Universal Credit

Universal Credit | Opening up work_

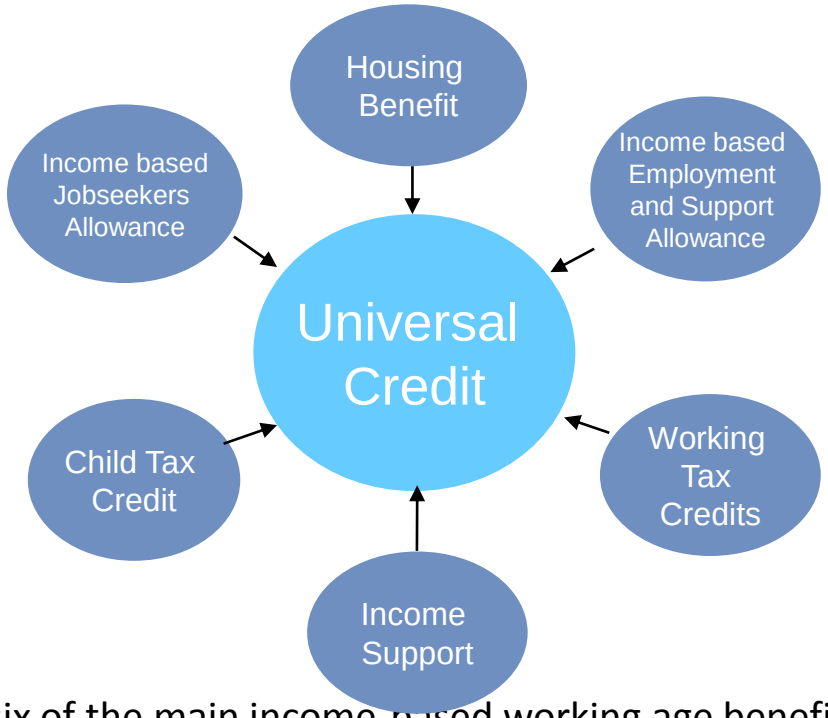
UC simplifies the welfare system

From six benefits to one

Deal with one organisation not three

- Universal Credit is a digital, flexible and personalised system
- It reduces barriers to work, incentivising people to move into work
- It also helps people a low income to earn more and get on in their job

