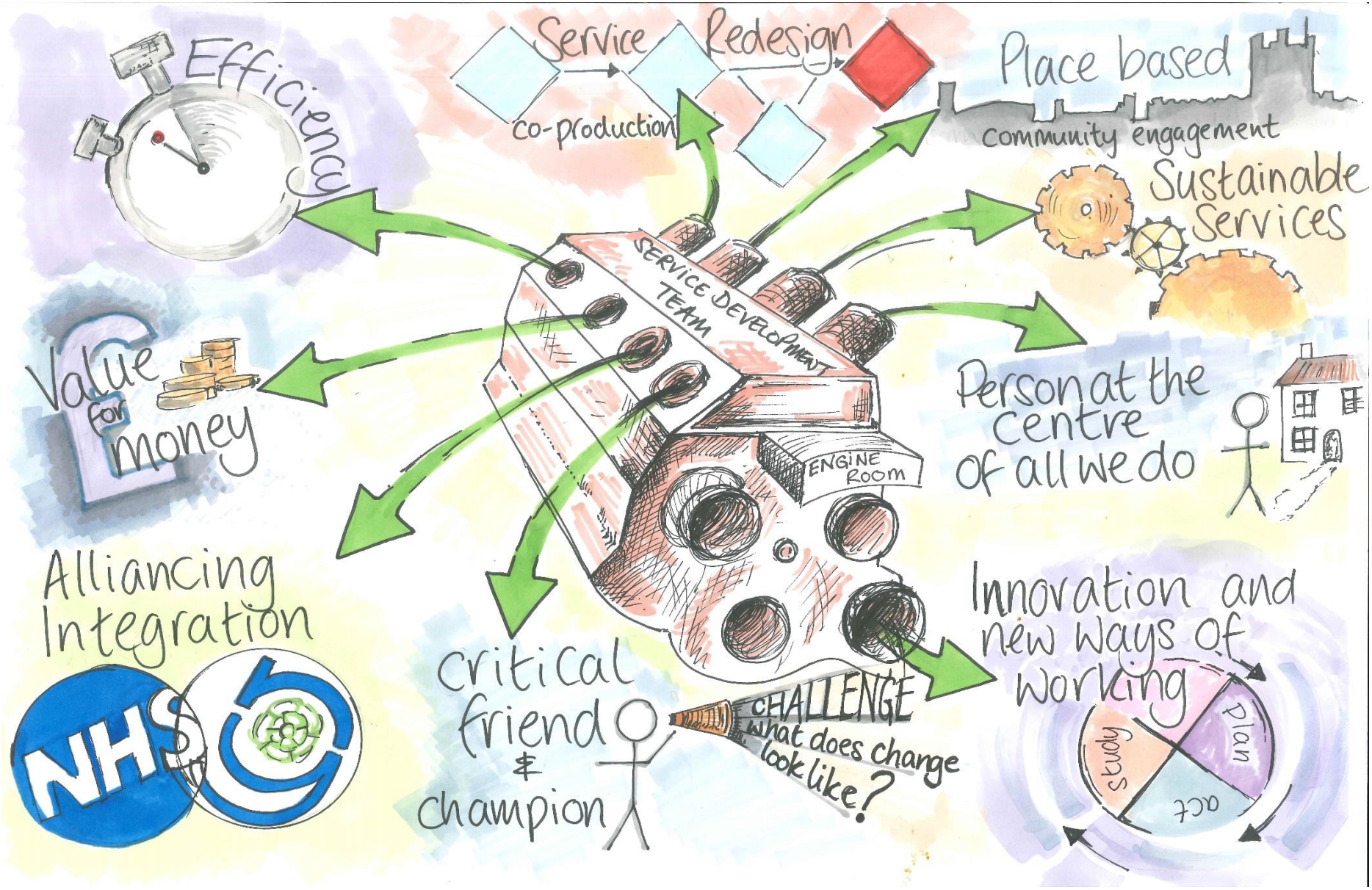

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1 INTRODUCTION

North Yorkshire is a large rural authority and the unique opportunities and challenges this brings to service delivery and to people's ability to access universal services are well understood, as is people's ability to develop and maintain social networks, particularly for those from minority groups. Transformation of services and the continuous development and shaping of the local care market will be key to providing high quality services within our communities in the future, including developing new and innovative solutions with and for people across the County.

As part of the Health and Adult Services Directorate, we are responsible for commissioning and developing a range of services across the County, specifically focussed within the geographical districts of Harrogate, Craven, Scarborough District (including Whitby,) Ryedale, Hambleton, Richmondshire and Selby. This allows us to ensure services are delivered in an efficient & effective manner while at the same time giving us the ability to focus on the individual needs of each local area.

2. PURPOSE OF THE DOCUMENT

In March 2020 the government issued guidance and legislation which informed our Covid 19 Emergency Response including, Discharge Service Requirements, the Coronavirus Act and Care Act Easements. These documents set out a number of duties and requirements, which necessitated immediate changes to the way we work and the implementation of a new interim Adult Social Care Model. This allowed us to rapidly reorganise our workforce, streamline some of our processes including hospital referrals, assessments and reviews and begin to commission services in a different way with the adult social care market. We would like to build upon the work that has already begun to transform services and this Strategic Plan outlines our vision for the further development of both providing and commissioning services over the next 3-5 years within a framework of national policy, local strategy and transformation plans to deliver this vision across the county.

3. STRATEGIC CONTEXT

In previous years, Government Policy on adult social care has often been fragmented and short-term, making it more difficult to plan ahead with some certainty. Although we are expecting further national guidance in the months ahead, the following section outlines some of the key messages we can draw from current policy which will continue to underpin our local development plans here in North Yorkshire.

3.1 NATIONAL POLICY

National Guidance over the last ten years has reinforced and consolidated key priorities for the effective delivery of adult social care services including:

- ***The Care Act (2014)*** which detailed how the law on adult social care works, placing more importance on advice and information, prevention, market shaping and introduced a legal framework in Safeguarding vulnerable people. It highlighted the importance of the communities around people, their carers and introduced a focus on the principal concept of wellbeing. In its formation, the Act introduced challenges for commissioners and providers but also opportunities for service development.

- Launched in 2015**,** ***The Better Care Act*** aimed to support local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. For North Yorkshire this offered a significant opportunity for improved joint working between all partners and our shared ambition is to be an exemplar of how to deliver an integrated approach to care in a complex, rural economy. Combined with the Joint Health and Wellbeing Strategy, our Better Care Fund Plan reinforces our commitment to improving outcomes for local people

- *Also in 2015,* ***Building the Right Support****: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism that display behaviour that challenges, including those with a mental health condition* outlined a clear framework for commissioners and providers to transform services locally to ensure that accessibility, equality and person-centred services continue to be developed and delivered locally.

- **The** ***Mental Health White Paper (January 2021)*** has been long anticipated and prompted concerns about rising detention rates and the over representation of people from black and other ethnic minorities in the use of detention. The reform process has taken an approach that encompasses not just law reform, but also considered issues around organisational culture, workforce and the systems which impact on practice. The overarching themes are of increased choice and control for people (including those detained under the Mental Health Act), a decreased use of statutory powers under the Mental Health Act, and a renewed focus on supporting people in the Community, and providing better mental health care overall.

Most recently, the Government White Paper, ***The Future of Health & Care 'Integration and Innovation: working together to improve health and social care for all' (February 2021)*** proposed a number of specific and targeted social care changes. It promised that further proposals will be brought forward this year on the reform of Adult Social Care, Public Health (National Institute for Health Protection) and Mental Health (Update Mental Health Act to 21st Century). This latest national guidance builds upon the themes introduced by earlier documents and specifically identifies key areas for Adult Social Care which will underpin any future development of our services in North Yorkshire.

