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

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

**4.1** Key Issues

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

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

All communication will be through the North Yorkshire alcohol strategy website: http://www.nypartnerships.org.uk/index.aspx?articleid=28432

**4.2** Resource Implications

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

**4.3** Equalities Implications

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

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

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

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

Currently a risk taking behaviour service is commissioned for children and young people.

**5.0** **Recommendations**

5.1 The Young People Overview and Scrutiny Committee is recommended to:

a. Note the information in this report.

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

**Katie Needham Consultant Public Health**
**HAS County Hall**

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

# North Yorkshire Alcohol Strategy

2014-2019

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

DRAFTv4

Forward – council
To add later

Forward – PCC
To add later

## Executive Summary

### Purpose

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

### Understanding the problem and building the case for action

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

Yet drinking responsibly within limits can be safe.

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

### What do we need to do?

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

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

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

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

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

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

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

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

## 1. Purpose

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

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

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

## 2. Understanding the problem and building the case for action

### 2.1. What harm can alcohol do?

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

**Health**
Alcohol harms health through three mechanisms

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

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

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

- Pancreatitis and stomach problems

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

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

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

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

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

## 2.2. What are the national drivers?

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

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

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

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

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

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

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

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

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

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

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

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

### 2.3. What are the local drivers?

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

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

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

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

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

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

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

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

## 2.4. What is the picture in North Yorkshire?

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

### Risk of alcohol related harm

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

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

**Health outcomes**

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

**Crime and antisocial behaviour**

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

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

**Vulnerable Groups**

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

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

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

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

NICE describe two approaches.

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

**Prevention and education**

NICE say that locally, licensing should:

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

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

NICE suggested that national policy should:

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

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

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

**Early identification and harm minimisation**

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

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

Non-NHS professionals should focus on people:

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

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

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

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

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

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

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

**Treatment & rehabilitation**

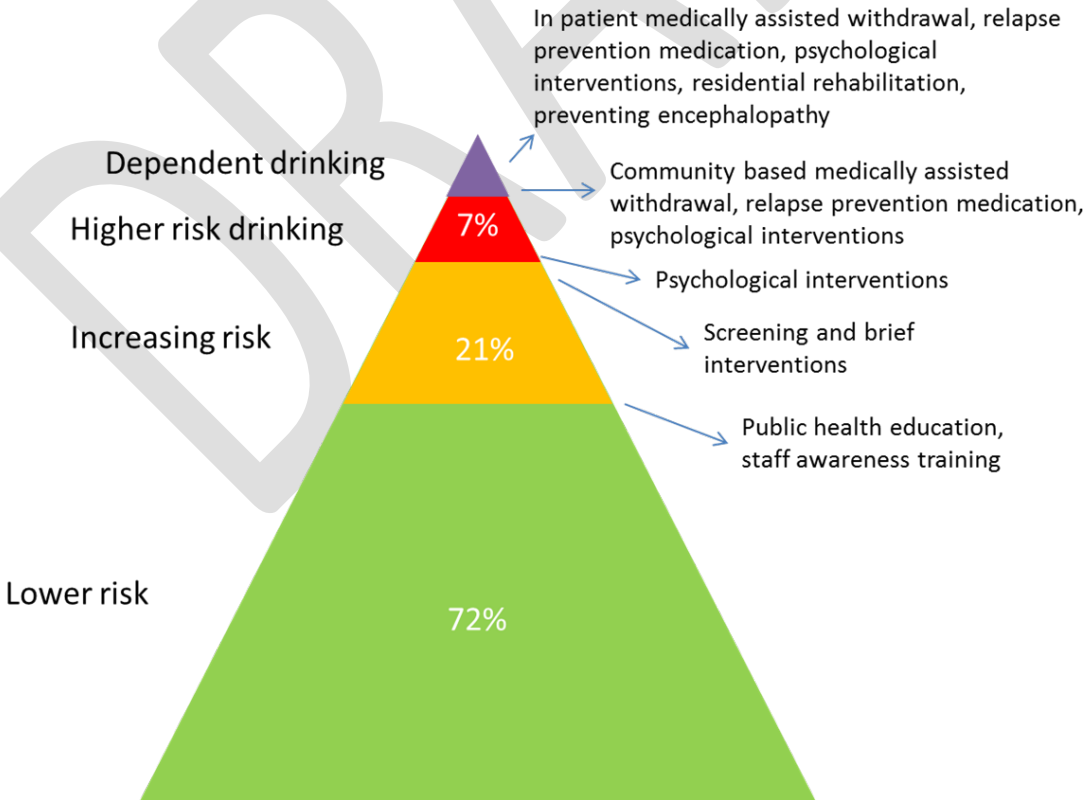
- For all people seeking help for alcohol misuse:
    - give information on the value and availability of community support networks and self-help groups;
    - help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that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