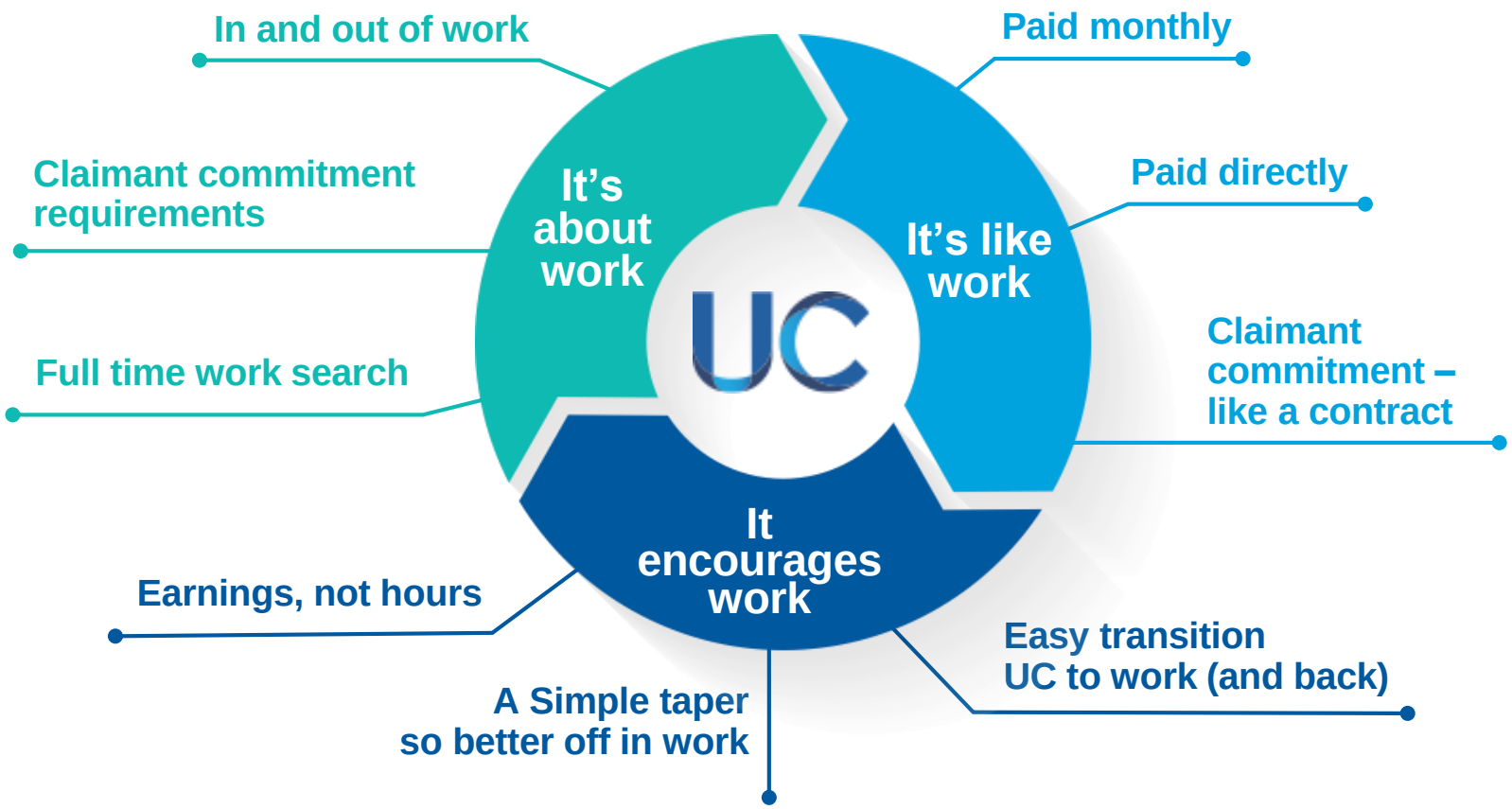
Universal Credit – simplifies the benefit system for working age people



- Universal Credit will replace six of the main income-based working age benefits. It is paid monthly and, where applicable, will include an element for housing costs (**NB Contribution based benefits will remain).** It is for people who are in work and out of work (**no 16 hour rule**)
- Universal Credit Full Service (UCFS) is claimed online and is a fully digital service.
- Universal Credit (Live Service) is available in all areas now but there is gateway criteria for claiming**.** **However**, Full UCFS, for couples, families, and for new claims to all of the above benefits, is now being gradually introduced across the country (**NB** temporarily claimants where the household has more than two dependant children will not be able to make a new claim for UC. They will need to apply for Child Tax Credit and any other legacy benefits including HB