The Future of Health & Care 'Integration and Innovation: working together to improve health and social care for all' *(February 2021)*

- **Working together and supporting integration** both within the NHS and across the NHS, local government and wider partners to improve the health and well-being of local people.
- **Integrated Care systems (ICSs)** will be established as statutory bodies to address the system's health, public health and social care needs
- **Duty to collaborate** across the NHS and local government to achieve the triple aims of the Long Term Plan: better health and well-being, better quality healthcare and ensuring the financial sustainability of the NHS.
- **The role of place** is essential for the joining up of care and support to be most effective, with the recognition of the uniqueness of each place in relation to its population, geography and history of partnership working.
- **Data Collection**, the White Paper proposes to improve the quality and availability of data across health and social care to remedy gaps in data to help understand capacity and risk in the system. The white paper also highlights the gap in data on services provided to people who fund their own care, as well as data that would help show how money flows to providers and the workforce. The white paper sets out how more and better data will aid planning for the future care of the population.
- **Assurance** – The Government understands that these proposals come following an extraordinarily challenging year for adult social care, which is why the initial focus will be to improve the quality, timeliness and accessibility of adult social care data, with the assessment and intervention elements to be introduced over time as the final element of the assurance framework.
- **Direct payments** The Government will legislate to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State so s/he can make direct payments of funding to any bodies engaged in the provision of social care services. Currently, the Secretary of State can only make such direct payments to not-for-profit bodies. It is clear that the power will not be used to amend or replace the existing system of funding adult social care and will only be used in exceptional circumstances.
- **Discharge to Assess** proposals to update the approach to hospital discharge by changing the legislative framework to enable a 'discharge to assess' model. This model includes enabling assessment for NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, to take place after an individual has been discharged from acute hospital care.
- **Better Care Fund** - The White Paper proposes to create a standalone legal basis for the Better Care Fund (BCF), separating it from the NHS Mandate setting process, which will no longer be on an annual basis.

Within the White paper there were also significant priorities identified around the role of **Public Health** which are summarised below:

- **Public Health power of direction** The Government will bring forward measures to make it easier for the Secretary of State to direct NHS England to take on specific public health functions. Under section 7A of the 2006 NHS Act, the Secretary of State for Health and Social Care can make arrangements for public health functions to be exercised by NHS England, however the Secretary of State cannot require NHS England to take the delegated function.
- **Obesity** The Government plans to allow ministers to introduce new strengthened food labelling requirements, including changes to front-of-pack nutrition labelling and mandatory alcohol calorie labelling. The government will introduce further restrictions to prohibit advertisements for products high in fat, sugar or salt being shown on TV before 9pm.
- **Fluoridation** The Government plans to streamline the process for the introduction, variation and termination of water fluoridation schemes in England by transferring the responsibilities for doing so, including consultation responsibilities, from local authorities to the Secretary of State for Health and Social Care.

In the following sections we will begin to outline our plans within a strategic framework underpinned by this national policy context. A great deal of work has already been started locally which will continue to be built upon using the lessons learnt as a result of the Pandemic and any future national guidance expected this year.

3.2. REGIONAL POLICY

This section of the Strategic Plan sets out a number of local strategies that have been developed over recent years in response to tackling some of the issues highlighted above. Regionally, the Association of Directors of Adult Social Services (ADASS) set out **nine statements** that they have recommended can help shape the future of adult social care. These principles are described below:

THE ADASS 9 PRINCIPLES FOR REFORM

1. **We need a public conversation about adult social care reform -** how we might design a system that enables people with care and support needs to live a good life. This should be clear about what can be expected of individuals, families, fellow citizens, communities and the state as part of a network of support.
   - **Care and support reform -** Protecting a person from having to sell their home to pay for care is certainly one element of the 'fairness debate' at the heart of the question about long-term reform. The scope of and ambition for social care reform must be far greater, supporting adults of all ages including unpaid carers, and have at its heart a commitment to the Care Act wellbeing principle whilst improving people's choice and control of the care and support they use to live their best life. Progress must be made quickly.
   - **People first and the value of social care** - what works for people, not what works for systems or structures. It must help support the realisation of the Think Local Act Personal 'Making it Real' framework that articulates what quality, personalised and community-based support looks like from the perspective of people, and also reflect the real and wide value of social care in its own right, both to people and to communities.
2. **Locally integrated care, built around the individual should be the norm -** Reform should be built on the principle of locally determined integrated care that achieves person-centred, person-led, co-ordinated care, treatment and support.
   - **Health and integration** - Health and social care are equally important and decisions and prioritisations about the future of each should reflect that. The needs of one should not be addressed to the detriment of the other and both should unite around embedding a far more preventative approach to wellbeing that works closely with public health and housing.
   - **The importance of 'local'** - Social care plays a key role in making connections in our local communities between a wide range of public, private, voluntary and community organisations that all work together in supporting people to be well, safe and independent.
3. **Review of how care markets operate -** A complete review of how care markets work and the suitability, sufficiency, sustainability, social value and quality of provision, with a consideration of regulation.
   - **Funding** - it should be used to help us move to a more person-centred and preventative model of social care that is rooted in supporting people's wellbeing in line with the Care Act and building resilience in our local public services and communities.
   - **Providers and commissioning** - Traditional services (such as residential care, domiciliary care and day centres) will continue to have a role to play in the future. However, they need to be part of a much broader local offer including smaller, more bespoke providers, micro-enterprises and wider community assets such as community-owned care, mutual aid and shared lives that have all played a part in responding to the current pandemic. These help bolster community resilience and their potential to help secure a more preventative approach to wellbeing that supports people to live safely and well at home must be harnessed.
4. **Address existing and historical inequalities** - A guiding principle of reform should be to address the current inequalities in the system that adversely impact on people with learning disabilities and mental health, and substance misuse issues, older people, those at the end of their lives, women and ethnic minority communities.

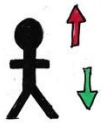
5. **Housing is central to care and to our lives -** Every decision about care is also a decision about housing. People should be supported to live at home and remain in their communities unless their needs can only be met elsewhere. We must support working age disabled people, rough sleepers, homeless people and others to establish and keep their own homes. We must build more care and support around people's homes, expanding and evolving housing-based care and support such as Extra Care housing.
6. **The need for a workforce strategy –** A strategy for; fair national care wages, training and career progression, together with greater support for informal carers.
   - **Workforce** - prominent consideration for Government, both as a standalone priority and in respect of its links with NHS workforce planning.
7. **Prioritise access to technological and digital solutions** - There should be a focus on ensuring that older and disabled people, families, carers and staff have access to the digital and technological solutions that will benefit them.
8. **Need a cross Government strategy -** A whole government strategy that enables people with care and support needs to live a good life. It is not just what the Department of Health and Social Care can do through a longer-term funding settlement; requiring active input from the Cabinet Office, Ministry of Housing, Communities and Local Government, Department for Business, Energy and Industrial Strategy, Department for Work and Pensions and across Whitehall more generally.
9. **Manage the transition** - There will need to be a funded and managed transition from the current care system to the new system that ensures service continuity for people with care and support needs. This includes specific support to see the care system through the coming winter period.

3.3 LOCAL POLICY

We will start this section with a baseline of **WHERE WE ARE NOW** and highlight some of the key **HEALTH AND WELLBEING** indicators that continue to shape both local policy & transformation planning within Health & Social Care Services.

Where we are now: The health and wellbeing of North Yorkshire

A **male** living in **Scarborough** district has a life expectancy of 78 years, which is **4 years less** than a male living in Hambleton district.



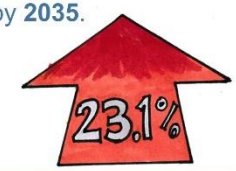
Males and females in **Scarborough** district have the **lowest life expectancy** at **birth**.

Smoking—All districts in North Yorkshire are **similar** to the England average with the exception of **Hambleton** which is **lower** (8.4%) and **Harrogate** is **higher** (14.4%).

69% of adults living in **Scarborough** are classified as **overweight** or **obese** which is **higher** than the England average.

All districts of North Yorkshire have **population densities** far **lower** than the England average.

23.1% of the **population** of North Yorkshire are aged **65+**. This is expected to **increase** to **29.8%** by **2035**.



Scarborough district has the **highest** rate of physical disability. The **2035** prediction is that the greatest need will be in **Harrogate** followed by **Scarborough** districts.

