NORTH YORKSHIRE COUNCIL

Health and Adult Services

Local Account 2021/2022

Contents

Introduction

This is the Local Account for North Yorkshire Health and Adult Services for 2021/2022. It is an account of what we have done to support people across the county during the last year, how we have invested public money, and what we aim to do in 2022/2023.

The main focus of this report is adult social care; however, the Council's Health and Adult Services directorate includes public health and this report should be read in conjunction with the Director of Public Health's Annual Report, available here: Director of Public Health annual report 2022 | North Yorkshire Partnerships (nypartnerships.org.uk).

2021/2022 was another year of challenges for us all as we collectively continued to respond to the COVID-19 pandemic, with successive waves of infection and frequent changes in pandemic controls. In addition, we experienced significant labour market competition for care workers, and had to increase our intervention into the independent care sector due to provider closures. Demand levels for social care rose and we found that people's needs were increasingly complex.

Health and Adult Services, along with our County Council colleagues, our partners and our communities, continued to respond, adapt and innovate to meet the ongoing challenges. As well as our ongoing response to the pandemic, we began work on new strategic plans and major transformation projects, and continued to liaise with our health partners on integration and health system changes. We invested in recruitment campaigns featuring people who access support, planned and tested out interventions in the care market and provided hands-on support to struggling care providers. We also took part in a Local Government Association (LGA) Peer Challenge, exploring NYCC's approach to COVID-19 outbreak management.

This all took place against the background of local government reform, with the announcement in July 2021 that the county council, and all seven district and borough councils would be replaced by a new single council for North Yorkshire in April 2023.

Our Adult Social Care and Public Health teams continued to build on the strong partnership working which was a feature of the first year of the pandemic, demonstrating their resourcefulness, resilience, determination and a clear focus on achieving the best outcomes for our communities.

We would like to thank all the colleagues and partners, communities and individuals with whom we work to co-design and deliver effective services. We would also like to gratefully acknowledge the support and encouragement of our Executive Portfolio Holders for Public Health, Prevention and Supported Housing during the period covered by this report, Councillor Caroline Dickinson, May 2017 to August 2021, and Councillor Andrew Lee, August 2021 to May 2022.

We hope that you will find this report interesting and helpful.

Cllr Michael Harrison
Executive Member

Public Health and Adult Social Care (from May 2022)

Adult Social Care and Health Integration (May 2017 - May 2022)

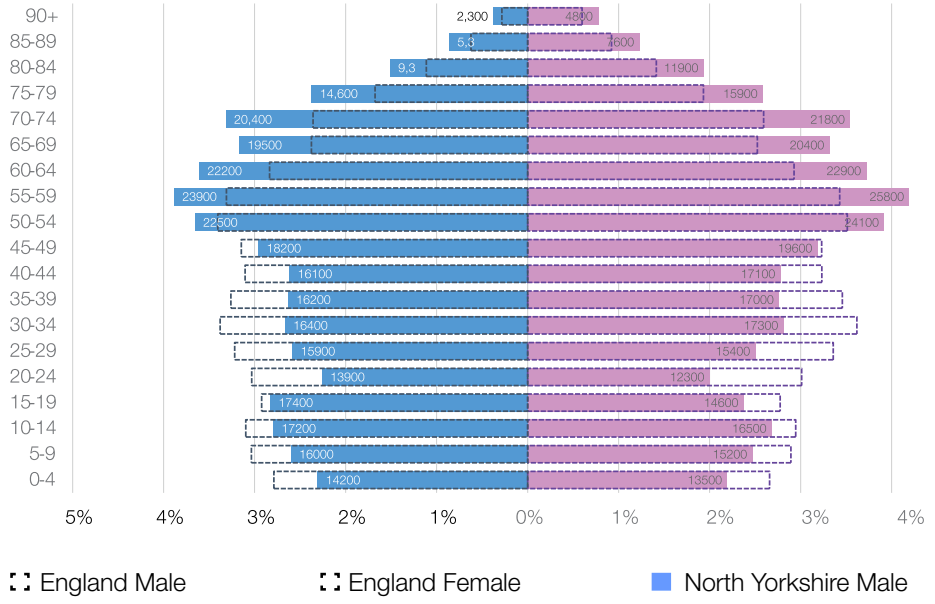
Richard Webb
Corporate Director

Health and Adult Services

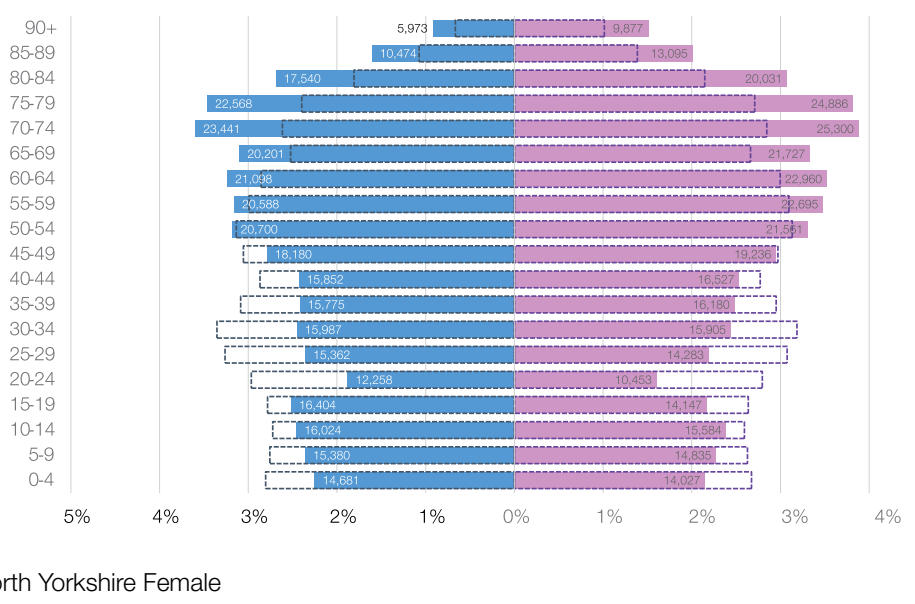
2 Who we are and what we do

North Yorkshire is England's largest county. It has some urban areas and is also highly rural, with up to 85% of the county being classified as 'super sparse'. We serve a total population of 615,400 people with 153,800 people (25%) over the age of 65 years[1]; with projected trends and inward migration of older people to the area, we expect this figure to increase to almost a third by 2035.

Age profile, North Yorkshire
ONS mid-year population estimates 2021



Projected age profile, North Yorkshire, 2043
ONS 2018-based population projections



England Male England Female North Yorkshire Male North Yorkshire Female

[1] 2021 census estimate.

Overall, North Yorkshire is a good place to live and work. Large parts of North Yorkshire have better than average life expectancy when compared with England as a whole. Looking at the 2021 Census data, North Yorkshire performs well in indicators for wellbeing and education, and for some economic indicators.

However, although we are among the least deprived local authorities in England, ranked 127th most deprived out of 151 upper tier local authorities[2], we know that there are pockets of deprivation and inequality, with significant variation across the county. There are 11 neighbourhoods in North Yorkshire that are amongst the most deprived 10% areas in England, predominantly in the east of the county.

In addition to those neighbourhoods, we are aware that inequalities exist across North Yorkshire – for example rural access to services, fuel poverty, affordable housing and digital exclusion. Census data shows that North Yorkshire performs below average for economic indicators relating to transport and broadband. Both nationally and locally, the health inequalities that already existed in our communities have been made worse by the pandemic; understanding and addressing these inequalities continues to be a focus for the work of the Council and our partners.

Health and Adult Services is one of the four directorates within North Yorkshire County Council. We have a strategic role to:

- lead the County Council's work on public health, adult social care, supported housing and partnership with the NHS;
- plan, invest and deliver services to support individuals and communities to be healthier and to live the lives they want to live;
- work with partners to build 'health' into the economy, education, planning, regulation, community safety and care; and
- develop service providers and ensure service quality.

We work with our communities and partners to support people to live a healthy, independent and active life through a range of prevention, social care and public health services. We commission services from independent providers, including the voluntary sector, and the NHS. We also directly provide a growing number of services in both social care and public health; in the case of social care services, this is in part because we are often the only viable provider in areas where the care market is fragile. Building care market capacity continues to be a key priority.

During 2021/22, the NHS system went through another phase of organisational change, resulting in the replacement of Clinical Commissioning Groups with Integrated Care Boards (ICBs). There are two main ICBs covering North Yorkshire: Humber and North Yorkshire ICB and West Yorkshire ICB. We work closely with the ICBs, four main acute and community NHS trusts, one community NHS trust and two mental health NHS trusts, over 70 GP practices and seven borough and district councils. In addition, people living in the Bentham and Ingleton areas are registered with GPs who are part of the Lancashire and South Cumbria ICB and access some services from the Lancaster and Kendal areas.

[2] Index of Multiple Deprivation (IMD 2019)

During 2021/22, there were 3,962 contacts to the Living Well service. This is an increase of 36% from the previous year, with a significant increase in referrals (32%) from our health care partners as their referral activity returned to the level typically seen before the COVID-19 pandemic.

The activity of our reablement teams has not recovered in the same way as Living Well activity, with the number of completed reablement involvements (1,548) showing a 9% reduction year on year – this is because a significant proportion of our reablement capacity was diverted during the year to provide domiciliary care in response to local care market pressures. Some large care providers went out of business and providers across the county struggled to recruit or retain sufficient staff to cover their existing care commitments, which resulted in providers handing care packages back to the local authority to find alternative care solutions.

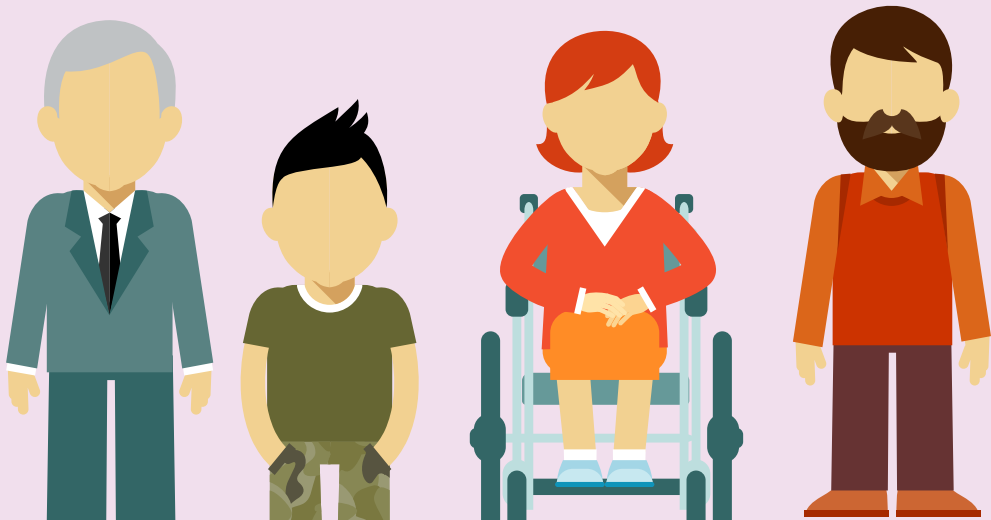
In relation to our CQC ratings, 92.3% of our residential care settings and 100% of our domiciliary care services were rated as “Good” or better overall.