Universal Credit | Opening up work_

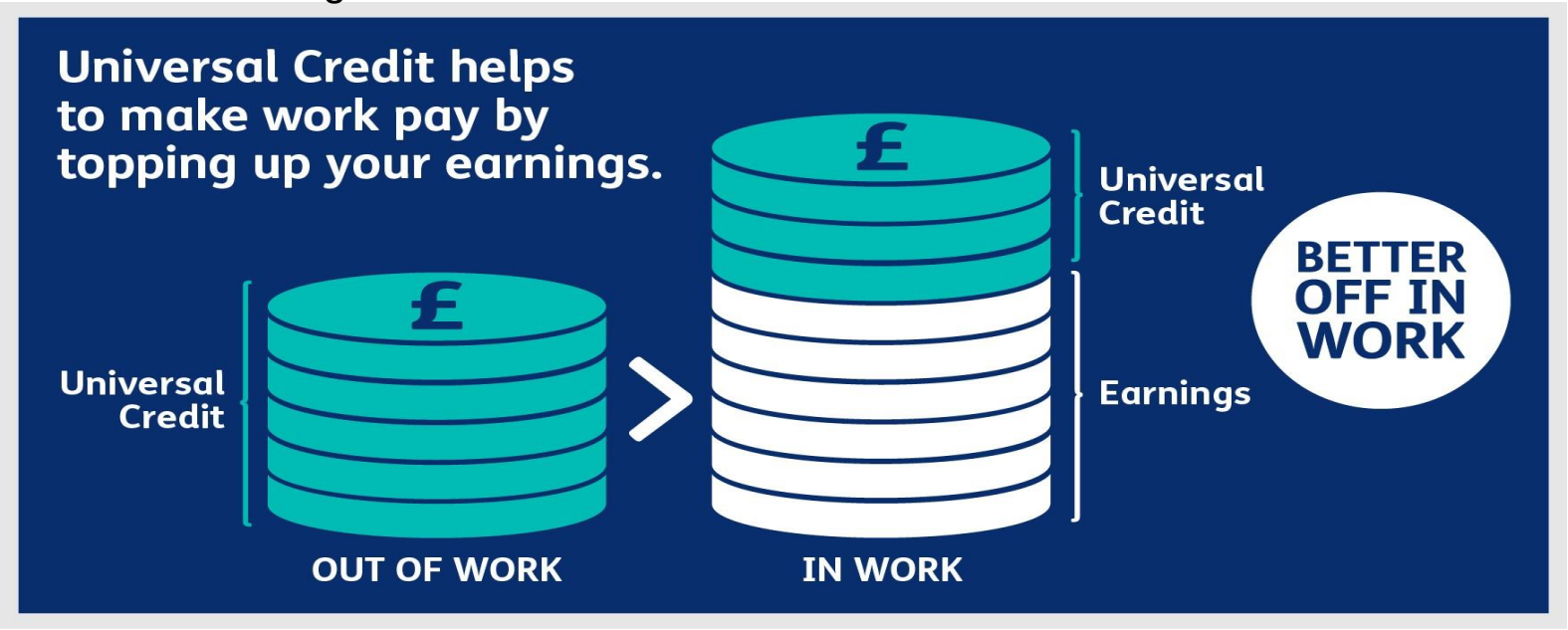
UC focuses on work



Universal Credit - making work, and more work pay

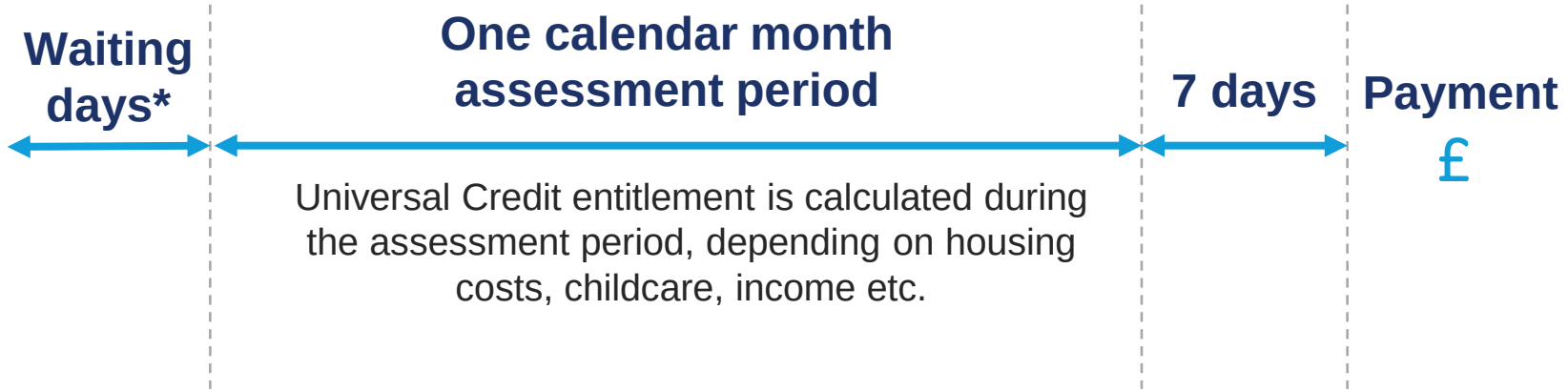
Universal Credit helps to ensure people are better off in work than on benefits by:

- **Removing the limit** to the number of hours someone can work each week.
- Reducing a claimant's Universal Credit payment **gradually** as their earnings increase, so they won't lose all their benefits at once if they're on a low income.
- The Universal Credit **taper** means that financial support is withdrawn at a **consistent and predictable rate**, meaning claimants can **clearly understand** the advantages of work