By **2035** the **greatest** number of people **aged 65+** with **dementia** are expected to be in **Harrogate** and **Scarborough**.

Current diagnosis rates **fall below** the **national average** across much of North Yorkshire, suggesting there may be **unmet demand**.

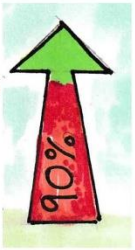
Suicide rates in **Scarborough** are significantly **higher** than the England average at **16 people per 100K**.

Craven district has the **highest percentage** of **residential care** homes which are **'good'** or **'outstanding'** while **Richmondshire** has the **lowest** number of **providers.**

Richmondshire and **Ryedale** districts have the **highest proportion** of **'good or 'outstanding' nursing homes.**

Average length of **stay** in a **care home** in North Yorkshire is **2.3 years** with **Richmondshire** having the **lowest length** of stay at **1.9 years.**

Selby, Harrogate, Scarborough and **Ryedale** districts are **above 90% occupancy** despite the Covid pandemic. **Nursing** occupancy rates are at **98%** demonstrating that **demand** may **outstrip supply**.



28.6% of **deaths** occurred in **care homes**. The **highest** proportion was in **Harrogate** district (34.4%) while **Hambleton** district had the **lowest** proportion (24.1%). The proportion of **deaths** at **home** was **highest** in **Hambleton** (34.7%) and the **lowest** was in **Harrogate** district (23.7%).

Harrogate and **Scarborough** districts are the **highest populated** in the county. It is estimated they will have the **highest** levels of **personal care** by **2035** for those aged 18-64.

Selby district has the **highest** number of **unsourced home care** packages.

3.3.1 LOCAL STRATEGIES

The Health & Wellbeing Board in North Yorkshire have also developed a number of key strategies to support the continuous improvement and development of services across the County, creating a strong foundation for future commissioning of health and adult care services over the next 4-5 years. Outlined below are some of the areas which have been identified as priorities and will continue to be an important part of our transformation agenda:

CARING FOR CARERS *"Carers themselves can live long and healthy lives and be able to continue to care as long as possible and as long as they would want to. We want to encourage more carer friendly communities, and promote carer issues across wider society". (2017-2022)*

- Improving information, advice, communication & engagement
- Improving identification of Carers
- Involving carers as experts
- Enabling carers to take a break
- Focussing on carer health
- Introducing carer health passports

BRING ME SUNSHINE – DEMENTIA STRATEGY *"This strategy brings together organisations from across Health & Social Care and the Voluntary Sector to speak with one voice on our aspirations for making North Yorkshire a place where people can live well with dementia".*

- Developing action plans across all localities
- Reviewing governance and establishing focussed working groups
- Improving engagement with people and their carers around diagnosis
- Developing information & advice
- Developing communications campaign to raise awareness
- Mapping a diagnostic pathway for early onset dementia and people with a Learning Disability

LIVE WELL, LIVE LONGER – LEARNING DISABILITIES STRATEGY "*People with a learning disability should have the opportunity to live long and healthy lives. They should be supported to exercise choice in their daily lives, feel happy, safe and supported, be active and fulfil their potential, enjoy the best health and wellbeing possible and, be respected and treated with dignity". (2017-2022)*

- Establishing 4 key workstreams to implement the strategy (Health; Practice & Training; Prevention & Reasonable Adjustments; Pathways & Information
- Improving engagement & involvement, training & resources with providers
- Reviewing accessibility of sexual health and weight management services
- Implementing an awareness campaign to increase uptake of health checks
- Improving co-production with advocates
- Promoting & supporting social prescribing/sport & exercise
- Improving employment support, supporting volunteers and equal opportunities for people living with a learning disability.
- Reviewing Direct Payments and improve awareness, understanding and uptake.

CHANGING THE LANDSCAPE OF AUTISM IN NORTH YORKSHIRE "*People with autism see things differently, and we want to see North Yorkshire as an 'autism friendly' place, so that this unique perspective is a welcome part of the local community, and that people with autism can contribute fully to local life, through education, employment opportunities and support for families". (2015-2020)*

- Improving engagement and producing more 'easy read' information & advice
- Producing an all-age JSNA for autism
- Developing a joint vision & commitment to action planning
- Establishing links with carers working groups to improve support

HOPE, CONTROL AND CHOICE – MENTAL HEALTH STRATEGY "*We will work together to ensure the people of North Yorkshire have the resilience to enjoy the best possible mental health, and to live their lives to their full potential, whatever their age and background, supported by effective, integrated and accessible services across all sectors, designed in genuine partnership with the people who need to make use of them and those who care for them" (2015-2020)*

- Improving Crisis Care Support including 24/7 crisis team availability & extended hours for Crisis Cafés
- Improving awareness raising around Mental Health including media strategy
- Rolling out Perinatal mental health checks countywide
- Producing joint Public Mental Health and Hope, Choice & Control action plans
- Ensuring participation of health/public health/CYPS representation to coproduce an all age strategy to include Therapeutic Health Care, Bereavement Services, Dual Diagnosis, Personality Disorder and Perinatal Services

4 WHAT DOES THIS MEAN FOR THE FUTURE DELIVERY OF HEALTH AND SOCIAL CARE SERVICES IN NORTH YORKSHIRE?

Whilst we have an excellent track record of successfully developing, designing and improving services for the people of North Yorkshire over the past few years, we recognise that we need to continue to work towards our vision that every adult has a longer, healthier and independent life and the ambitious goals identified within our **Council Plan for 2021-25**:

- People are **safe**, with individuals, organisations and communities all playing a part in preventing, identifying and reporting neglect or abuse
- People have **control and choice** in relation to their health, independence and social care support
- People can **access** good public health services and social care across our different communities

HEALTH & ADULT SERVICES - OUR KEY PRIORITIES

In developing our vision described in ***HAS 2025*** we have considered what **outstanding adult social care and public health services** might look like which is underpinned by both policy and the experience of the people who work for us, with us and those we provide and commission our services on behalf. We have a strategic role in:

- Leading the County Council's work on public health, adult social care, supported housing and partnership with the NHS
- Planning, investing and delivering services to support individuals and communities to be healthier and to live the lives they want to live
- Working with partners to build 'health' into the economy, education, planning, regulation, community safety and care
- Developing service providers and ensuring service quality.

To achieve this we will work together to:

- Increase the number of healthy years that people live
- Support people to be as independent as possible for as long as possible
- Support people to be part of their communities
- Support people to have choice and control over their lives - and protect their best interests where they lack capacity
- Keep people safe from harm or abuse

We will deliver this vision by focusing on 3 key goals:

OPPORTUNITIES FOR EVERYONE, EVERYWHERE

MY TIME AND EXPERIENCES ARE VALUED

MY HOME, MY COMMUNITY, MY CHOICE

In 2019 over 50 events took place across the county with the people who deliver our services. These *'Summer Conversations'* highlighted a number of issues and priorities which have also been incorporated within this strategic plan.

5. TRANSFORMATION PROGRAMME 2021-25

5.1. METHODOLOGY

The ***Market Development Board*** was established in 2020 to oversee the Council's Care Act duties of market shaping and oversight of North Yorkshires care market. It has recently embarked on an ambitious programme to transform the way we commission and deliver those services which includes a review of the current Approved Provider Lists and developing new models for procuring residential & nursing care, domiciliary and non-regulated services. To achieve the changes required to meet the strategic goals identified by the Council we have established 8 Workstreams:

- Planning & Performance (Data & Intelligence)
- Cost of Care
- Residential & Nursing Strategy
- Non-regulated care transformation
- Reimagining Homecare
- Communications and stakeholder Engagement
- Supported Living
- Housing solutions

WHAT WILL WE DO TO ACHIEVE OUR VISION?

Collaboration and Integration

- Build and maintain links and information sharing networks with the market
- Supporting partners and influencing the market.
- Involving partners (recognising them as partners and not consumers)
- Acknowledging excellence in practice.
- Research and Engagement.