Based on our assessment of our performance in 2021/22 against the Adult Social Care Outcomes Framework and the Local Authority Health Profiles, our strengths are:

- Support for adults in contact with secondary mental health services to enable them to live independently, and to be in paid employment;
- The proportion of people using social care services who receive self-directed support;
- Procuring NHS Health Checks for adults aged 40-74 – uptake rates above national and regional average; and
- Healthy Child Programme – health visitor mandated contact completion rates above national average and the average for similar rural counties.

Our areas for further development are:

- A high level of permanent admissions to care homes for residential and nursing care;
- A low proportion of people who receive direct payments;
- A relatively low proportion of smokers engaged in Stop Smoking services;
- An increase in overweight and obese children in both reception and Year 6 for the 2020/21 school year; and
- Understanding and managing the changing demands for adult social care services post pandemic.



Areas for further development	Actions taken
Comparatively high level of permanent admissions to care homes for residential and nursing care	Our key aim is to keep people in their local communities with the maximum degree of independence for as long as possible. To achieve this, we need to ensure the right mix of care provision is available locally by: • Focusing on market development for domiciliary care to provide more options for people to return home with appropriate care in place; • Working on increasing the uptake of direct payments to provide more options for support at home (see actions below) • Service Development and Health Integration teams working with Health colleagues on the provision of short-term options / placements for reablement to prevent long-term residential and/or nursing admissions.
Low proportion of people who receive direct payments	To build on our learning about the reasons for low uptake of direct payments, we are recruiting a Senior Service Development Officer to support development of the direct payments offer. Actions will include: • Engaging with people who have direct payments to understand what works and what could be better; • Reviewing communications to make sure that they are user-friendly; • Working closely with assessment teams to strengthen understanding of direct payments offer; • Researching Personal Assistant (PA) pay rate to understand how that aligns with other sectors, with aim to support and grow the PA market; • Enabling people to use direct payments to get support from self-employed PAs with appropriate safeguards in place.
Relatively low proportion of smokers engaged in Stop Smoking services	Initiatives to increase take-up include: • Introduction of a 1-year pilot offering pregnant smokers incentives to quit smoking with up to £200 in 'love to shop' vouchers in £50 increments at various stages of the quit attempt; • 1-year pilot offering e-cigarettes as a means of quitting smoking; • Creation of workplace quit clubs NYCC staff can sign up to and quit together; • People who use the service, staff and partners share their experiences and expertise to help to design new approaches via email or text messages; • Working on re-introducing face-to-face interventions as well as continuing with online access so that we can offer as many access options as possible to the hardest to reach prevalence of smokers.

Areas for further development	Actions taken
Increase in overweight and obese children in both reception and Year 6	As well as our Healthy Schools and Early Years programme and National Child Measurement Programme, new initiatives have been delivered to help promote a healthy weight with children, young people and families in North Yorkshire: • **Family weight management services and support:** In partnership with Leeds Beckett University, NYCC helped to develop and pilot a fully remote/digital child weight management service. Co-produced with local families and delivered via a co-designed website, the Back2Basics service was piloted with local families during 2022. Findings will inform the development of a new family weight management service offer. • **Healthy catering in schools and early years:** A healthy packed lunch leaflet was developed in response to requests from local primary schools, following consultation with schools, families and key partners. This was disseminated to primary schools from February 2022, and is currently being adapted for early years settings. Work has also been underway to identify and address the barriers to free school meals uptake. • **Family support for healthy weight and oral health** - workforce development: supporting families who most need help with healthy weight and oral health issues by skilling up the people who work with them (see section 3 for more information about this initiative).
Understanding and managing the changing demands for adult social care services post pandemic	As we move further beyond the direct impact of the pandemic, we need to understand how people's needs are changing and how we need to respond to those emerging needs. We are: • Exploring new, innovative ways of working e.g. online assessments & reviews • Employing additional resources to ensure timely annual review of people's services • Ensuring that we maintain timely and consistent communications with people who may be waiting for services

3 What we did in 2021/2022

During 2021/2022, Health and Adult Services continued our strategic development alongside the ongoing response to the pandemic. Working collaboratively across our teams and services, and bringing in the voice and experience of people who access support, we co-designed our new HAS 2025 Plan 'Longer, healthier, independent lives'.

This year, we have used the structure of the HAS 2025 Plan to show you some of our key achievements and challenges as we implement our strategic priorities. This is not intended as an exhaustive list of all our work; instead, we have worked with our teams to bring you some examples that show a range of initiatives at directorate, service and team levels. We have also included some of our challenges and how we plan to tackle them.

Our Priorities

Our Vision: "People living longer, healthier, independent lives."

Longer, healthier, independent lives: Our plan for Health and Adult Services in North Yorkshire 2022-2025

1 Opportunities for everyone, everywhere

Reducing inequality across North Yorkshire *"I will have access to the same services and life opportunities wherever I live or whatever my life circumstances".*

Staying well and healthy *"I will have the information and support I need to keep myself as healthy and well as possible".*

Protecting the health of North Yorkshire's residents *"I will live in a community that promotes good health across all ages and have access to information and services to support my own health and wellbeing."*

Improving mental health and wellbeing *"I will know where to get information, advice and support when I need it".*

2 My time and experiences are valued

Respecting people's time *"I will only need to tell my story once to get the support I need. This will be based on my needs, and not delayed by decisions on how it will be funded".*

Listening to people's experiences *"My experiences will be heard and used to help make decisions about the way services are designed and delivered".*

Embracing technology together *"I will be able to interact with the County Council in more accessible ways, and have support to use technology to enhance my quality of life if needed".*

A life outside of caring *"As a carer I will feel valued and have a full and more balanced life".*

3 My home, my community, my choice

My home, my choice *"I will be supported to live independently in my home of choice as long as possible".*

Outstanding Services *"I can access high quality, affordable services within my community".*

Strengthening communities to create opportunities *"I will have the opportunity to be an active part of my community where my contribution is recognised".*

Priority 1

Opportunities for everyone, everywhere

"I will have access to the same services and life opportunities wherever I live or whatever my life circumstances."

Reducing inequality across North Yorkshire

Examples of good practice

Adult Weight Management – tackling health inequalities

Mental Health team – liaison and joint working with local Disability Employment Advisers for Department for Work and Pensions (DWP)

COVID-19 vaccinations – addressing inequalities

Our challenges

Size and rurality of the county, impacting on range and availability of services

Ending of government grant funding for Adult Weight Management programme

What we're going to do

Develop place-based approach with partners

Continue Adult Weight Management bespoke projects, using underspend and other funding

Reducing inequality across North Yorkshire

Examples of good practice

Adult Weight Management – tackling health inequalities: with targeted government grant funding, we developed and delivered 'bespoke' adult weight management programmes for specific groups of people who currently are under-represented in the service and/or experience health inequalities. The programmes included a group for Pakistani heritage women in Skipton; four bespoke programmes for participants living with learning disabilities: a Walk and Talk session for those living with mental illness, an older people's group, a men-only group, funding for 1-2-1 sessions and in rural areas. We worked with people from these communities to develop the programmes.

Mental Health team – liaison and joint working with local Disability Employment Adviser for Department for Work and Pensions (DWP): often the DWP may be the first agency that comes across people in crisis if they attend due to benefit, finance/debt issues. Working with DWP, mental health teams are accepting referrals for people not supported by secondary health services (but in crisis) to address the social aspects of debt, as well as exploring other support where appropriate, e.g. preventing bailiff attendance and reducing debt/charges due to mental health reasons, which the Breathing Space process (short-term debt respite scheme) could not have achieved.

COVID-19 vaccinations – addressing inequalities: North Yorkshire and City of York Public Health teams worked with NHS colleagues to support the roll-out of COVID-19 vaccinations. We set up a COVID-19 Vaccine Assurance Group, chaired by the NY Director of Public Health, which included a focus on addressing vaccine inequalities. Targeted support was offered to various groups including refugees and areas with higher proportions of ethnic minority groups less likely to access vaccination. This scheme of work has allowed the development of targeted vaccination approaches to continue into other vaccination programmes, and the lessons learnt to be embedded into local practice.

Reducing inequality across North Yorkshire

Our challenges

Adult Weight Management: the additional Government grant funding for Adult Weight Management in 2021/22 was not continued into 2022/23; it was confirmed in May 2022 that we could use our underspend to further fund local projects until 31st December 2022. We used this to continue some of the 'bespoke' programmes and optional additional 1:1 support for participants, which has proven beneficial in terms of participation and weight loss.

Rurality: the size, geographical and social diversity of the county, with its highly rural areas and more deprived coastal communities, creates challenges for the delivery of consistent, cost-effective services. In some areas, having a choice of services can be particularly difficult as there are few providers.

What we're going to do

Adult Weight Management: for 2022/23, we will be using underspend to fund 3 new programmes for adults with learning disabilities, using the learning from 2021/22 to make further adjustments to how they are delivered. We are also funding an additional programme for women of Pakistani heritage in Craven, where the model was particularly successful; a new men-only programme; a "couch to 5k" social running project for people living with mental ill health in Hambleton; and extending funding of the rural programmes, one men's programme and an over-65s programme. We are taking this learning to develop and transform Adult Weight Management Services.

Place-based working: we will continue to develop our place-based focus within Health and Adult Services, as well as contributing to the development of the new locally-focused council and working closely with health partners as they develop their place-based approach. We will also use knowledge of gaps in provision in our social care market development and commissioning. This place-based working will enable us to deliver local services better for local people, working with key partners in each area to ensure individual needs are met, and will continue to develop alongside Local Government Reorganisation locality working.

Priority 1

Staying well and healthy

"I will have the information and support I need to keep myself as healthy and well as possible."

"NYCC's approach to communications has been agile and collaborative. Using a range of internal and external channels, as well as social media, it has been flexible, responsive, and utilised varied local voices to good effect. This can be seen in its multi-disciplinary press conferences, held in conjunction with relevant partners, allowing public messages to be shaped by all organisations. The amplification of local public and service user voices in its communications has been well received (e.g. Respect & Protect)." LGA COVID-19 Peer Challenge report, 2021

"Thanks to your team [Knaresborough and Ripon Independence] for their care, friendliness, understanding, advice, information and compassion which has really helped me."