Universal Credit | Opening up work_

UC is paid monthly

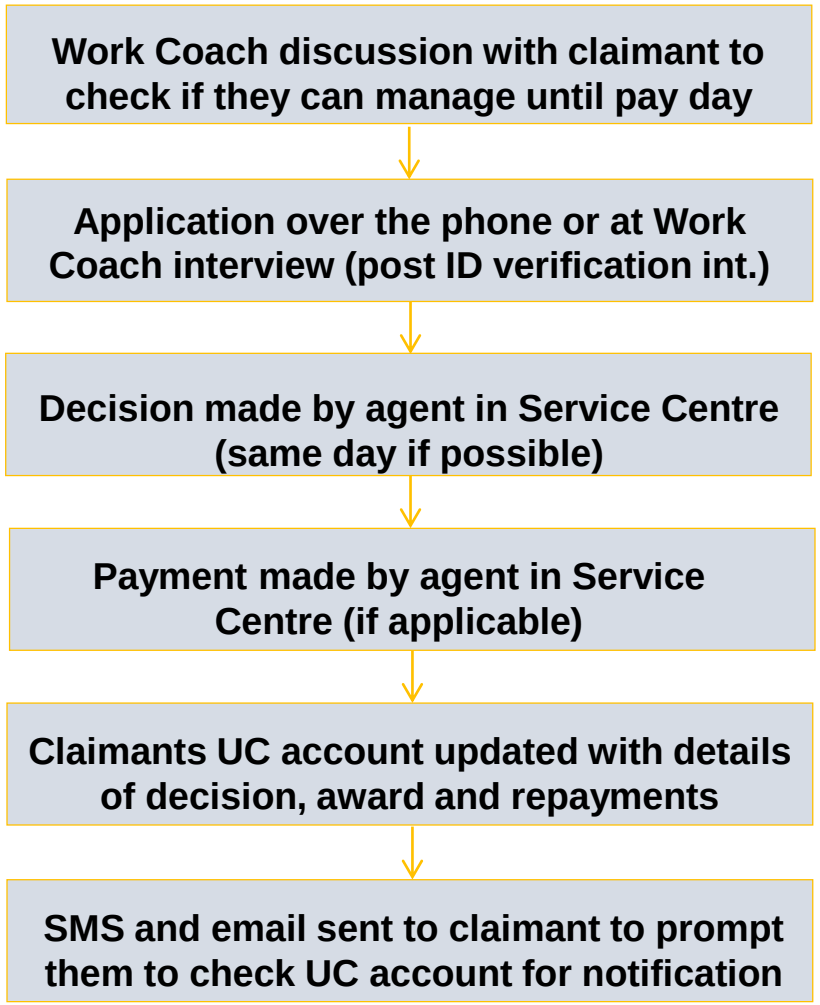


Advance Payments

- Advance payments are available to anyone who needs extra support
- They are paid back over six months

* A number of groups are exempt from waiting days, including care leavers, those with a serious illness, prison leavers, and victims of domestic violence, along with those who recently claimed JSA, ESA or income support