Transparently reviewing commissioned services

- Ensuring that all reviews of current contracts are outcome based and not service based.
- Carefully looking at what we buy and why we buy it.
- Reviews should compare demand (stock and flow), use of care (amount of care per person) and cost of care (unit cost of care.) We ask ourselves 'Is it doing what we want it to do'?

Recognising barriers and effectively removing them.

- Innovatively thinking about procurement law
- Testing the market by adopting locality based pilots

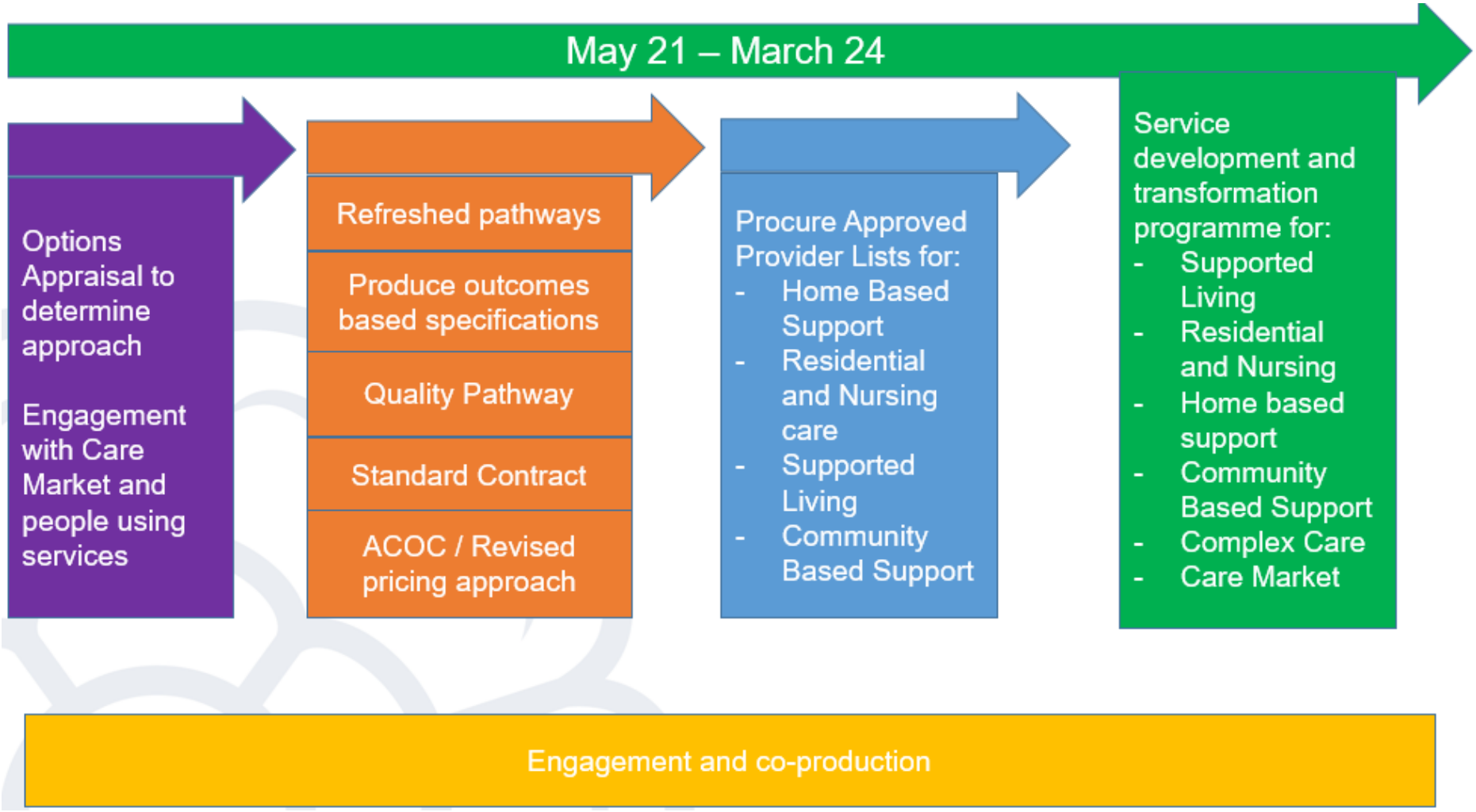
Supporting Evidence Based Market Development to inform future commissioning and investment

- Reviewing historically commissioned services
- Recognising research and best practice
- Effective and responsive recording of what we are buying and its effectiveness at meeting outcomes

Data Collection:

- Reinvestment opportunities
- Spend by outcomes
- Clarity of spend
- Service and quality improvements

5.2 TRANSFORMATION PHASING 2021-24



5.3 HAS SERVICE DEVELOPMENT TRANSFORMATION PROGRAMME

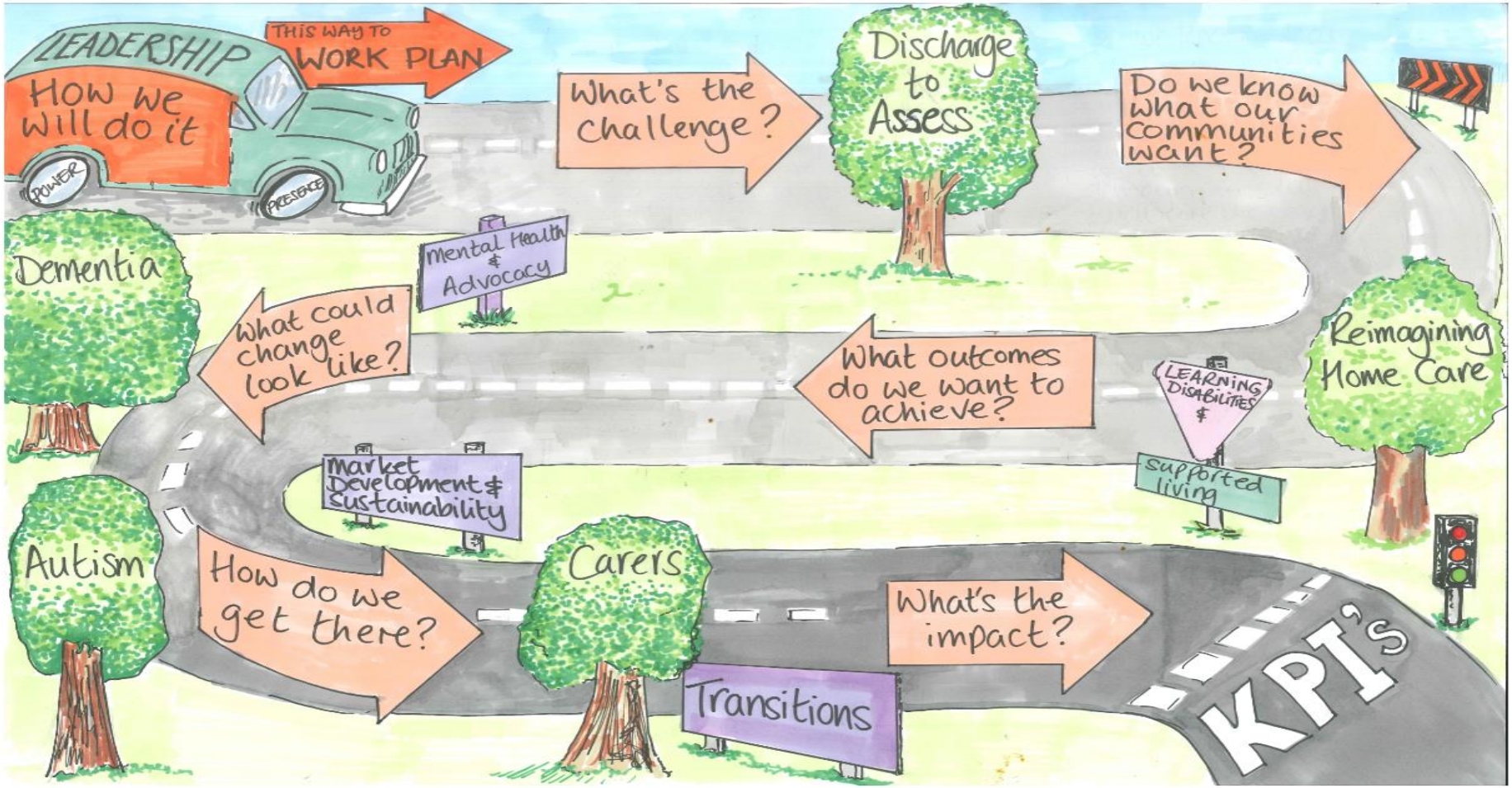
Market Intelligence	Market Shaping					Local Community Integrated Support
	Contractual Mechanisms for Provider Lists	Residential & Nursing Care	Non-Regulated activities incl. Day Services	Supported Living	Reimagining Homecare	
• Locality profiles, Market statement • Provider Relationship Management • Links to local communities and Voluntary Sector • Market and provider sustainability • Public health Intelligence • Best Practice	• Standard contract template • Revised terms & conditions • Embed quality pathway • Link to brokerage review • Formal procurement	• Strategy development • Test new models of care • Discharge to assess and intermediate care • Care Rooms • NYCC in house services	• Revised payment structure • Community integration • Utilisation of Direct Payments and Individual Service Funds • Model of complex care	• New contracting mechanism for Care/ Support service • New arrangement for securing properties • Outcome based specification • Transforming Care Link • Needs Analysis	• Geographical Zoning • Micro-enterprises • Framework Agreements • Reeth Pilot • Rapid Response • Outcomes based specification	• Community Mental Health • Carer Pathway • Dementia Support • Prevention & Wellbeing • Advocacy • Transitions • Safe Hospital • Discharge • Intermediate Care