Examples of good practice

Selby Health Matters

Mental Health – walking groups

North Yorkshire Learning Disability Partnership

Accessible information

Our challenges

Helping people with long-term health conditions to stay active and healthy

Barriers to accessible information

What we're going to do

Continue to focus on prevention

Develop more local interventions for good health

Continue our work to champion good practice in accessible communication

Staying well and healthy

Examples of good practice

Selby Health Matters: community health partnership worked with local Primary Care Networks on a pilot involving people with frailty and high blood pressure to find out what more we could do to support patients with long-term health conditions to live well and independently in the community, reducing the need for future hospital care. The feedback provided is helping develop new community services with patients, for patients: NHS Vale of York Clinical Commissioning Group - Population Health Management (valeofyorkccg.nhs.uk)

Mental Health – walking groups: building on the success of the walking group already in place, the Hambleton Mental Health team have made links with Hambleton District Council to start another walking group in another area, which means two can run at the same time. In addition, people supported by adult mental health services have priority access to the Take that Step Programme and the Exercise Referral Scheme (£36 for 12-week gym membership).

North Yorkshire Learning Disability Partnership Board: working with NYCC's self-advocacy support service Keyring, self-advocates and health colleagues, we co-designed easy read activity packs on annual health checks and physical activity. You can find the packs here: Easy Read Resources | North Yorkshire Partnerships (nypartnerships.org.uk)

Accessible information: during 2021/22, Healthwatch North Yorkshire (HWNY) and Healthwatch York (HWY) carried out a project to assess the health and care system's compliance with the Accessible Information Standard. We supported HWNY to engage with the engagement forums and groups we work with, and we are undertaking our own review to ensure good practice in accessible information is embedded within the organisation. You can read HWNY and HWY's joint report here: Accessible-Information-Report-June-2022.pdf (healthwatchyork.co.uk)

Staying well and healthy

Our challenges

Helping people with long-term health conditions to stay active and healthy, particularly during pandemic restrictions: COVID-19 has disproportionately affected people who have underlying health conditions, whether through more severe outcomes from COVID-19 infection, reduced access to health care, or through the impact of shielding measures.

Accessible information: the first year of the pandemic highlighted barriers to accessible information for some of our communities, with little in the way of accessible communications on COVID-19 being made available at national level to begin with. This meant that we had to create and share our own accessible information.

What we're going to do

Focus on prevention: we will continue to focus on prevention both for infectious diseases and wider preventable causes of ill health across the life course, from supporting children and young people to have the best start in life through to developing healthy ageing work to ensure North Yorkshire is an age-friendly community. We will continue to keep health inequalities central to public health work, including championing inclusive health for key groups such as refugees and asylum seekers and Gypsy/Roma/Traveller communities.

Champion accessible communication: we will continue our work to champion good practice in accessible communication, including building capacity in behavioural science (understanding how people behave) alongside our engagement forums. We will provide public information on key health issues such as vaccination to enable individuals to make informed choices to improve their health.

Priority 1

Protecting the health of North Yorkshire's residents

"I will live in a community that promotes good health across all ages and have access to information and services to support my own health and wellbeing."

Examples of good practice

Outbreak Management

Managing outbreaks in In-House Provider Services

Annual Health Checks

Family support for healthy weight and oral health – workforce development

Our challenges

Impact of pandemic management on staying healthy

Making sure that people with a learning disability can access the health care that they are entitled to

What we're going to do

Further develop our approaches to health protection

Self-advocates will raise awareness of annual health checks

Continue to work with partners to improve population health

Protecting the health of North Yorkshire's residents

Examples of good practice

Outbreak Management: following the third national lockdown in January 2021, the government announced a roadmap for lifting lockdown restrictions. The summer saw the reopening of key economic sectors and the Public Health team developed Events guidance to support the visitor economy. A key success was the successful delivery of the Great Yorkshire Show in July 2021. In the winter of 2021/22, the Omicron variant further challenged outbreak management. The care sector worked collaboratively with the Public Health team and Adult Social Care colleagues to implement outbreak management guidance and the roll-out of vaccination programmes.

Managing outbreaks in In-House Provider Services: throughout the COVID-19 pandemic, we have worked extremely hard to manage outbreaks to keep people safe. One of the ways we did this was via an outbreak checklist developed in collaboration with Public Health colleagues from North Yorkshire and York. This checklist was used across all services to keep staff, people and visitors safe, with specific versions for different types of provider service – e.g. reablement, short breaks and extra care housing providers.

Annual Health Checks: nationally, people with a learning disability are at higher risk of a range of health conditions and early mortality; to help address this, they are entitled to an Annual Health Check with their GP. The Transforming Care team actively promote Annual Health Checks for people with a learning disability from 14 years upwards, and Annual Health Checks are a priority topic for the North Yorkshire Learning Disability Partnership Board.

Family support for healthy weight and oral health – workforce development: the healthy weight and oral health workforce development project aims to support families who most need help with healthy weight and oral health issues by upskilling the people who work with them, such as foster carers, Early Help workers and social workers. We have started by finding out what people already know and what information and training they need. As a result of this work a new healthy weight and oral health resource bank was developed and disseminated to staff groups, and we will work more on this in 2022.

Protecting the health of North Yorkshire's residents

Our challenges

Impact of pandemic management on staying healthy: whilst the national lockdowns helped to keep people safe, the restrictions changed how we all lived our lives and led to some health and wellbeing impacts. People experienced challenges in staying active, accessing healthcare, and having enough social interaction. There were also disruptions to healthcare, as re-prioritisation of hospital staff impacted non-emergency care such as planned treatments and operations.

Annual Health Checks: the Transforming Care team found that GPs did not always have the right information and that some people with a learning disability were not registered with a GP. We worked with our National Health Service England colleagues to check that people known to Health and Adult Services were registered with a GP and on the Learning Disability Register.

What we're going to do

Outbreak management: continue to manage COVID-19 outbreaks and develop our 'business as usual' health protection model, moving away from the Outbreak Management Hub. We will continue to work with partners and the public on what 'Living with COVID-19' means, and develop our health protection capacity to deal with other local outbreaks including avian flu.

Annual health checks: self-advocates working with North Yorkshire Learning Disability Partnership Board will be focusing on annual health checks during 2022-23 to help build awareness and uptake. They will also be working on other health topics including the learning disability care coordinator role. There's more information about their work here: North Yorkshire Health Task Group | North Yorkshire Partnerships (nypartnerships.org.uk)

Partnership working for healthier people and places: we will continue to work with internal and external partners to tackle the wider determinants of health, including the development of inclusive and sustainable approaches to the economy, housing, and local planning. We will continue to provide and develop core public health services including sexual health, drug & alcohol support services, NHS health checks, and smoking cessation services to support individuals to improve and maintain their own health.

Priority 1

Improving mental health and wellbeing

"I will know where to get information, advice and support when I need it."

Examples of good practice

Mental Health Transfer of Care Coordinator

Voice of people with mental health conditions

Mental Capacity Act and Deprivation of Liberty Safeguards – accessible information

Our challenges

Hearing from and involving people with lived experience of mental health services

What we're going to do

Review learning from Mental Health Transfer of Care Coordinator pilot

Progress options appraisal for voice of people with mental health conditions

Co-produce information to support people to understand their rights

Improving mental health and wellbeing

Examples of good practice

Mental Health Transfer of Care Coordinator: the Health Integration team established a pilot role to work between care and mental health teams to support timelier transfers of information and to coordinate the care around the person. This pilot aimed to reduce unnecessary delays for people leaving mental health wards, as well as ensure that all professionals supporting the person had access to the most up to date information so that they could make appropriate decisions about their care and support needs. The pilot was regularly reviewed and as part of this, the team spoke to people leaving mental health hospitals to seek their feedback on things we could do better, and worked to implement the feedback throughout the pilot.

Voice of people with mental health conditions: we commissioned ThriveLab to explore how best to engage and involve people with lived experience of mental health conditions/services in shaping services. People with lived experience were involved throughout this project, on the steering group, via 1-2-1 conversations and engagement sessions, and shared their views in different ways including creating a video about good involvement.

Mental Capacity Act and Deprivation of Liberty Safeguards – accessible information: this is complex legislation that can be hard for people to understand. To help make sure that people have the information they need, the Practice Team created an accessible, plain English resource on our website, working with the Participation and Engagement team to gain feedback on the resources from people who access services.

Improving mental health and wellbeing

Our challenges

Voice of people with mental health conditions: we want to work with people with lived experience to co-produce our services; however, there's no consistent way of doing this at the moment. The work by ThriveLab will provide options for developing a shared approach.

What we're going to do

Mental Health Transfer of Care Coordinator: the Health Integration team will review and evaluate the pilot and decide on next steps. Initial findings have shown the role adds value and is helping people to leave the hospital sooner.

Voice of people with mental health conditions: we will work with people with lived experience and partners to respond to the findings of the ThriveLab project and implement the chosen option to develop ways to co-produce.

Mental Capacity Act and Deprivation of Liberty Safeguards – accessible information: we will work with people who access services to co-produce information to support people to understand their rights under the legislation.

Priority 2

Respecting people's time

"I will only need to tell my story once to get the support I need. This will be based on my needs, and not delayed by decisions on how it will be funded."

"She really has gone above and beyond keeping us informed every other day, making sure we all understand what's going on, and making sure we are all okay […]. (Compliment received by the Richmond Planned Care Team)

Examples of good practice

Meeting people's needs at our 'front door'

Hospital Discharge Hubs

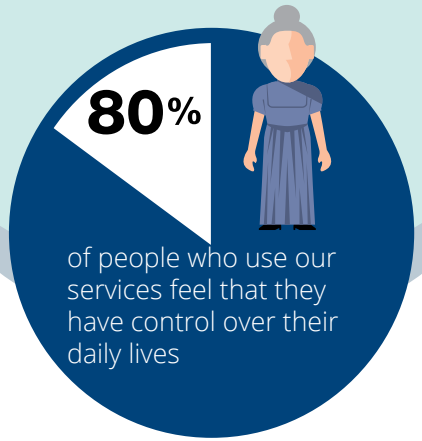
Trusted assessments with the Vale of York Care and Support team

Reducing bureaucratic requirements for Direct Payments

Shared Care Record

Our challenges

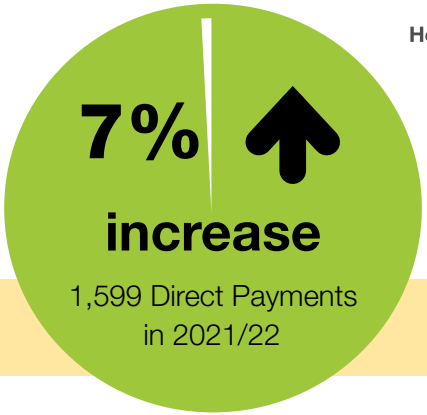
Care market pressures and gaps in availability of care to allow people to return home



What we're going to do

Focus on recruitment and developing local care options to support a safe transition from hospital to home

Examples of good practice



Meeting people's needs at our 'front door': the Care and Support Team in the Targeted Prevention service is a professional multi-disciplinary team sitting within the Customer Service Centre. The team provides professional support, information, advice and guidance to people at the 'front door' of Adult Social Care. During 2021/22, the team handled an average of 750 contacts per month and were able to resolve 64% of those with no further involvement required from social care teams. The team continued to embed a new conversation record starting at the 'front door', which informs carer assessments and ensures people are only asked to provide information once. The team was also strengthened with the addition of two new social worker posts to respond to increasing demand for services.