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

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

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

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



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

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

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

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

**Reducing offending and Night Time Economy**

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

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

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

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

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

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

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

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

- Responsible drinking
- Responsible retailing
- Enforcement
- Environment

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

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

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

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

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

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

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

## 2.7. Modelling the scale of the unmet need

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

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

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

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

## 2.8. What people have told us

### Stakeholder event

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

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

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

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

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

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

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

Comments received about alcohol were around the following themes:

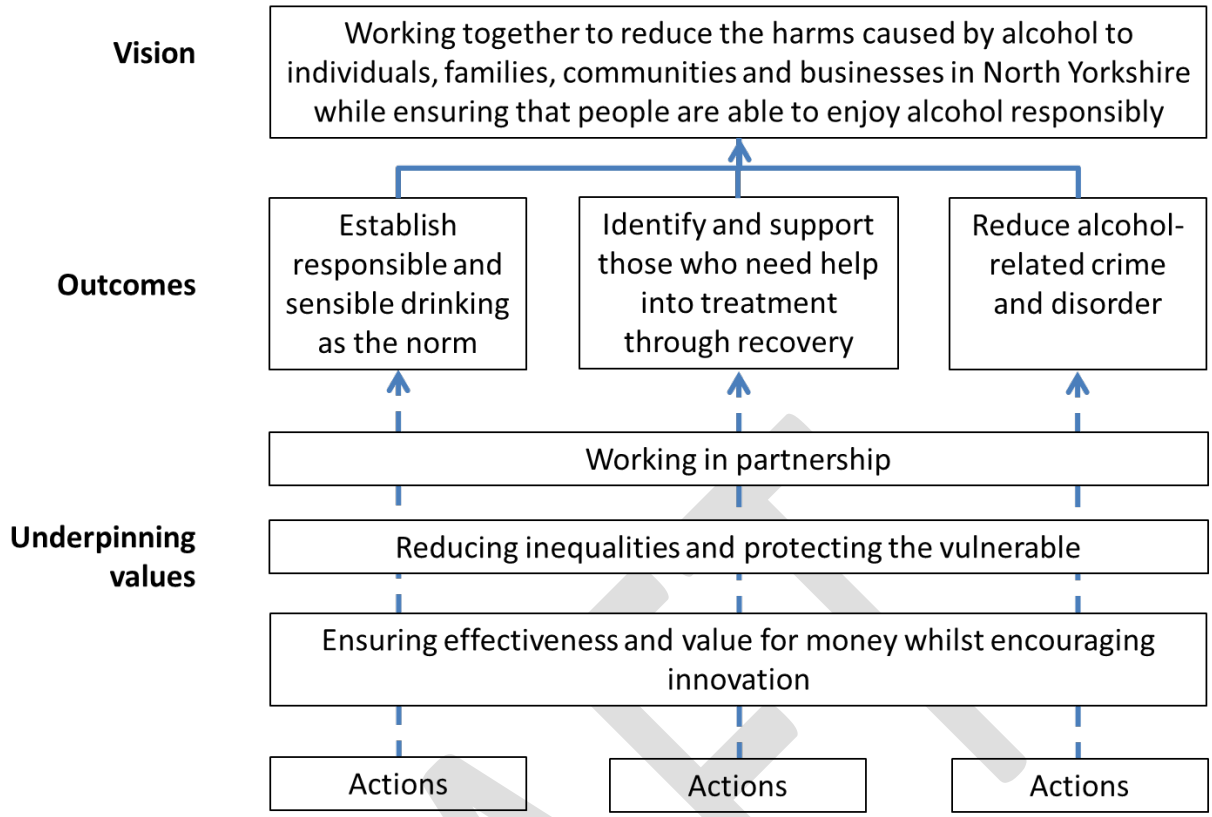
- For both crime and anti-social behaviour, alcohol is seen as the key causation factor. It can also lead to other issues e.g. 'risky' sexual activities.
- Chronic health problems due to excessive alcohol consumption - Inability of A&E and other acute services to meet the demands of this type of patient.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