Enablers

- Community engagement/Alliancing/Co-production
- Workforce Strategy
- Housing & Technology Solutions
- Cost of Care/Provider and Market Sustainability

6. HOW DO WE PLAN TO DELIVER THIS STRATEGY?

The **following section** contains a **high level summary** of our overall **Service Development Plan** for the next 3-5 years, followed by more detailed **locality focussed** plans, prepared by each Service Development Manager. Together they set out how we aim to deliver the objectives set out within the national and local strategies described earlier in this document and continue to provide outstanding services to the people of North Yorkshire.



COMMISSIONING & SERVICE DEVELOPMENT PLAN ON A PAGE 2021-25

As a Council our VISION IS...

"We want North Yorkshire to be a thriving county which adapts to a changing world and remains a special place for everyone to live, work and visit"

- People are safe, with individuals, organisations and communities all playing a part in preventing, identifying and reporting neglect or abuse
- Every Adult has a longer, healthier and independent life
- People have control and choice in relation to their health, independence and social care support
- People can access good public health services and social care across our different communities

To deliver this VISION in Health & Adult Services we will focus on 3 KEY GOALS...

- *Opportunities for everyone, everywhere*
- *My time and experiences are valued*
- *My Home, My Community, My Choice*

In COMMISSIONING & SERVICE DEVELOPMENT our OBJECTIVES will be...

MARKET OVERSIGHT & RELATIONSHIP MANAGEMENT

MARKET INTELLIGENCE
Develop & implement 5 Individual Locality Plans
Prepare District Profiles for each area
Review & Relaunch Market Position Statement

RELATIONSHIP MANAGEMENT
Establish relationships with locality providers/teams
Improve communication/engagement with the market to inform future market shaping

FINANCIAL STABILITY
Improve market stability with less reliance on Covid funding
Ensure revised Hardship Process is embedded
Review high cost care jointly with health

STRATEGIC PLANNING
Business continuity & Winter Plans in place
Review & further development of Strategic Market Development Board (SMDB)
Maintain Regional ADASS network & sharing best practice

MARKET SHAPING & TRANSFORMATION

REIMAGINING HOME CARE
Establish geographical zoning based on market intelligence
Development of new models of care with 'home first' principles embedded
Development of outcomes based specifications and contract templates
Roll out of micro provider pilots
Review & increase use of Direct payments & Individual service funds
Evaluation of Reeth Project

SHARED LIVES
Completion of Strategic Review including engagement and development of revised specification
Completion and sign off options appraisal
Procurement/transfer of new service

SUPPORTED LIVING
Development of outcomes based specification with clearly defined model
Development of a detailed needs analysis to inform all locality plans using strength based assessment information
Evaluation of Skipton Supported Living Scheme
Procurement of new Supported Living Framework/provider list
Ensure strength based assessments provide the required intelligence around property requirements
Maintain link to Transforming Care Partnership

RESIDENTIAL & NURSING CARE
Residential & Nursing Strategy is in Place
Develop Needs Analysis to inform all locality plans
Implementation of 'Care Rooms' Pilot in Selby

NON-REGULATED ACTIVITIES AND DAY SERVICES
Development of a revised payment structure
Community integrated locality commissioning plans in place
Development of 'Complex Care Model'

TRANSFORMED APL PROCUREMENTS
Produce Procurement planning and timeline
Development of Standard Contract Templates
Development of Standard Terms & Conditions embedding quality pathway

COMMUNITY INTEGRATED SUPPORT

DEMENTIA SUPPORT
Collaborate with providers to further enhance dementia support

MENTAL HEALTH COMMUNITY
Review of Contracts in line with White Paper

PREVENTION & WELLBEING
Links to the principle of Community support organisation Infrastructure and community hub development

CARERS
Coproduction & Procurement of Carers' info, advice & Sitting Services

DISCHARGE TO ASSESS
Safe discharge pathways with 'home first' principles in place
Undertake Joint Review of 'Home from Hospital'
Undertake Joint Review of Intermediate Bed Base with NHS

ADVOCACY
Undertake strategic review of advocacy services with links to CCGs

TRANSITIONS
Embed Pathway to inform commissioning intentions

In delivering these Priorities our staff will be guided by 10 PRINCIPLES...

Be Consistent · *Be Community-minded* · *Be Reflective* · *Be Curious* · *Be Accountable* · *Be Collaborative* · *Be Confident* · *Be Sustainable* · *Be Restless for Better* · *Be Inclusive*

What we will do:

People living longer, healthier and independent lives in North Yorkshire.

Our priorities are:

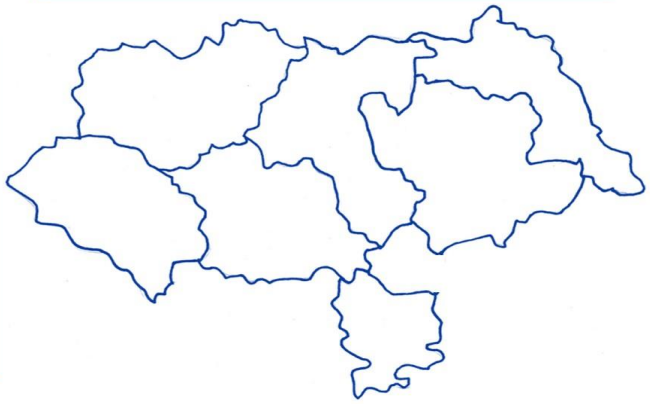
- Dementia care
- Reducing inequalities
- Improving emotional resilience and wellbeing
- Collaboration
- 'Home First' approach
- Creating outstanding services
- Empowering resilience communities

Our priorities are:

- Sustainability in the care home market
- Specialist dementia support
- Home care
- Supported living / accommodation
- Extra Care facilities
- Empowering people to deliver complex care
- Carer support
- Prevention
- Support for those living with autism

Our priorities are:

- Dementia care
- Reducing inequalities
- Improving emotional resilience and wellbeing
- Collaboration
- 'Home First' approach
- Creating outstanding services
- Empowering resilience communities



Our priorities are:

- Home Care
- Supported Accommodation
- Residential and nursing care
- Community assets
- Speciality support
- Creating a strong and sustainable workforce
- Assisted technology and innovation
- Supporting carers

Our priorities are:

- Supported living accommodation
- Home care
- 'Home First' approach
- Meaningful daytime opportunities for people living with Learning Disabilities and Dementia
- Special Dementia Care and Support
- Rurality / Social Isolation / Access to Services

Our priorities are:

- Cost of care
- Domiciliary care
- Dementia services
- Supported living /accommodation
- 'Home First' approach
- Integration and partnerships
- Day services
- Pathways and engagement

Our priorities are:

- Home Care
- Supported Accommodation
- Residential and nursing care
- Community assets
- Speciality support
- Creating a strong and sustainable workforce
- Assisted technology and innovation
- Supporting carers

Craven

Health inequalities in Craven, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Higher
Life expectancy at birth (female)	Higher
Life expectancy at birth (male)	Higher
Smoking prevalence in adults aged 18+	Same
Percentage of adults classified as overweight or obese	Lower
Suicide rate (Per 100,000)	Same
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Same
% of adults who "often or always" felt lonely (Oct20 - Feb21)	Lower

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Lower
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Higher
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Same
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Same
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Lower
Open services per 1000 population aged 65+	Lower

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	171	164
People Aged 65+ predicted to have a moderate of severe learning disability	44	57
Population aged 18-64 predicated to have a serious physical disability	313	289
Dementia Diagnosis Projections (for people aged 65+)	1137	1638
People aged 65+ predicted to be living in care homes with or without nursing	614	942

Craven District Commissioning Programme 21/22

- Increase supported living / accommodation options for those who need it when they need it by:
  - Introducing at least 2 shared lives properties
  - Increasing the number of supported living units by at least 25%
  - Developing a longer term commissioning plan for the delivery of supported living in Craven for the next 5 years
- Reduce outstanding domiciliary care packages in rural Craven by at least 50%
- Increase the number of people leaving hospital on Pathway 1 to 45%, in line with national standards
- Increase responsiveness of the home care market in Craven to ensure national requirements and timescales of the Discharge to Assess model are implemented
- Develop an options appraisal and action plan to strengthen the home care market in North Craven
- Identify opportunities to work collaboratively to develop/improve discharge pathways
- Launch a pilot project to improve access to meaningful daytime opportunities in Craven, embedding learning from the COVID-19 pandemic
- To define joint commissioning intentions with Health to enhance specialist dementia care in Craven
- Develop a business case to test travel-training models being piloted in other rural local authority areas
- Increase Assistive Technology referrals by 50%

Priorities

Supported living / accommodation

Work with colleagues in Social Care to establish a solid understanding of short and long-term need for accommodation with care and support in the district, and work with Craven District Council and the market to develop a range of supported living / accommodation solutions to meet this need.

Domiciliary care

Work with the market to overcome barriers and develop ability to respond to and meet the social care needs, including night time needs, of people in more rural areas and people with more complex / specialist needs, in a cost effective way.

Hospital discharge / Home first approach

Establish a robust evidence base for development of locality based solutions to support a 'Home First' approach to hospital discharge, prevent hospital and care home admission and support carers (considering joint commissioning opportunities).

Meaningful daytime opportunities

Establish a robust evidence base for developing community-integrated solutions to support people to engage in meaningful daytime opportunities that empower people to develop life skills and meet their changing needs.

Specialist dementia care and support

Establish a solid understanding of the need for specialist dementia care in the District, and work with key stakeholders to develop and increase accessibility of services to meet this need in a cost effective way.

Rurality, social isolation and access to services

Work collaboratively with all partners in the District on the prevention agenda, by considering collaborative opportunities across the system to reduce social isolation and digital exclusion, and promote access to services, particularly in rural areas.

Hambleton

Health inequalities in Hambleton, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Higher
Life expectancy at birth (female)	Higher
Life expectancy at birth (male)	Higher
Smoking prevalence in adults aged 18+	Lower
Percentage of adults classified as overweight or obese	Same
Suicide rate (Per 100,000)	Same
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Lower
% of adults who "often or always" felt lonely (Oct20 - Feb21)	Lower

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Higher
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Same
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Lower
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Lower
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Higher
Open services per 1000 population aged 65+	Lower

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	277	256
People Aged 65+ predicted to have a moderate of severe learning disability	69	88
Population aged 18-64 predicated to have a serious physical disability	501	439
Dementia Diagnosis Projections (for people aged 65+)	1677	2453
People aged 65+ predicted to be living in care homes with or without nursing	550	840

Hambleton Commissioning Programme 21/22

- Work with Health colleagues to produce a community mental health hub(s) to support people across the mental health pathway to reduce health inequalities
- Work in partnership with NYCCG/Health/TEWV/Providers to increase diagnosis rates in line with the England average
- Work in partnership with key stakeholders to define specific pathways and joint commissioning intentions to enhance specialist dementia care in the locality
- Complete a thorough gap analysis (including geographical) to identify urban and rural differences and the impact these have on care/support delivery
- Undertake an engagement exercise with all providers on the Approved Provider List in Hambleton
- Build a business case to explore a pilot project that enables people to trial the concept of supported living in Hambleton
- Build a business case to explore the need for respite care for early onset dementia
- Increase referrals to the Home from Hospital Service by 20%
- Work with Stronger Communities to reach out to Community Support Organisations in the area prior to September 2021 to explore the viability for future service provision to strengthen community assets

Priorities

Reducing inequalities

Design, co-produce and implement sustainable support based on demographic need for people living with mental and emotional health conditions. Empowering people to build and maintain independent living skills including managing complex behaviours such as people living with dementia, alcohol and substance use issues.

Improve emotional resilience and wellbeing

Undertake a systematic review of care and support services, linking with the transformation programmes for Housing Solutions, Supported Housing, Residential and Nursing Care, Reimagining Homecare and Non-regulated services to build an evidence base for future commissioning intentions.

Collaboration

Understand current locality provision and issues in relation to discharge pathways to improve service delivery and future commissioning intentions.

Home First approach

Develop a comprehensive supported accommodation pathway, which supports and empowers people with diverse needs to stay in Hambleton if this is their choice. Ensure that a comprehensive range of housing solutions and strategies for affordable housing are in place.

Creating outstanding services

Support a diverse provider market and help them to remain sustainable. Collaboratively work with our market, building strong, trusting relationships with partners where best practice can be shared and "excellence" can be defined.

Empowering resilient communities

Build on the positive work of the Community Support Organisations during the pandemic. Empower people and communities to obtain proportionate information, advice and support at the right time.

Dementia Care

Work with stakeholders to establish an understanding of the need for specialist dementia care in Hambleton. Work with the market to develop and increase accessibility to services to meet needs in a cost effective way, to increase diagnosis rates, define pathways and enable joint commissioning to provide people with the care and support they need as close to home as possible.

Harrogate District

Health inequalities in Harrogate, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Higher
Life expectancy at birth (female)	Higher
Life expectancy at birth (male)	Higher
Smoking prevalence in adults aged 18+	Same
Percentage of adults classified as overweight or obese	Lower
Suicide rate (Per 100,000)	Same
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Higher
% of adults who "often or always" felt lonely (Oct20 - Feb21)	Lower

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Higher
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Lower
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Higher
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Higher
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Lower
Open services per 1000 population aged 65+	Same

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	489	449
People Aged 65+ predicted to have a moderate of severe learning disability	107	139
Population aged 18-64 predicated to have a serious physical disability	875	796
Dementia Diagnosis Projections (for people aged 65+)	2911	4184
People aged 65+ predicted to be living in care homes with or without nursing	1705	2578

Harrogate Commissioning Programme 21/22

- Complete a needs assessment and cost of care analysis of the care home market in Harrogate, developing an options appraisal considering new approaches to working with providers
- Work with stakeholders and home care providers around key issues to produce solutions to alleviate pressure in the system including meeting needs outside of 'normal hours'; limited or lack of capacity, recruitment of staff, complexity and specialisms
- Work with the current domiciliary care framework providers to support the service to be successful, increasing capacity
- Support the development of the dementia care village business case, develop needs assessment information and support the project to deliver various types of dementia accommodation with appropriate wrap around care and support model
- Work with Harrogate Borough Council and other key stakeholders to develop accommodation schemes to meet needs across the locality, particularly for people living with autism / learning disabilities and those coming through transitions with more complex needs
- Work with HARA stakeholders to consider opportunities to develop provider and VCS alliancing models, enabling better system wide effectiveness, holistically working to implement crisis services, which are able to meet the 2-hour response time
- To map meaningful daytime opportunities available in Harrogate, including detailed understanding of levels of service/support, capacity, ability to support complex needs/ costs
- Work to source alternative funding solutions for the community anchor organisations, whilst delivering place based, grass roots services to meet needs