Hospital Discharge Hubs: We developed hospital discharge hubs to deliver consistent discharge support to residents through access to the 'discharge to assess' pathway with temporary full funding of initial care and support. The discharge hub team also supported timely discharges for residents from hospitals out of county. We are gathering feedback from people about their needs and choices, and gaps in provision, and listening to this to help us shape service commissioning.

4,382 people received a Discharge to Assess assessment, 62% of people discharged went home, 23% went on a short-term placement and 15% to a care setting to be assessed for long-term needs.

Trusted assessments with the Vale of York Care and Support team: via a new trusted assessment form within hospitals, assessment by our social care staff in hospital is kept to the minimum necessary, so that a comprehensive assessment only takes place once. This happens out of the hospital setting, when the individual is ready and more settled and in a place of recovery. We hold weekly unsourced packages of care meetings where we scrutinise care records, read feedback from individuals and their families and we use this to allocate appropriate care when it is available, paying attention to people's wishes, priorities and risks.

Reducing bureaucratic requirements for Direct Payments: the legislative requirements to provide evidence of how direct payments are spent are there for good reasons, but can feel bureaucratic and onerous for people. The Direct Payments team recognises that it is important for people to live as full a life as possible without barriers created by these requirements; their approach considers each individual's ability and where appropriate adapts the requirements, fostering trustful relationships and enabling people to get on with their lives. 1,599 Direct Payments in 2021/22 (7% increase)

Shared Care Record: as part of digital transformation work, the Council has worked with health partnerships to implement the new shared care record, which provide direct access for social care and health teams to a person's health and care history. Reducing the amount of time spent contacting each other to obtain or clarify that information has resulted in faster decision making and more connected care pathways.

Respecting people's time

Our challenges

Availability of care to help people leave hospital and return home: because of unprecedented pressures in the market, we have often not had the full range and availability of services for people when discharged from hospital in some parts of North Yorkshire. We are working with private providers to stimulate market availability in areas where services are more difficult to find, and a new discharge grant scheme was rapidly set up to offer family members a payment for caring for relatives on a short-term basis. We are also supporting people with temporary care, sometimes in a place other than home, including a care rooms pilot in the Selby area. This is where people receive support in another person's home, over a very short period of time. However, we sometimes struggle to then source care to enable people to return home at a time they feel ready. While it's preferable to be in a residential home whilst waiting than a hospital bed, it does still lead to frustrations.

What we're going to do

Hospital discharge: we will continue to work with care providers to expand into areas where provision is harder to find, and convene regular local accommodation meetings to share information about gaps in accommodation options for people with care and support needs. We will also continue the development of a virtual home-based ward model with the NHS, with rapid access to therapy support to make best use of the virtual ward, and continue with the care rooms pilot across a wider geographical area. During periods of unprecedented challenge, we will continue to hold panel meetings to discuss complex discharge cases and find solutions for individuals to support hospital flow.

Speed up assessments: our brokerage service is developing with additional staff; we are recruiting into assessment roles including 'growing our own' professional workforce and international recruitment with the aim of ensuring people's needs are assessed as quickly as possible.

Priority 2

My time and experiences are valued

"My experiences will be heard and used to help make decisions about the way services are designed and delivered."

"NYCC's 'user-by experience' centred ethos has paid dividends, with care users describing extremely positive experiences of NYCC's support. They reported feeling more engaged, listened to and their views acted upon more than ever before." LGA COVID-19 Peer Challenge Report, 2021

HAS Whitby Planned Care: "I'd intended to email before to thank you from us all. It's such a relief to have you as our advocate, really appreciated."

Chair of North Yorkshire Disability Forum about the Keeping in Touch Care Home Visiting Task Group: "To have care providers and care home residents and relatives brought together to form policy in a short space of time was a huge success for us and for North Yorkshire County Council."

Listening to people's experiences

Examples of good practice

Approved Provider Lists – What Makes a Good Life?

North Yorkshire Safeguarding Adults Board

Transitions Pathway Review

Our challenges

Outdated service specifications

Barriers to carrying out accessible engagement during the pandemic restrictions

What we're going to do

Use new service specifications to commission services, and co-produce the next phase of service transformation

Use learning from pandemic to co-design hybrid engagement (digital and in-person)

Listening to people's experiences

Examples of good practice

Approved Provider Lists – What Makes a Good Life? As part of the review of the Approved Provider Lists (APLs), the Service Development team worked with Inclusion North and Keyring self-advocates to carry out engagement with people who use services, focusing on finding out what a good life or a good day means to them.

This provided a wealth of invaluable information that has fed into the development of the new APL service specifications to ensure the services we commission and the models of care we offer are as outcome focused as possible. It also forms the foundation for the next stage, co-producing service transformation.

North Yorkshire Safeguarding Adults Board (NYSAB) carried out an engagement project to find out what people know about the NYSAB and safeguarding; what they think of our existing communication and engagement methods; their suggestions for the best way to communicate about safeguarding; and how they want to share their experiences in a way that is meaningful and informs change. 392 people took part in the engagement and 7 recommendations were made based on the feedback: NYSAB (safeguardingadults.co.uk)

Transitions Pathway Review: the Care and Support Transitions team wanted to find out about family carers' and young people's experiences of moving from children's social care to adult social care (known as 'transitions'). The team worked with Inclusion North to identify young people who had recently experienced the transitions process and asked them, and family carers, for their feedback via easy read surveys and follow-up telephone interviews. This highlighted areas that were working well – for example, that the process was happening early and was very family centred – and areas for improvement – for example, that there could be more written information and signposting so that families knew what to expect.

Our challenges

Approved Provider Lists – What Makes a Good Life? The current service specifications were very outdated and were not co-produced with people who use services. Time was a challenge due to a tight deadline to re-procure the APLs; however, in partnership with Inclusion North and Keyring, a two-phase approach to engagement and co-production was designed.

North Yorkshire Safeguarding Adults Board: challenges included conducting meaningful engagement during a pandemic in a way that was accessible. A particular challenge was to find ways to ensure we heard from seldom-heard groups. We worked with self-advocates to co-produce an accessible survey and accessible presentation to be delivered both virtually and in person sessions. Self-advocates, along with others who have taken part in the engagement work, continue to work with us to co-produce an action plan to implement the recommendations.

Listening to people's experiences

What we're going to do

Approved Provider Lists – What Makes a Good Life? The new APLs will be procured and the services commissioned via the new APLs will go live in 2022/23. The new outcome-focused service specifications and Standards & Outcomes Framework will be used to monitor the quality of commissioned services. The initial engagement has also provided a foundation for co-production of the adult social care transformation programme.

Hybrid engagement: we have learned a lot about how to use digital platforms for accessible and meaningful engagement during the pandemic, and we are bringing this learning into our plans to move to hybrid methods (digital and in-person), co-designing our approach with our engagement forums.

Priority 2

Embracing technology together

"I will be able to interact with the County Council in more accessible ways, and have support to use technology to enhance my quality of life if needed."

Examples of good practice

Transforming Care Team – person-centred discharge planning

Technology Enabled Care (TEC) – support to stay independent

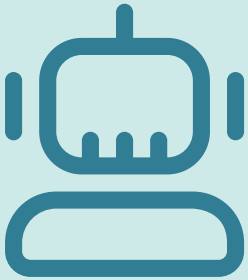
Own Fone – reducing delays in hospital discharge

Digital inclusion – overcoming barriers to access

Our challenges

Barriers to uptake of TEC

Reaching people at risk of digital exclusion



What we're going to do

Work across adult social care to develop practice knowledge and confidence around TEC

Begin recommissioning of assistive technology contracts with focus on integration and use of domestic digital devices

Embracing technology together

Examples of good practice

Transforming Care Team – person-centred discharge planning: during the pandemic, we have embraced using WhatsApp and Microsoft Teams to talk to people we support and work with hospital teams to engage the person from the start in their discharge planning. In one example, we were able to send the person plans of the accommodation being developed so they could have input in the layout of the flat they would be moving into. This took several months, but the person has settled well back into the community and the accommodation they helped develop.

Technology Enabled Care – support to stay independent: the Housing, Technology and Sustainability team continue to innovate in the use of Technology Enabled Care (TEC), supporting people to remain independent through its use. A bespoke offer is given to each individual, and our TEC service has provided over 700 unique items. We continue to pilot new products which focus on preventative and predictive interventions such as ARMED, a wearable device which uses personal analytical data to identify whether the person is at risk of falling; Brain in Hand, a smartphone app to help manage a range of conditions such as mental health, autism and anxiety to help people maintain independence; and Canary, a sensor-based system which does not require an internet connection or a phone line.

Own Fone – reducing delays in hospital discharge: this initiative was developed by our Health Integration team during the pandemic to assist with safe hospital discharges. People leaving hospital were offered a lightweight device that acts as a mobile phone which can be easily worn on the person and pre-programmed to include up to 12 numbers. The aim was to combat any delays in putting in telecare or assistive technology in people's homes, and therefore reduce delays in hospital discharge. 50 handsets were procured and shared with our 5 acute trusts, and the supplier Own Fone worked with people to develop their offer.

Digital inclusion – overcoming barriers to access: many of our teams worked to overcome barriers to digital access during the pandemic, including the Direct Payments team, the Living Well and Supported Employment teams, Living Well Smokefree team, Mental Health teams and Assessment teams. Examples of interventions include: digital champions, working with Citizens Online to provide support to individuals to make the most of technology, e.g. a tablet loan scheme; access to smart phones for a smoking reduction scheme for pregnant smokers; using video-conferencing to keep in touch and reduce isolation; working with A1 Community Works to provide kit and support to use it.

Embracing technology together

Our challenges

Uptake of TEC: we are innovating and developing the capabilities of assistive technology to help people maintain their health and independence; however, we have more work to do to encourage the uptake of technological solutions. This requires a culture shift for both practitioners and people who use services.

Digital exclusion: the use of technology has accelerated rapidly over the past two years and the move to digital platforms during the pandemic highlighted the extent of digital exclusion. This remains a challenge whether based on connectivity, cost or knowledge.

What we're going to do

Uptake of TEC: we created a practice lead post placed in the Housing, Technology and Sustainability team to work across Adult Social Care to develop practice knowledge and confidence to build tech solutions into support planning. The post was created in 2021/22 on a fixed-term basis and made permanent in 2022. We will also be recommissioning the assistive technology contracts (from April 2024), with a focus on better integration with children's services and health partners, and on enabling people to use their own devices to make use of customer comfort and familiarity with standard tech.