## 3. What do we need to do?

### 3.1. Our Vision

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

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




### 3.2. Outcome areas

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

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

These areas will be used to develop the action plan

#### 3.2.1. Establish responsible and sensible drinking as the norm

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

We will:

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

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

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

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

We will:

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

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

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

### 3.2.3. Reduce alcohol-related crime and disorder

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

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

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

## 3.3. Underpinning Values

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

### 3.3.1. Working in partnership

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

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

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

### 3.3.2. Reducing inequalities and protecting the vulnerable

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

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

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

### 3.3.3. Ensuring effectiveness and value for money whilst encouraging innovation

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

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

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

## 4. How will we measure success?

### 4.1. Governance

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

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

### 4.2. Outcome indicators

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

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

*these need further development

## References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[23] http://www.nypartnerships.org.uk/index.aspx?articleid=28432

## Appendix 1: Definitions

The Department of Health defines alcohol misuse into three categories:

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

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

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

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

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

**NORTH YORKSHIRE COUNTY COUNCIL**

**YOUNG PEOPLE OVERVIEW AND SCRUTINY COMMITTEE**

**4 April 2014**

# Work Programme Report

## 1.0 Purpose of Report

1.1 This report asks the Committee to:

a. Note the information in this report.

b. Confirm, amend or add to the list of matters shown on the work programme schedule (attached at Annex A).

## 2.0 Mid Cycle Briefing – 2 April 2014

The lead members of the Committee met for the mid cycle briefing on the 2nd April 2014.

## 3.0 Work Programme Schedule

The Work Programme Schedule is attached at Annex A and Members are asked to consider, amend and add to the Committee's Work Programme.

## 4.0 Future dates for the Committee

The dates of the next meetings are:

- Friday 27 June 2014
- Friday 24 October 2014

## 5.0 Recommendations

5.1 The Committee is asked to:

a. Note the information in this report.

b. Approve, comment or add to the areas of work listed on the Work Programme schedule.

**Bryon Hunter, Scrutiny Team Leader**
**Central Services**
**County Hall, Northallerton**

| | |
|---|---|
| Report compiled by: | Lorraine Laverton Corporate Development Officer Ext: 2108 |
| Email: | lorraine.laverton@northyorks.gov.uk |
| Date: | April 2014 |
| Background Documents: | None |
| Annex: | Annex A – Work programme table |

**Annex A**

# YOUNG PEOPLE OVERVIEW & SCRUTINY COMMITTEE
# WORK PROGRAMME 2014/15

## Scope

The interests of young people, including education, care and protection and family support.