UC Advance process



Universal Credit | Opening up work_

UC Performance is good

76%

of new claimants are paid in full at the end of the first assessment period*

96%

of new claimants receive some payment at the end of the first assessment period

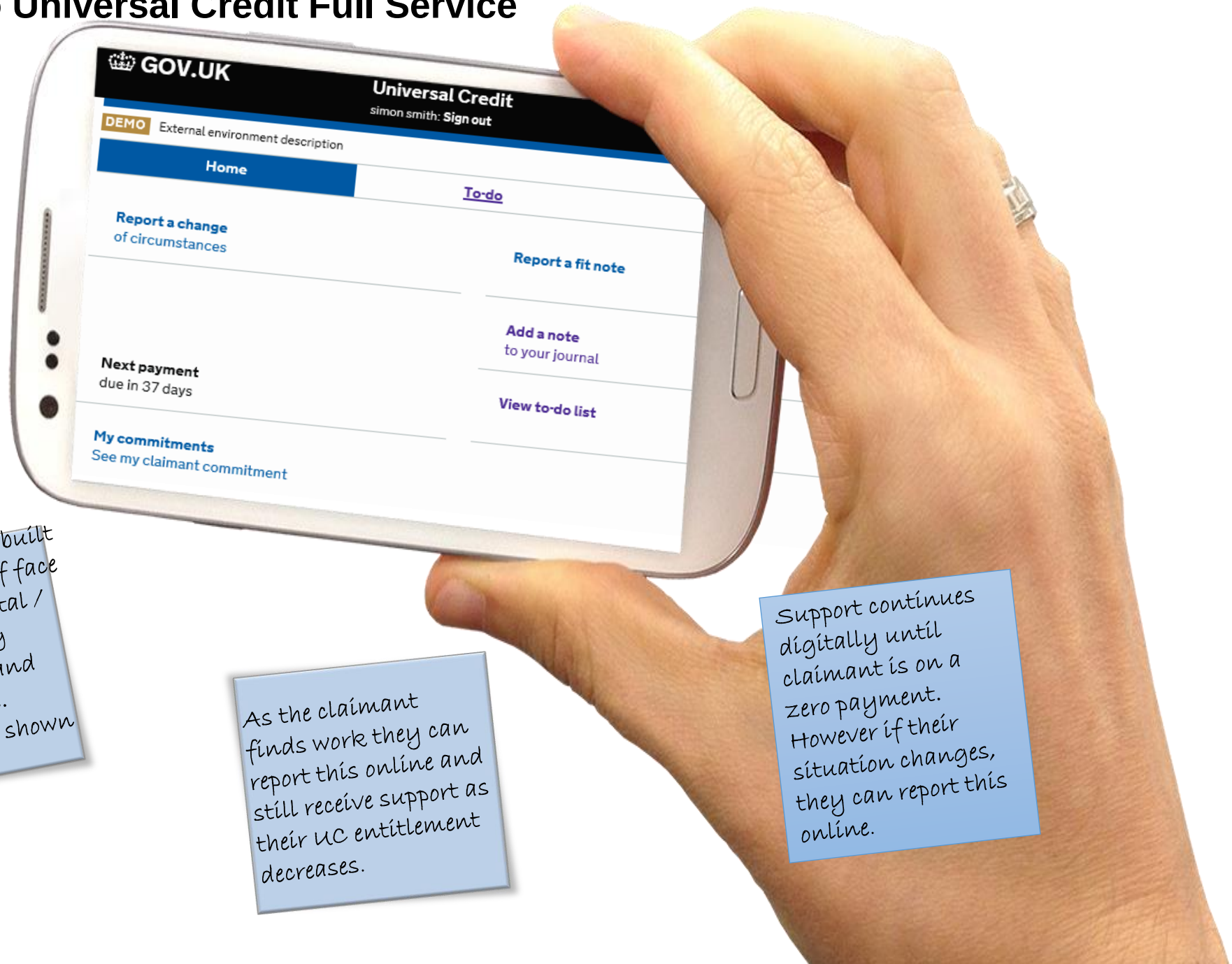
92%

of claimants are paid on time during their claim

Performance has maintained strong over the summer when we rolled out to 29 sites

** Of the new claims where payment has not been made by the due date, a third of these are because the Claimant Commitment has not been signed, the remainder are due to outstanding verification issues (e.g. proof of rent or childcare costs).*

Access to Universal Credit Full Service



A relationship is built with a mixture of face to face and digital / remote coaching using To Do's and Journal entries. Payments are shown too.

As the claimant finds work they can report this online and still receive support as their UC entitlement decreases.

Support continues digitally until claimant is on a zero payment. However if their situation changes, they can report this online.