Priorities

Cost of care

Support, develop and manage the care home market in the Borough of Harrogate to ensure that it is able to meet the needs of the population, in a high quality and cost effective way. Attention will be given to the high placement costs, which adversely affect this area

Domiciliary care

Transformation of domiciliary care services to address key issues, by identifying and implementing solutions, to respond to issues in relation to capacity, complexity, geography and rurality and responder services

Dementia services

Support the development and delivery of the dementia care village scheme in Harrogate

Supported living /accommodation

Work to establish a needs assessment in relation to supported living and implement schemes in partnership with key stakeholders to deliver high quality, affordable accommodation with appropriate care and support models (for example, Maltkiln and other schemes to meet complex needs)

Home First

Contribute to the development of Harrogate and Rural Alliance (HARA) services and systems to avoid and prevent admission to hospital. Introduce the right combination and capacity of provision to support people to live in their own homes, maintaining independence, health and wellbeing for as long as possible.

Integration and partnership

Contribute to the development of HARA services and systems, supporting a whole system preventative approach to avoid admissions and enable effective discharges from hospital via good quality Home First and Discharge to Assess models to develop effective care pathways

Day services

Development outcome focused and community integrated solutions to support people to engage in meaningful daytime opportunities.

Pathways and engagement

Work with Stronger Communities, Living Well and community groups to support people, including those who do not wish to engage with statutory services to develop plans to support people living with mental and emotional health, housing, debt management, budgeting, substance misuse and life skill needs.

Richmondshire

Health inequalities in Richmondshire, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Higher
Life expectancy at birth (female)	Same
Life expectancy at birth (male)	Higher
Smoking prevalence in adults aged 18+	Same
Percentage of adults classified as overweight or obese	Same
Suicide rate (Per 100,000)	Same
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Lower

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Lower
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Lower
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Same
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Same
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Same
Open services per 1000 population aged 65+	Same

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	173	153
People Aged 65+ predicted to have a moderate of severe learning disability	33	46
Population aged 18-64 predicated to have a serious physical disability	286	248
Dementia Diagnosis Projections (for people aged 65+)	783	1195
People aged 65+ predicted to be living in care homes with or without nursing	433	711

Richmondshire Commissioning Programme 21/22

- Work with Health colleagues to produce a community mental health hub(s) to support people across the mental health pathway to reduce health inequalities
- Work in partnership with NYCCG/Health/TEWV/Providers to increase diagnosis rates in line with the England average
- Work in partnership with key stakeholders to define specific pathways and joint commissioning intentions to enhance specialist dementia care in the locality
- Complete a thorough gap analysis (including geographical) to identify urban and rural differences and the impact these have on care/support delivery
- Undertake an engagement exercise with all providers on the Approved Provider List in Richmondshire
- Build a business case to explore a pilot project that enables people to trial the concept of supported living Richmondshire
- Build a business case to explore the need for respite care for early onset dementia
- Increase referrals to the Home from Hospital Service by 20%
- Work with Stronger Communities to reach out to Community Support Organisations in the area prior to September 2021 to explore the viability for future service provision to strengthen community assets
- Review year 1 of the Reimagining Home Care Pilot in Reeth and surrounding areas and start to consider future commissioning intentions of this pilot project as we enter into year 2

Priorities

Reducing Inequalities

Design, co-produce and implement sustainable support based on demographic need for people living with mental and emotional health conditions. Empowering people to build and maintain independent living skills including managing complex behaviours such as people living with dementia, alcohol and substance use issues.

Improve emotional resilience and wellbeing

Undertake a systematic review of care and support services, linking with the transformation programmes for Housing Solutions, Supported Housing, Residential and Nursing Care, Reimagining Homecare and Non-regulated services to build an evidence base for future commissioning intentions.

Collaboration

Understand current locality provision and issues in relation to discharge pathways to improve service delivery and future commissioning intentions.

Home First Approach

Develop a comprehensive supported accommodation pathway, which supports and empowers people with diverse needs to stay in Hambleton if this is their choice. Ensure that a comprehensive range of housing solutions and strategies for affordable housing are in place.

Creating Outstanding Services

Support a diverse provider market and help them to remain sustainable. Collaboratively work with our market, building strong, trusting relationships with partners where best practice can be shared and "excellence" can be defined.

Empowering Resilient Communities.

Build on the positive work of the Community Support Organisations during the pandemic. Empower people and communities to obtain proportionate information, advice and support at the right time.

Dementia Care

Work with stakeholders to establish an understanding of the need for specialist dementia care in Richmondshire. Work with the market to develop and increase accessibility to services to meet needs in a cost effective way, to increase diagnosis rates, define pathways and enable joint commissioning to provide people with the care and support they need as close to home as possible.

Ryedale

Health inequalities in Ryedale, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Higher
Life expectancy at birth (female)	Higher
Life expectancy at birth (male)	Same
Smoking prevalence in adults aged 18+	Same
Percentage of adults classified as overweight or obese	Same
Suicide rate (Per 100,000)	Same
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Lower

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Lower
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Lower
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Lower
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Lower
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Same
Open services per 1000 population aged 65+	Lower

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	167	170
People Aged 65+ predicted to have a moderate of severe learning disability	43	56
Population aged 18-64 predicated to have a serious physical disability	304	297
Dementia Diagnosis Projections (for people aged 65+)	1062	1523
People aged 65+ predicted to be living in care homes with or without nursing	361	575

Ryedale Commissioning Programme 21/22

- The Microenterprises contract is due to end in November 2021. Review the impact of the service and make further recommendations to support people with domiciliary care needs living along the A64, A170 corridor in addition to rural areas. With an aim to reduce outstanding packages in this area by 100%
- Undertake a review in partnership with Tees, Esk and Wear Valley NHS Foundation Trust of all dementia services available in Ryedale and write a co-produced business case to reduce health inequalities in the area
- Pilot a 24 hour outreach service in Ryedale which links in directly to assistive technology to offer meaningful carer respite and reduce the number of people using short term care home stays by 20%
- Link in with local universities to explore opportunities for social work students to undertake paid work experience immediately following qualification
- Launch a pilot to incentivise working in the care sector in Ryedale including enhanced training, annual increments, and provision of electric vehicles as part of an employment package
- Work with Ryedale District Council to develop an intermediate support service which aims to support 5 people to live independently in the community, reducing the requirement for supported accommodation
- Roll out a training and wellbeing programme for all identified unpaid carers to reduce frequency of crisis intervention required by 20%

Priorities

Domiciliary care

Build and maintain sustainable domiciliary care provision throughout the locality. Promote a 'Home First' approach and reduce the number of outstanding packages in Ryedale, being inclusive of people with enduring mental health needs and learning disabilities in the provision of domiciliary care.

Supported accommodation

Develop a comprehensive, quality supported accommodation pathway, which builds daily living and independent living skills. The pathway will support people with diverse needs and unique personal circumstances, empowering people to stay in the Ryedale District if this is their choice.

Residential and nursing care

Develop a new generation of Extra Care accommodation (including residential and nursing hybrids.) Ensure that both new and existing accommodation is responsive to fluctuating and progressive individual needs associated with those living with learning disabilities, physical and mental health needs.

Community assets

Equip communities with the tools they need to promote personalisation, strengthen community assets and self-organise. (This includes enabling access to Direct Payments and Individual Service Funds). Empower people and communities to obtain proportionate information, advice and support at the right time.