Digital Inclusion: we will continue to promote the use of TEC to support people to remain independent as well as piloting new and emerging products such as ORCHA social prescribing apps (ORCHA), and continue to work with organisations such as Citizens Online to reduce barriers to digital inclusion.

Priority 2

A life outside of caring

"As a carer I will feel valued and have a full and more balanced life."

1,007 carers assessments were completed during 2021/22

Examples of good practice

Carers Support Service

Direct payments used in flexible ways to support carers

Carers – information, advice and guidance

Our challenges

To reach more carers and improve response times

What we're going to do

Implement the re-procured Carers Support Service and monitor outcomes

A life outside of caring

Examples of good practice

Carers Support Service: the NYCC Carers Support service was successfully re-procured, ensuring that provision for adults and young carers was brought together into a single, unified contract agreement. Engagement sessions were held with carers of all ages and backgrounds, allowing carers to directly influence the new specification, and identify the key issues and priority outcomes that were of greatest importance to them.

Direct payments used in flexible ways to support carers: over the last 2 years, some people were not able to access their usual services. This left carers delivering higher levels of support, which increased the pressures on their own resilience and mental welfare. The Direct Payments team supported and encouraged carers, and practitioners, to think about alternative ways for their loved ones to continue to receive support to reduce the impact on their own wellbeing, including different ways of using direct payments. Carers told us they felt genuinely cared for and that this support helped them to keep safe and well.

Carers – information, advice and guidance: the Targeted Prevention team carried out engagement with carers and stakeholders to find out what was important to them. The feedback informed the development and testing of options for an online self-serve offer alongside traditional access routes.

A life outside of caring

Our challenges

Our challenge is to identify and work with an increased number of carers and improve response times, reaching people at the earliest point possible to enable us to offer early intervention and prevention, and provide the most appropriate support.

What we're going to do

We will implement the refreshed, unified service Carers Support Service, ensuring that a quality information, advice and support service is available to all our carers, particularly in times of crisis, to avoid care breakdown or hospital admission. We will also improve the online self-serve offer and increase take-up – with accessible information, advice and guidance – through an improved online assessment and online review.

Priority 3

My home, my community, my choice

“I will be supported to live independently in my home of choice as long as possible.”

“I would like to express my gratitude for the recent care I have had from the NHS. Due to a car accident resulting in a broken ankle, I spent four days in the Friarage, then six weeks in respite care at Orchid House Thirsk. The care I received in both was exemplary and Orchid house has the bonus of delicious lunches from the Bistro. Now that I am home, I have wonderful North Yorkshire County Council reablement carers I have met since my accident, really seem to care. The system wouldn’t work without good management from above and I count myself very lucky to have experienced such efficiency. Thank you to everybody.”

My home, my choice

Examples of good practice

Supported Living – a new home

Extra Care developments – local community hubs

REACH Project

Helping people to stay at home in rural areas

Choice and control for people over where they live

Our challenges

Access to suitable sites for extra care developments

Recruitment difficulties particularly in rural areas

Uptake of Direct Payments

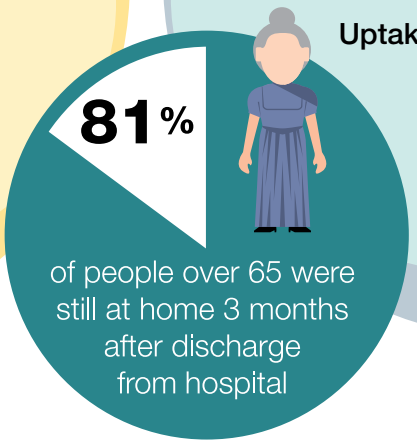
What we’re going to do

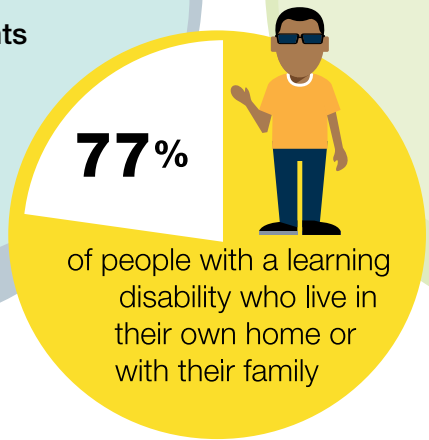
Explore Extra Care options for people with more complex needs and in rural areas

Develop dementia support hubs

Expand the REACH model to support more people

Use the learning from our rural homecare projects to develop more pilots





Eller Beck, Skipton

Bowland View, Bentham

Filey Fields Court

Examples of good practice

Supported Living – a new home: the Transforming Care team supported three people, including one person in hospital, who wished to live more independently. We worked with our Service Development team to design a supported living scheme in Harrogate. The challenge was building up the relationship with the three people involved during a period of COVID-19 restrictions. Online quizzes, bake-offs and chats were organised to help them get to know each other and when allowed, meet ups were organised. They met the provider supporting them on several occasions to ensure they knew the staff and their manager. The three people were also involved in organising what they wanted in the bungalow and with support from the TCP team and their families they have made the accommodation their home.

Extra Care developments – local community hubs: the Housing, Technology and Sustainability Team have opened three new Extra Care schemes since August 2021 and now have 28 schemes with over 1500 units of high-quality accommodation, with support all across North Yorkshire. As well as providing accommodation, Extra Care acts as a community hub hosting libraries and public spaces whilst also providing space for respite and discharge to assess services. Our most recent scheme at Bentham has been developed in close collaboration with the local community especially members of the Bentham Extra Care Group who have been involved in the scheme from concept to delivery. A total of 1,538 extra care places (13% increase on 20-21)

REACH Project (Reducing Exclusion for Adults with Complex Housing Needs) in Scarborough supports people with complex needs relating to mental health, substance misuse and offending behaviour. The project provides dedicated multi-agency support to help people to develop the skills required to manage their own tenancies and live independently. The project was set up in partnership between the county and district councils, the mental health service provider, the police service and others in response to the need in the community, bringing partners together to provide a single point of support.

Filey Fields Court

Filey Fields Court

Filey Fields Court

My home, my choice

Examples of good practice

Helping people to stay at home in rural areas: it can be very difficult to source care in rural areas. As part of our response to this, we have carried out pilot projects to find new and innovative ways to provide care:

- **Micro-enterprises:** between 2019 and 2021 to support the development of micro providers to deliver domiciliary care in people's own homes and communities. The project successfully established 12 new providers in the Ryedale district (and wider) and supported a total of 39 people to remain at home.
- **Reimagining Home Care – Reeth:** this 2-year pilot, which started in May 2021, looks at innovative ways of enabling people with assessed needs to remain at home for as long as possible in a selected area, working with an established care and support provider using technology, community assets and volunteers.

Choice and control for people over where they live: our in-house care provider workforce has been flexible and adaptable to ensure that people's needs are met. For example, in Harrogate we responded to a provider failure to ensure continuity of support for people with learning disability and/or autism, in consultation with the people who use the service, their families and advocates. We made sure that there was no break in services and people continued to receive support in their own homes. This intervention enabled people to continue to live where they wanted to, rather than the potential alternative of residential accommodation for some to cover the provider gap.

My home, my choice

Our challenges

Extra Care developments: access to suitable sites for development remains a challenge, especially in high-cost areas such as Harrogate.

Helping people to stay at home in rural areas: both projects experienced recruitment challenges (made worse by the pandemic); the micro-enterprises project had challenges with the direct payments process and uptake of direct payments. To tackle these challenges, the micro-enterprises project appointed a project manager and amended the Direct Payments process, and the Reeth project appointed a "Care Connector" to enable the more innovative methodology to be developed moving into the second phase of the project.

What we're going to do

Extra Care developments: the Housing, Technology and Sustainability team will continue to develop Extra Care by pursuing developments in Malton and Harrogate, working closely with development partners and district and borough council colleagues. The next phase of the programme will focus on how we can develop Extra Care for people with more complex needs as well as smaller-scale schemes to support our rural communities.

REACH project: the project will continue to expand to support more people and create capacity for move-on accommodation. Phase 2 planning for a purpose-built supported housing development will take place.

Helping people to stay at home in rural areas: the learning from these projects will inform future pilots and service delivery models. The second phase of the Reeth project is anticipated to link more into community assets (groups, networks, local community buildings and so on), thus decreasing the need for formal services organised and/or delivered by councils and health services.

Priority 3

Outstanding Services

“I can access high quality, affordable services within my community.”

“My mother is a resident at xxx. On several occasions over the last 12 months, my mother has needed the assistance of the onsite carers who always respond quickly and efficiently. The kindness and compassion they show goes over and above one’s expectations. Two carers in particular who responded to an emergency call need to be commended for their exceptional personal and professional skills. Their kindness and compassion in their handling the situation was outstanding.”

“Health and Adult Services have been extremely supportive to ourselves as an organisation but also clients and their families, and the outcomes have always been positive and sometimes stopped readmissions into hospital.”

“A proactive relationship-based approach is evidenced in NYCC’s proactive engagement with care homes, care settings and care users. The positive impact of this is evident in the strength of the relationships forged during the pandemic with these partners. The dedication, energy and collaborative team working which has made this possible was evident through a ‘willingness to pull out all the stops’. There has also been innovation is service delivery. For example, the additional investment in the Quality Improvement Team (QIT) has had a transformational impact on the ground, including direct vaccination intervention to support struggling care providers and to assist the NHS with vaccine roll-out in care homes.”
LGA COVID-19 Peer Challenge report, 2021

Examples of good practice

Quality and Service Continuity – Quality Pathway

Quality and Service Continuity - integrated quality team

Day services – grants for alternative provision

Selby Homecare

Our challenges

Supporting the care market during challenging economic times, made worse by the pandemic

Ensuring that people have continuity of good-quality support

81% of beds in our residential homes in NY are rated as 'outstanding' or 'good'

What we're going to do

Fully implement the Quality Pathway and integrated Quality team

Build on the learning from delivering community-based support in new, more flexible ways

Explore options for extending the new homecare rapid-response in-house service

Only 1.2% of complaints against the total number of people supported by ASC

Outstanding services

Examples of good practice

Quality and Service Continuity – Quality Pathway: 2021/22 saw the further planning of the Quality Pathway, a new proactive risk-based approach to monitor and improve social care services. This will ensure the population of North Yorkshire receive good quality services and where issues are identified, providers are fully supported to make the required improvements so they can continue to operate safely.

Quality and Service Continuity – integrated Quality Team: following the success of the multi-agency care setting response created during the pandemic, planning is underway to implement an integrated Quality Team for the county to fully support the introduction of the Quality Pathway. A joint approach between NYCC Adult Social Care and health commissioners, this involves working more closely with Humber & North Yorkshire Integrated Care Board and enhancing the positive working with their Quality Team.