## Meeting dates

| | | | | | |
|---|---|---|---|---|---|
| ***Scheduled Mid Cycle***<br>Attended by Lead Members of Committee | ***2 April 2014***<br>***2:00pm*** | **16 May 2014**<br>**10:30am** | **12 Sept 2014**<br>**10:30am** | **5 Dec 2014**<br>**10:30am** | **13 March 2015**<br>**10:30am** |
| ***Scheduled Committee Meetings***<br>*Agenda briefings to be held at 9.30am prior to Committee meeting. Attended by Lead Members of Committee* | ***4 April 2014***<br>***10:30am*** | ***27 June 2014***<br>***10:30am*** | ***24 October 2014***<br>***10:30am*** | ***30 January 2015***<br>***10:30am*** | ***1 May 2015***<br>***10:30am*** |

## In-depth Scrutiny Review

| Meeting | SUBJECT | AIMS/TERMS OF REFERENCE | ACTION/BY WHOM |
|---|---|---|---|
| Timescale – Oct 2013 – 27 June 2014 | Online safety of children and young people | Agreed by the Young Peoples Overview & Scrutiny Committee at the meeting on 18 Oct 2013. Task Group: C Cllrs Joe Plant, Val Arnold, David Jeffels, Janet Sanderson and co-opted member Graham Richards | Member Task Group<br>Richard Irvine |

| Meeting | SUBJECT | TERMS OF REFERENCE | ACTION/BY WHOM |
|---|---|---|---|
| **4 April 2014** | **Exec Member / Corp Director Update** | Update from Executive Member / Corporate Director as available | Exec / Corp Director |
| | **2020 North Yorkshire** | Programme update | Gary Fielding |
| | **Children & Young People's Plan** | To comment on the draft Children & Young People's Plan | Pete Dwyer |
| | **School organisation arrangements** | School places. - The increase in the birth rate is putting pressure on some primary schools in North Yorkshire. Members have requested a briefing on what is being done to ensure there are enough primary school places in North Yorkshire | Carolyn Bird/ /Suzanne Firth |
| | **Public Health - Healthy Child Programme** | To receive a progress report on the healthy child programme which incorporates new LA responsibilities in relation to children and young people aged 5-19 | Louise Dunn |
| | **Public Health - Draft Alcohol Strategy** | To comment on the Public Health Draft Alcohol Strategy | Claire Robinson |
| | **Work Programme report** | Asking the Committee to comment / amend the work programme for the Committee | Lorraine Laverton |
| ***27 June 2014*** | **Executive Member / Corporate Director Update** | Update from Executive Member / Corporate Director as available | Executive Member / Corporate Director |
| | **The Promise** | Community Engagement Promise - Youth Participation | Jon Coates |
| | **Public Health - Draft Mental Health Strategy and Draft Tobacco Control Strategy** | To comment on the Public Health - Draft Mental Health Strategy and Draft Tobacco Control Strategy | Claire Robinson Katie Needham |
| | **Welfare Reform Act 2012** | Update following initial briefing in March 2013 on the impact of the benefits reforms on children, young people and their families. | Jonathan Spencer |
| | **Child Poverty in North Yorkshire** | Overview of the prevalence of child poverty in North Yorkshire together with a briefing on the local solutions to reduce the extent and impact of child poverty in high priority communities | Corporate Director/ David O'Brien |
| | **Accommodation and Homelessness** | The Young Peoples Accommodation Pathway for 16-25 year olds was launched on the 1 November 2011. Update and progress report | David Walker CYPS |
| | **Work Programme report** | Asking the Committee to comment / amend the work programme for the Committee | Lorraine Laverton |

| Meeting | SUBJECT | TERMS OF REFERENCE | ACTION/BY WHOM |
|---|---|---|---|
| ***24 October 2014*** | **Executive Member / Corporate Director Update** | Update from Executive Member / Corporate Director as available | Executive Member / Corporate Director |
| | **Child sexual exploitation** | Update on work ongoing to prevent child sexual exploitation | Susan Colville |
| | | | |
| | **Work Programme report** | Asking the Committee to comment / amend the work programme for the Committee | Lorraine Laverton |
| ***30 January 2015*** | **Executive Member / Corporate Director Update** | Update from Executive Member / Corporate Director as available | Executive Member / Corporate Director |
| | | | |
| | | | |
| | **Work Programme report** | Asking the Committee to comment / amend the work programme for the Committee | Lorraine Laverton |

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

| *Reports to be scheduled* | | |
|---|---|---|
| | | |