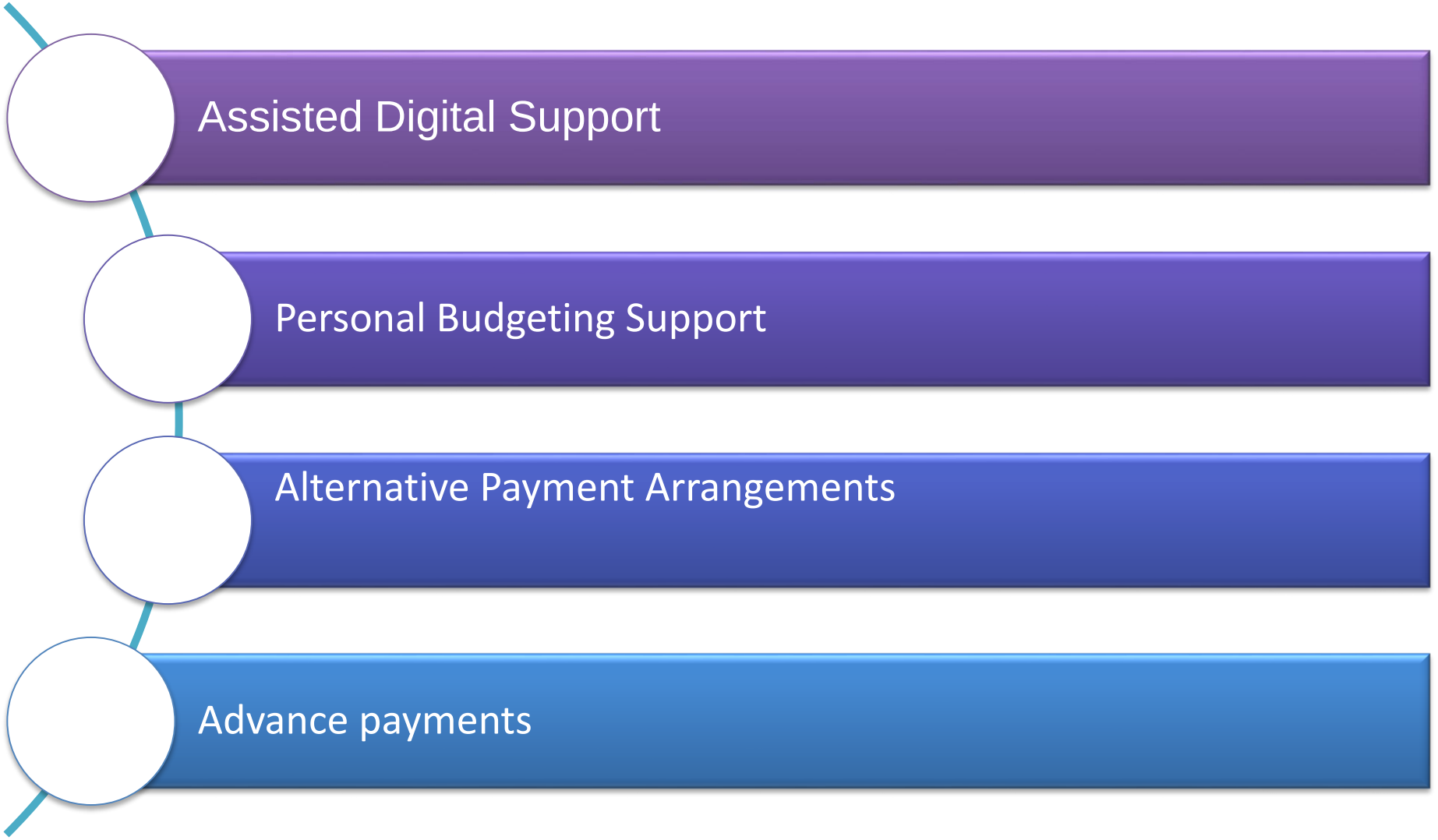
Universal Credit (FS) - conditionality groups

Claimant Characteristics	Conditionality Group
• Working Enough Regime: Those whose earnings are over either the individual or household Conditionality Earnings Threshold (CET) OR self-employed and Minimum Income Floor applies	No work related requirements
• No Work-Related Requirements Regime: Those not expected to work at present: This includes those too sick to work, those with significant caring responsibilities and lead carers where their youngest child is aged under 1yr	
• Work Focused Interview Only Regime: Those expected to work in the future but are currently nominated lead or responsible carers for children. This includes lead carers where their youngest child is aged 1 year	Work focused Interviews
• Work Preparation Regime: Those expected to work in future but not expected to look for work at this stage. This includes those assessed as having Limited Capability for Work (LCW) and those who are the lead carer where their youngest child is aged 2 years	Work preparation
• Light Touch Regime: Those whose individual or household earnings are above the Administrative Earnings Threshold (AET) but insufficient to take them above the relevant individual or household CET	All work related requirements
• Intensive Work Search Regime: For those not working and those who are working but earning very low amounts who can work and are expected to take intensive action to secure work or more work.	

Universal Credit Full Service – Where Next.