Day services – grants for alternative provision: most Day Services had to close in the initial stages of the pandemic, and so a COVID-19 Day Services Support Fund was set up to make additional funds available to develop blended/alternative service offers, and financial relief where providers were unable to meet costs due to the restrictions. The Service Development team built up close and mutually supportive relationships with Day Services providers, and the financial support was based on listening to care providers about their ongoing challenges. Providers demonstrated flexibility and ability to adapt to ensure they were still able to meet the needs of the people they support in different ways.

Selby Homecare: one of the two domiciliary care framework providers in the Selby district ceased trading on 22nd June 2021. As an emergency measure, the service was brought under the management of the Selby Reablement Team Registered Manager in order to maintain a safe, consistent service with minimal disruption to people. A full consultation process took place with the former care providers' staff members and people accessing the service, and the feedback from this led to the creation of a permanent rapid-response in-house service.

Outstanding services

Our challenges

Recovery of day services: despite the easing of Covid-19 restrictions, some providers continued to have constraints on their delivery because of the restrictions still in place, and/or due to their service models. They therefore still required support from the COVID-19 Day Services Support Fund to develop alternative means to support people, or to provide financial relief in the event that alternative service delivery was not possible.

Selby Homecare: the Council does not ordinarily provide long-term community care directly to residents of North Yorkshire. The necessary response to this provider failure was therefore a significant undertaking, but was managed successfully through excellent team working and communication.

What we're going to do

Quality and Service Continuity – feedback and voice: we will continue to develop the mechanisms and tools for people in receipt of social care to have a voice in the quality of the care they receive, as part of the implementation of the Quality Pathway.

Day services – grants for alternative provision: we will build on the learning from delivering community-based support in new, more flexible ways. The feedback from providers and people who use services is that this more flexible approach to delivering community-based support services was welcome, alongside a safety net of building-based services for people with more complex needs requiring that level of support. The new APL service specification for community-based support has been designed using this feedback.

Selby Homecare: it is anticipated that the rapid-response in-house service will make a considerable contribution towards stabilising people whose care packages have been brought in house. Over time, this model will be extended to stabilising people with complex needs, as well as potential collaboration with NHS Continuing Health Care teams around a co-designed and co-funded model.

Priority 3

Strengthening communities to create opportunities

"I will have the opportunity to be an active part of my community where my contribution is recognised."

Examples of good practice

Supporting people to speak out and become involved in our work

Community resilience and volunteering

Community-led wellbeing and prevention

Our challenges

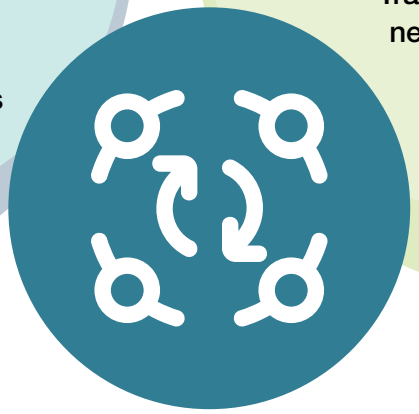
Building resilience in the care market and communities to reduce provider failures and increase options for community support

Meeting the funding challenge to maintain and build on the Community Support Organisations (CSOs) innovations

What we're going to do

Continue to innovate and develop community assets for wellbeing and prevention

Transition from CSOs to a new Community Anchor Organisation model



Strengthening communities to create opportunities

Examples of good practice

Supporting people to speak out and become involved in our work: we continue to work with and support user-led engagement forums such as North Yorkshire Disability Forum and North Yorkshire Learning Disability Partnership Board, and invest in workforce capacity to co-produce our services. During 2021/22, we explored hybrid meetings – a mix of in-person and online – offering flexibility and choice for forum members. The forums have also found new ways to get their voice heard during the pandemic, including online councillor meetings, press conferences, focus groups and creating videos to communicate to a wider audience. You can read more about this activity in section 4.

Community resilience and volunteering: in response to the pandemic, the Stronger Communities team worked with the voluntary sector to very rapidly form a network of 23 Community Support Organisations (CSOs) with 31 voluntary community and social enterprises and ultimately a wider network of over 150 grassroots groups. CSOs involved many people from their local communities as volunteers, and a survey in 2021/22 highlighted that most volunteers had new perspectives because their experience had brought them into contact with people from different backgrounds to them. You can read more about the experiences of people involved in CSOs here: Director of Public Health annual report 2022 | North Yorkshire Partnerships (nypartnerships.org.uk)

Community-led wellbeing and prevention: the Service Development and Stronger Communities teams have worked together to set up a pilot grant scheme in Selby and Craven to fund voluntary and community sector groups to support people in the district to live happy, healthy independent lives and reduce demand for long-term care. Feedback from the pilot has been positive: “We’ve been able to explore new ways to provide support.” “Enabling change, radical impacts to quality of life – for some, saving lives and their families.” “Lasting improvements in physical and mental wellbeing.” “Creating the futures people didn’t realise they could have.”

Strengthening communities to create opportunities

Our challenges

Developing resilience in our communities: provider failures have been a challenge throughout 2021/22 and we continue to develop and test creative ways to support providers and communities to develop resilience. The community grants pilot is one example of this.

Community Support Organisations – funding: the funding source for the CSOs was temporary for the COVID-19 response, and the challenge was to find ways to continue to build on the excellent emergency response work and increased community resilience, and cohesion, that it had created.

What we're going to do

Build on community assets for community wellbeing and prevention: our intention is to continue to harness and build on community assets, sustaining the capacity and momentum of the new initiatives and grassroot innovations that have emerged through the new community-led grants-based approach. This will be done by using the learning from the pilot grant schemes in Selby and Craven to develop a countywide grants approach.

Community Anchor Organisations: so as not to lose the good work of the CSOs and to help to realise the ambitions of the ***'People, Place, Power'*** strategy that the Stronger Communities team had been developing before the pandemic, the team are working with the CSOs to help pave the way for a transition from CSO grant arrangements in 22/23 to the development of a new Community Anchor model in 23/24.

Workforce

"There is a strong understanding of the structural and locality specific factors which have a bearing on recruitment and capacity challenges, which in turn impact on NYCC's ability to respond and recover. This is particularly the case for the care sector where proactive interventions are in train to address this." LGA COVID-19 Peer Challenge report, 2021

"I just wanted to pass something on to you. I was talking to my neighbour's daughter yesterday and asking how her Mum is doing as she is in the hospice now. She said that you personally had helped them as a family so much and at a time of real crisis for them all and particularly their Mum. She couldn't praise you enough for everything that you had done for her Mum. She didn't actually know what job I have in 'the council' so it was genuine, unprompted and heartfelt; many kind words and all meant for you personally."

The care sector, including the County Council, has experienced significant recruitment challenges for some time and it became even more difficult during the pandemic.

We have developed some new approaches to recruitment and retention as a result, particularly for professionally qualified staff. We have undertaken a number of broad recruitment campaigns on different themes and have developed alternative roles to try to attract different candidates. The Make Care Matter recruitment campaign went live in November 2021 and involved people with lived experience of accessing care and support services, who took part in TV adverts and press conferences: Make Care Matter - care professional opportunities | North Yorkshire County Council

However, we are carrying large numbers of vacancies, which has an impact on waiting times for assessment and staff caseloads. We are maximising opportunities afforded by recruitment agencies to employ agency staff and are pooling our colleagues to work as one team to make sure there is consistency wherever people may live.

One example of a new initiative to improve retention comes from our Targeted Prevention teams. In response to staff survey feedback about lack of progression across Targeted Prevention roles, a new apprenticeship for social prescribing was commissioned and the first cohort identified to start in 2022. Similar initiatives are underway in other services, including Public Health.

Staffing for In-House Provider Services: like every other part of the care provider market, staffing in particular has been a huge challenge for our in-house provider services, with a major impact from colleagues having to isolate. To respond to the staffing challenges, the service and workforce demonstrated great flexibility and adaptability. Provider Services colleagues moved around to different services where needed, and people from all parts of the Council, including some who had never worked in care, came to work in care services. As part of the winter planning for 2021/22, we ran a campaign asking NYCC colleagues to volunteer to cover shifts, and provided skills assessment and training.

Support for care providers: during the pandemic, the Government issued a number of grants to care sector providers via local authorities, including the Workforce Recruitment and Retention Fund grant. NYCC matched funding to allow providers to bid for up to £40,000 depending upon their workforce size, to support recruitment and retention initiatives. Challenges for the sector included issues with staff turnover, staff illness and agency costs. Providers submitted ideas around how to alleviate some of these challenges including staff bonus, training, recruitment campaigns, technology and wellbeing benefits/packages.

Direct Payments – personal assistants: over time it has become increasingly difficult to find and employ personal assistants, and it is much harder to find support at short notice, for example if a person's usual personal assistants are unwell. We also know from feedback that some people do not want the responsibility of being an employer but do want choice and control over who supports them. We therefore formed a partnership with an organisation which has built a digital platform for self-employed personal assistants. The organisation vets the self-employed personal assistants to support safer recruitment practices, and it means that people do not need to take on employer responsibilities when choosing the individuals they want to work with.

Developing our workforce:
The extensive training and continuous professional development offer available to our workforce is led by the cross-Directorate Organisational Development Group. Some examples of our development programme innovations in 2021-22:

Creation of revitalised practice induction for new Health and Adult Services recruits: co-created within the Adult Social Care Practice team, we used feedback from previous new starters, students and exit interviews to improve induction pathways around wider practice. Practice senior officers meet with new starters and provide a standardised offer to ensure they receive consistent support when joining our teams.

Creation of the Practice Library: a central resource library for all Health and Adult Services colleagues, along with a weekly Practice bulletin circulated to all directorate colleagues via email to update on current topics, resources and training updates.

Equality, Diversity and Inclusion (EDI): we have invested in staff capacity to lead our EDI developments, and examples of our workforce EDI activities in 2021/22 include: acting on feedback from colleagues to ensure recruitment, induction and training support the development and retention of a diverse workforce, with co-designed solutions; strengthening our directorate EDI working group; co-creating an ongoing series of talks to the Health and Adult Services Leadership Forum delivered by people with lived experience on EDI topics including Trans awareness, Lesbian, Gay and Bisexual awareness and anti-racist practice; and developing an intranet EDI resource library.

In-house provider services: our care provider service continues to focus on professionalising the workforce through workforce planning as well as recruitment. The training offer has been strengthened, with a nationally recognised diploma qualification offered to the whole provider workforce. The service is also developing models of care to support people with learning disability and autism, in recognition of the Health and Social Care Act 2022 which makes it mandatory for care professionals to be skilled, knowledgeable and competent in working with people with learning disability and autism. We are reviewing in-house training and rolling out the national Oliver McGowan training.

Section 4 – How did we do?