Specialist support

Provide sustainable support to those with mental and emotional health needs (underpinned by collaboration and co-production with local communities and specialist organisations.) Empower people to build and maintain independent living skills, including managing complex behaviours.

Creating a strong and sustainable workforce

Engage, collaborate and co-produce with our market to understand recruitment and retention challenges in the Ryedale area, and to commission services that incentivise careers in the care market.

Assistive technology and technology innovation

Firmly embed assistive technology within all care pathways, and ensure that the health and care workforce are continually familiarised with the changing landscape of assistive technological solutions.

Supporting unpaid carers

To create a carer friendly Ryedale, making sure that all unpaid carers in the area know where to turn to for help, as and when they need it. Make sure they are able to cope, and are sustained within their caring role. Make sure they are able to live a life of their own. Make sure they have their views and voices heard, leading to genuine improvements in health and care provision.

Scarborough District

Health inequalities in Scarborough District, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Higher
Life expectancy at birth (female)	Same
Life expectancy at birth (male)	Lower
Smoking prevalence in adults aged 18+	Same
Percentage of adults classified as overweight or obese	Higher
Suicide rate (Per 100,000)	Higher
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Lower
% of adults who "often or always" felt lonely (Oct20 - Feb21)	Higher

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Higher
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Higher
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Higher
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Higher
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Higher
Open services per 1000 population aged 65+	Higher

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	324	307
People Aged 65+ predicted to have a moderate of severe learning disability	85	109
Population aged 18-64 predicated to have a serious physical disability	583	533
Dementia Diagnosis Projections (for people aged 65+)	2077	2934
People aged 65+ predicted to be living in care homes with or without nursing	995	1460

Scarborough District Commissioning Programme 21/22

- Stabilise the cost of nursing and residential care provision to pre-pandemic levels
- Launch a co-produced intermediate care bed pilot project, which seeks to enhance quality, improve sustainability and provide value for money. The pilot will underpin a home first approach, supporting 100% people to return home following a short stay
- Conduct a scoping exercise to determine gaps in services for people living with autism
- Send out a training needs analysis to all care providers in the District to identify challenges in delivering complex care. Formulate a training plan
- Embed the new commissioning model and process for supported living across Scarborough and Whitby which seeks to reduce outstanding packages of care for people with complex needs from 27 to 20 in 2021/2022
- Build a business case to explore the viability of building supported living accommodation in Whitby
- Work in collaboration with partners across children's and adult's services to develop sustainable accommodation options for people aged 16-25 by developing a transitions plan
- Build a business case for the development of Extra Care housing in Whitby

Priorities

Market sustainability
Work collaboratively with health and our partners to build sustainable residential, nursing and domiciliary care models for the future across the Scarborough district.

Specialist dementia support
Commission a range of high quality affordable dementia services within local communities, providing people with the care and support they need as close to home as possible.

Domiciliary care
Ensure the provision of high quality domiciliary care services across the district, providing people with the care and support they need as close to home as possible, and minimising the need for care home admissions, emergency hospital admissions and delayed discharges from hospital.

Supported living / accommodation
Ensure that appropriate support is available for people to secure and maintain independent living. Work with other partners to ensure that strategies and plans for affordable housing provision are aligned to the needs of vulnerable people in the Scarborough District.

Extra Care facilities
Develop a new generation of Extra Care services including residential and nursing hybrids and small-scale schemes ensuring existing developments are able to meet increasing complex needs, providing equitable access to people under the age of 65

Empowering people to deliver complex care
Increase the availability of support that helps people stay well and living independently for longer. Work with partners to jointly commission a range of support options available to people, including in times of crisis, to avoid carer breakdown or hospital admission

Carer support
Supporting all unpaid carers across the district to know where to turn to for help, as and when they need it. Make sure they are able to cope, and are sustained within their caring role

Prevention
Work with partners including Stronger Communities, Living Well Teams and the Voluntary Sector to redesign and deliver community based opportunities to meet the diverse needs of our population

Support for people living with autism
Increase the support available to people who self-care, resulting in more people managing their health and social care needs in their community, including through Direct Payments. Commission a range of high quality affordable specialist services within local communities, providing people with the care and support they need as close to home as possible.

Selby District

Health inequalities in Selby, and how they compare to the England average	Higher / Lower
Population Density (people per sq km)	Lower
% population aged 65+	Same
Life expectancy at birth (female)	Same
Life expectancy at birth (male)	Higher
Smoking prevalence in adults aged 18+	Same
Percentage of adults classified as overweight or obese	Same
Suicide rate (Per 100,000)	Same
Dementia diagnosis rate for people aged 65+ in 2020 (% of estimated cases)	Lower
% of adults who "often or always" felt lonely (Oct20 - Feb21)	Higher

Support Provision (Source NYCC Dashboard) and how they compare to the Nork Yorkshire Average	Higher / Lower
Services commissioned for those with a primary support reason of 'Learning Disability' (Per 10K Adults)	Lower
Services Commissioned for those with a primary support reason of 'Physical Disability' (Per 10K Adults)	Lower
Number of people residing in a permanent placement offering dementia care (Per 10K adults)	Lower
Residential & Nursing care services commissioned for those aged 65+ (Per 10K adults)	Lower
Domiciliary care services commissioned for those aged 18+ (Per 10K adults)	Lower
Open services per 1000 population aged 65+	Same

Health projections:	2020	2035
People aged 18-65 predicted to have a moderate or severe learning disability, hence likely to be in receipt of services	294	312
People Aged 65+ predicted to have a moderate of severe learning disability	54	71
Population aged 18-64 predicated to have a serious physical disability	497	502
Dementia Diagnosis Projections (for people aged 65+)	1230	1910
People aged 65+ predicted to be living in care homes with or without nursing	499	844

Selby District Commissioning Programme 21/22

- Introduce 5-7 additional care agencies to join the domiciliary care Approved Provider List across the Vale of York, with a remit to deliver care packages
- Reduce the hours of unsourced care packages across the Vale of York from an average of 220 hours per week to less than 50 hrs per week
- Recruit 5 hosts and deliver 50 nights of support as part of the Care Rooms pilot
- Launch a 'Rapid Response' pilot to support 20 customers with complex needs and divert people from unnecessary care placements
- Pilot 3 new area-based grants to develop community strengths and assets in the Selby District. Aim to launch in October 21

Priorities

Domiciliary care

Build and maintain sustainable domiciliary care provision throughout the locality. Promote a 'Home First' approach and reduce the number of outstanding packages in the Selby District whilst being inclusive of people with enduring mental health needs and learning disabilities in the provision of domiciliary care.

Supported accommodation

Develop a comprehensive, quality supported accommodation pathway, which builds daily living and independent living skills. Develop an accommodation pathway, which supports people with diverse needs and unique personal circumstances. Empower people to stay in the Selby District if this is their choice.

Residential and nursing Care

Develop a new generation of Extra Care accommodation (including residential and nursing hybrids.) Ensure that both new and existing accommodation is responsive to fluctuating and progressive individual needs including people living with learning disabilities, physical and mental health needs.

Community assets

Equip communities with the tools they need to promote personalisation, strengthen community assets and self-organise. (This includes enabling access to Direct Payments and Individual Service Funds as appropriate.) Empower people and communities to obtain proportionate information, advice and support at the right time.

Specialist support

Provide sustainable support to those with mental and emotional health needs (underpinned by collaboration and co-production with local communities and specialist organisations.) Empower people to build and maintain independent living skills, including managing complex behaviours.

Creating a strong & sustainable workforce

Engage, collaborate and co-produce with our market to understand recruitment and retention challenges in the Selby District, and to commission services that incentivise careers in the care market.

Assistive technology and technology innovation

Firmly embed assistive technology within all care pathways, and ensure that the health and care workforce are continually familiarised with changing landscape of assistive technological solutions.

Supporting unpaid carers

Create a carer friendly Selby, making sure that all unpaid carers across the district know where to turn to for help, as and when they need it. Make sure they are able to cope, and are sustained within their caring role. Make sure they are able to live a life of their own. Make sure they have their views and voices heard, leading to genuine improvements in health and care provision.