Adult Social Care performance

During 2020/21, we supported the following number of people:	
9,504	With long-term support services
6,297	With community-based packages
3,207	With residential packages
1,338	With extra care places
2,911	With contact from the Living Well Service
1,482	With Direct Payments

During 2021/22, we supported the following number of people:	
10,464	With long-term support services
6,571	With community-based packages
3,893	With residential packages
1,538	With extra care places
3,962	With contact from the Living Well Service
1,599	With Direct Payments

All 2021/22 figures in relation to the support we have been able to offer people show an increase on figures for 2020/21; however, the number of long-term support services, community-based packages and residential packages remained below pre-pandemic levels.

The number of Direct Payments returned to pre-pandemic levels and both contacts from the Living Well Service and the number of extra care places exceeded pre-pandemic levels.

Compliments and Complaints

We aim to provide the best possible services to those who use adult social care and public health services, and we value and encourage feedback. We want to know where things go wrong so that we can put them right and prevent them from happening again. Customer feedback is essential to the Directorate as it helps to shape our services and we can learn vital lessons from customer feedback to ensure we deliver a high standard for everyone. We also want to know where we have delivered a great service, as well as giving residents the opportunity to comment on what we do, or make suggestions on how we could make things better.

Information about the Adult Social Care complaints process and how to submit a comment or compliment can be found here: Complaints, comments or compliments | North Yorkshire County Council

Compliments

During 2021/22, 884 compliments were recorded for Health and Adult Services, 9% more than in 2020/21. However, this is still a significant reduction in compliments compared to pre-pandemic levels. This is in the main because financial assessors were not undertaking home visits and were therefore unable to hand out feedback forms as they normally would. We have incorporated some examples of compliments into section 3.

Complaints

372 complaints were received in 2021/2022, an increase of 1.1% compared to 2020/2021.

72 complaint reviews were received, a decrease of 5.3% year on year.

450 enquiries were received, a decrease of 9.6% year on year.

MP Enquiries

93 MP enquiries were received in 2021/22, a 26% decrease compared to 2020/2021. The reason for the decrease was because of the better understanding of the COVID-19 pandemic, which resulted in constituents contacting their MPs to ask them to raise concerns on their behalf far less frequently than they had done in the previous year.

Local Government & Social Care Ombudsman

During 2021/2022, we received a total of 16 cases from the Local Government and Social Care Ombudsman; this was a decrease of 23.8% compared to 2020/2021.

Of the 14 cases closed in 2021/22, no fault was found in 7 of them, with fault being found in the other 7.

Keeping people safe – our safeguarding work
The safeguarding year in numbers

3,079	Information gathering exercises in response to safeguarding concerns, a 2.5% increase on 2020/21
23%	The decrease in safeguarding concerns received from the previous year
32%	Percentage of safeguarding concerns related to adults aged 18-64
34%	Percentage of safeguarding concerns related to adults aged 65-84
34%	Percentage of safeguarding concerns related to adults aged 85 and over
61%	Percentage of safeguarding concerns related to female adults
91%	Percentage of enquiries following which risk was reduced or removed, down from 93% in 2020/21
3,466	Number of Deprivation of Liberty applications received, down 1.5% year on year
44%	Percentage of reported abuse occurring in the adult at risk's own home, down from 51% in 2020/21
43%	Percentage of reported abuse occurring in care homes, up from 36% in 2020/21.
75%	Percentage of adults at risk who felt their outcomes were fully met, up from 70% in 2020/21.

The 2.1% increase in safeguarding concerns received is likely due to the country reopening more fully in 2021/22.

The drop from 51% in 2020/21 to 44% in 2021/22 of reported abuse in the person's own home brings the figure closer to pre-pandemic levels.

The increase from 36% in 2020/21 to 43% in 2021/22 of reported abuse in care homes reflects the increased access to care homes for family members following the easing of lockdown restrictions.

Safeguarding Week 2021

Between 21st and 25th June 2021, the North Yorkshire, City of York and East Riding Safeguarding Adults Boards, Safeguarding Children Partnerships and Community Safety Partnerships worked together to deliver a virtual awareness raising campaign on how to report abuse of children, young people and adults.

The Safeguarding Week campaign has previously involved local events taking place across the region; however, due to the pandemic restrictions in place, the campaign moved online in 2020. To ensure we could reach as many people as possible and create opportunities for learning, awareness raising and development, we organised a week of online webinars and workshops delivered by inspiring experts in their field.

Previous Safeguarding Week campaigns have been directed towards professionals, but in support of a prevention and early intervention approach, and to inform the public of the great work being completed, the campaign was made available for both professionals and members of the public.

Public-facing sessions raised awareness of key issues and provided insight into how every member of the public can play a key role in keeping themselves, their families and the wider community safe – reinforcing the message that "safeguarding is everybody's business".

The North Yorkshire Safeguarding Adults Board hosted the following sessions:

- Carers' Panel which addressed keeping safe in care and support settings. The recording was viewed over 200 times during Safeguarding Week and continues to be shared by care providers and partners. It is available here: https://www.youtube.com/watch?v=OAhZQaM2zDU
- Suicide prevention which was delivered by inspirational speaker Pat Sowa. 162 people were in attendance, the highest attendance of any session throughout the week.

  The recording and slides from Pat's presentation are available here: https://www.youtube.com/watch?v=HRXKQHi_dg0

We recorded a podcast with the North Yorkshire Learning Disability Partnership Board Keeping Safe Champion, Sam Suttar. The podcast was all about reporting safeguarding concerns, understanding abuse and signposting people to the accessible keeping safe guides. You can listen to the podcast here: https://anchor.fm/nyselfadvocates/episodes/Safeguarding-e10o95h

The week was a great success with many people getting involved with the online activities and sharing the key messages and resources throughout the week.

Headline numbers:

2450	registered attendees;
34	sessions delivered;
97%	of attendees said that the week provided a good learning opportunity;
98%	of attendees said that they found the content of the sessions informative; and
97%	of attendees said they found the content engaging.

Working Together with people who use services

In 2021/2022, we continued to work closely with people and communities to ensure their voices are heard across Health and Adult Services. Their insights have played a pivotal role, not only in shaping our ongoing response to the pandemic but across the full range of our daily work. People who use services are experts in their own experience and only by working in partnership with them and their communities can we design and deliver the best services for North Yorkshire.

We have continued to support people to take part in accessible and inclusive ways. This has included working with partners and commissioned services such as our Keyring self-advocacy support service to find ways of involving people both online and offline, and via hybrid approaches. This has been vital to ensure we are hearing from a diverse range of people, including those at risk of digital exclusion.

The groups we currently support / work with regularly are:

- North Yorkshire Disability Forum and the five local disability forums
- North Yorkshire Learning Disability Partnership Board and its associated local forums and groups
- Older People's Forums
- Harrogate Mental Health Service User and Carer Involvement Group

We also work with a wide network of voluntary and community groups, colleagues and partners to reach out into communities across North Yorkshire.

Our achievements

Working with user-led groups, communities and colleagues in 2021/22, we collectively completed a range of projects. Here are some highlights:

- Held regular joint forum meetings with Richard Webb, Corporate Director Health and Adult Services, to discuss issues about the pandemic response, as well as other issues relating to adult social care and public health.
- Held workshops about what makes a good life, to shape the specifications for our new Approved Provider Lists.
- Forum members and self-advocates shared their experiences of engaging with us during the pandemic with the Care & Independence Overview and Scrutiny Committee.
- Collaborated with colleagues, partners, KeyRing and self-advocates to create activity packs on a range of topics for people with learning disability and/or autism, including annual health checks and fitness.

- Worked with forum members and self-advocates to make adverts for the Make Care Matter recruitment campaign, encouraging people to take up a career in adult social care.
- Completed an externally-facilitated options appraisal for voice and representation of people with lived experience of mental health services.
- Worked with NYCC Stronger Communities to commission a new countywide network and Partnership Board for older people.
- Worked with forum members and self-advocates to establish the Accessible Transport Group, bringing together disabled members and County Council officers to identify barriers and collectively seek solutions to issues faced by disabled people.

We want to build upon these successes in 2022/2023, further embedding engagement and co-production in our daily work. As part of this, we will continue to work on developing our Engagement Framework to ensure we have the conditions for excellent co-production across our Directorate.

We will also continue to extend the range of ways people can get involved, reach out to people and communities whose voices are less well represented in our work, and support the development of involvement networks. This includes working with the recently commissioned Age Friendly Network, as well as progressing work to involve and listen to people with lived experience of mental health needs.

We want as many people to be involved in our work as possible. There is a wide range of ways you can get involved from joining one of the user-led groups or networks we support, to taking part in our consultations. Follow the links below to find out more:

https://www.nypartnerships.org.uk/adults

https://www.northyorks.gov.uk/consultations

Age Friendly Network - Community First Yorkshire

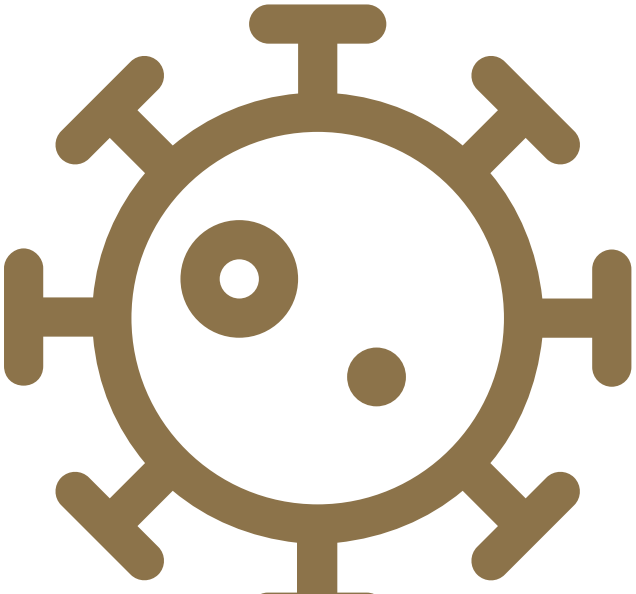
COVID-19 Peer Challenge

In September 2021 we took part in a Local Government Association (LGA) Peer Challenge, exploring NYCC's approach to COVID-19.

A team of external officers and political leaders explored nine areas of our outbreak management response, including governance and leadership, partnership working, and approach to care settings. The team reviewed key documents and information before a virtual visit, during which they gathered information and views from more than 19 meetings speaking to over 120 people, including a range of council staff together with councillors, external partners and stakeholders, and community representatives.

The Peer Challenge team said in its report: "NYCC is rightly proud of – and should celebrate – what it has achieved at such pace in incredibly challenging and turbulent circumstances. As NYCC and its Districts and Boroughs navigate the next stages of the pandemic, they do so whilst simultaneously managing transition to a unitary structure. This is likely to bring issues such as resilience, wellbeing, and capacity into even starker focus than for other authorities. There is nevertheless optimism that closer operational collaboration and achievements during the pandemic can provide a positive foundation to build on for the changes and challenges to come." LGA, 2021

You can read more about the peer challenge, including its recommendations, here: Report - LGA (northyorks.gov.uk)

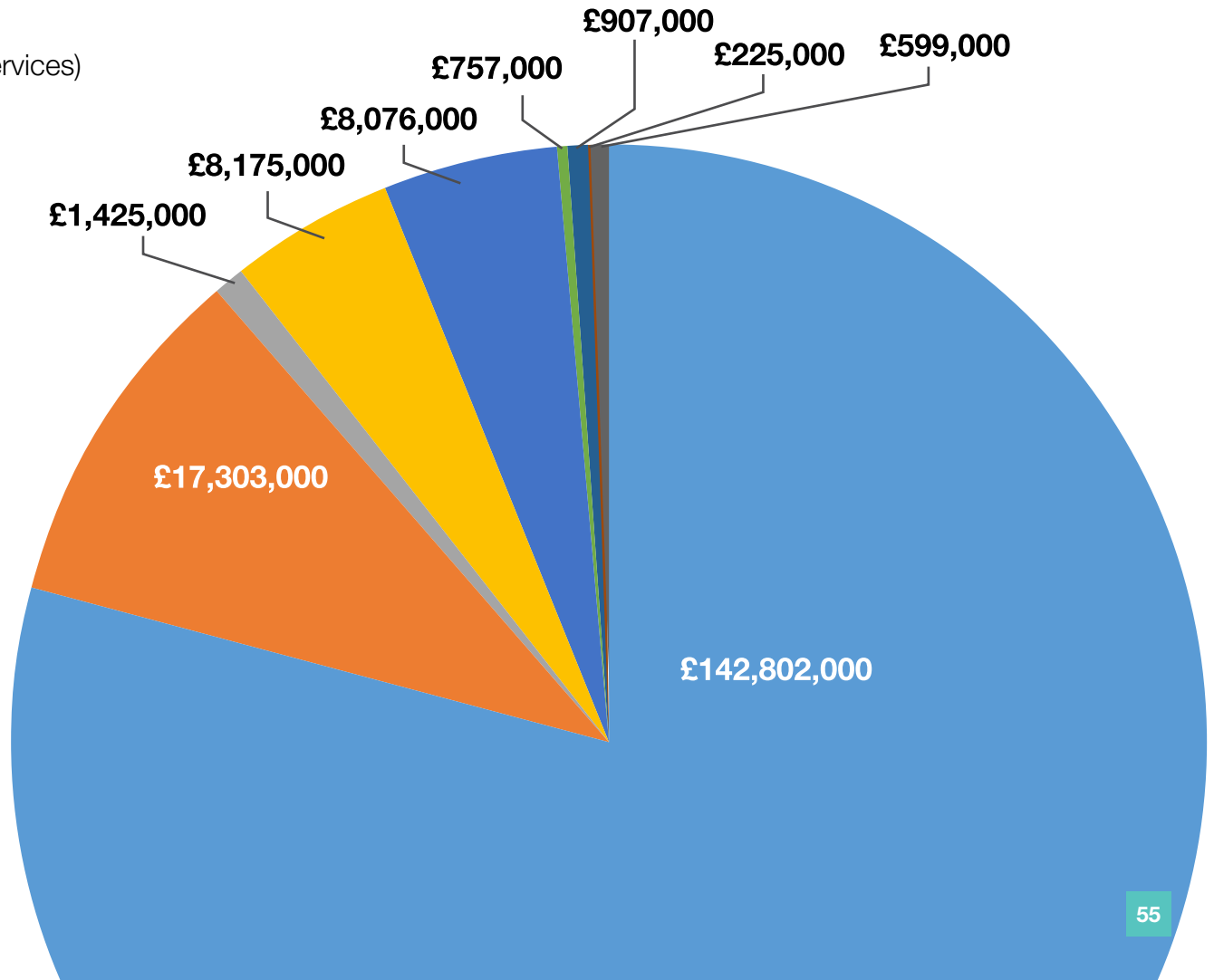


Section 5 - How much did we spend?

The Adult Social Care (ASC) net spend for 2021/22 was £180,268,000. It was invested in a range of services as illustrated below:

ASC Net Spend 2021-22

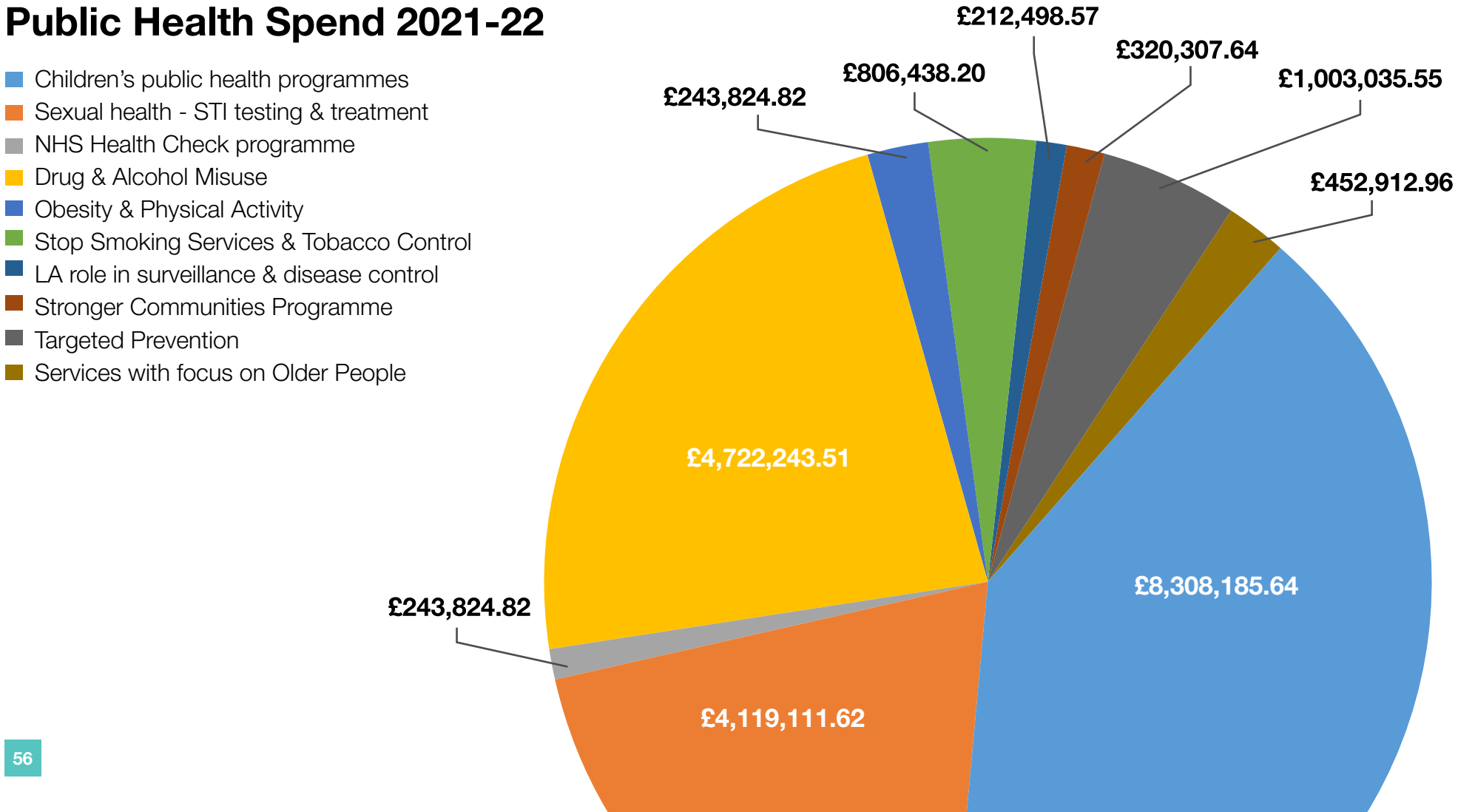
- Care & Support (including commissioned services)
- Provider Services & EC/PCAH
- Mental Health Services
- Targeted Prevention
- Commissioning & Quality
- Integration & Engagement
- Resources Unit
- Director & Cross-Directorate
- COVID-19 costs



Section 5 - How much did we spend?

The Public Health spend against the Public Health Grant in 2021/22 was £20,682,011. It was spent on the following public health services and interventions as illustrated below:

Public Health Spend 2021-22



Section 6 - What are we going to do in 2022/23?

Planning for recovery from COVID-19

The pandemic, whilst extremely challenging for everyone and personally devastating for many, also led to rapid innovation and learning as we responded to the crisis; we want to take forward the most useful elements, such as greater health integration, accessible digital services to enhance in-person provision, place-based working and community delivery models.

In the coming year, we plan to focus on the following areas:

- We will be implementing our new plan to take Health and Adult Services forward to 2025: 'Longer, healthier, independent lives', structured around three key priorities:
  - Opportunities for everyone, everywhere
  - My time and experiences are valued.
  - My Home, My Community, My Choice
- We will re-procure our Approved Provider Lists for adult social care, which is what we use to commission care and support for people with eligible social care needs. New service specifications and a new standards and outcomes framework have been developed. The new lists will have a strong focus on enabling people's independence and allow us to drive up the quality of care. We will also look towards co-producing the next stage of service transformation.
- We will be planning for the implementation of the Care Quality Commission (CQC)'s new regulatory model in 2023. Under its new Assurance Framework, the CQC will carry out inspections of local authorities' Adult Social Care services from January 2024.
- In July 2021, following government consultation, it was announced that the current county, district and borough councils would be replaced by a new unitary council for North Yorkshire in April 2023, with City of York Council remaining as it is. Health and Adult Services colleagues continue to contribute to planning for the new council and the many opportunities that it will afford.

Pounds and Budget

Our budget priorities over the coming year include:

- Continue to explore market development opportunities, including the publication of the Cost of Care report and implementation of new Approved Provider Lists;
- Prepare for the changes in relation to social care charging reform; and
- Continue our active budget management to ensure value for money, matching operational performance data with financial impact.

Workforce

Our priorities for our workforce include:

- Supporting our workforce to build and sustain their resilience as we prepare to respond to future challenges – and opportunities;
- Implement our new Care and Support structure to support the Adult Social Care operating model and new ways of working;
- Build on our Make Care Matter recruitment campaign to promote careers in health and social care and encourage more people to work in the sector;
- Continue to develop the skills and confidence of our workforce through the Organisational Development programme for the Directorate; and
- Develop a workplace where colleagues have space to share ideas, and influence the way we all work.
- Continue to develop opportunities to collaborate and integrate with partners, and develop innovative and hybrid ways of working which focus on the individual rather than organisational barriers.

NORTH YORKSHIRE COUNCIL

Health and Adult Services

Local Account 2021/2022

Contact us

Online: www.**northyorks.gov.uk/contactus**
By telephone: **0300 131 2 131**

North Yorkshire Council, County Hall, Northallerton, North Yorkshire, DL7 8AD

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