Timing	Our future plans.
From May 2016	Rollout of the full service across nation and regions will be a phased delivery approach with around 5 jobcentre areas going live each month.
From July 2017	We will accelerate delivery to 30 jobcentre areas per month going live with the full service, then 55 per month between October and December 2017.
From 2018	This will increase to 65 per month, finishing with the final 57 jobcentres in September 2018
From 2019 through to 2022	The managed migration of existing benefit claims will start in July 2019 and complete in March 2022.

Supporting claimants with complex needs



Alternative Payment Arrangements

For a minority of claimants, alternative payment arrangements may be required; these might include -

- paying the housing element directly to the landlord
- making more frequent than monthly payments
- splitting the payment within the household.

We will also have the option to make rent payments direct to the landlord if a claimant reaches a certain level of rent arrears.

Alternative Payment Arrangements

Tier One factors – Highly likely / probable need for alternative payment arrangements
Drug / alcohol and / or other addiction problems e.g. gambling
Learning difficulties including problems with literacy and/or numeracy
Severe / multiple debt problems
In Temporary and / or Supported accommodation
Homeless
Domestic violence / abuse
Mental Health Condition
Currently in rent arrears / threat of eviction / repossession
Claimant is young either a 16/17 year old and / or a Care leaver
Families with multiple and complex needs

Alternative Payment Arrangements

Tier Two factors - Potential need for alternative payment arrangements
No bank account
Third party deductions in place (e.g. for fines, utility arrears etc)
Claimant is a Refugees / asylum seeker
History of rent arrears
Previously homeless and / or in supported accommodation
Other disability (e.g. physical disability, sensory impairment etc)
Claimant has just left prison
Claimant has just left hospital
Recently bereaved
Language skills (e.g. English not spoken as the ‘first language’).
Ex Service personnel
NEETs - Not in Education, Employment or Training

More Information

- Universal Credit illustrated guides for partner organisations - https://www.gov.uk/guidance/universal-credit-toolkit-for-partner-organisations

- Universal Credit and rented housing (https://www.gov.uk/government/publications/universal-credit-and-rented-housing—2) explains what UC means for landlords, local authorities and tenants. The products hosted here include the Social Landlord Support Pack, Personal Budgeting Support (PBS) and Alternative Payment Arrangement (APA) guide.

- Universal Credit and you (https://www.gov.uk/government/publications/universal-credit-and-you) gives an introduction to Universal Credit for people who are claiming it. To request this in an accessible format please email: accessible.formats@dwp.gsi.gov.uk. Please tell us what format you need. It will help us if you say what assistive technology you use, e.g. if you use, for example, a screen reader and need a version of this document in a more accessible format,.
- Money Advice Service (https://www.moneyadviceservice.org.uk/en) - help for tenants

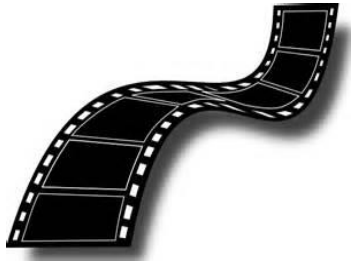
- Money Manager (https://obs.moneyadviceservice.org.uk/) tool provides personalised, independent advice to help people manage their budget and monthly Universal Credit payments.

- **Universal Credit Service Centre (Full Service) telephone number** - 0345 6004272

- **Universal Credit Service Centre (Live Service) telephone number** - 0345 6000723

Universal Credit Digital Service

Creating a digital UC account.



https://www.youtube.com/channel/UC7Km4IXfVJB1n8SQUmkJD0Q

Also information on Gov.UK Verify is on YouTube

https://www.youtube.com/watch?v=s3FqoQ3dUzo

The Community Crisis Intervention Practitioner (CCIP) Service

North Yorkshire & York & Selby

Tees, Esk & Wear Valleys NHS Foundation Trust

History and context

- Transformation Care for People with a Learning Disability (born out of events at Winterbourne View)
- TCP – identified that there was a local need to explore how we managed people in crisis/people with a behavioural presentation to help reduce the need for MH hospital admissions
- NYY&S LD services alongside TCP developed a proposal for a pilot project to support people who may be at risk of admission to MH Hospitals
- Funding of 150,000 came from NHSE and was match funded from TEWV.

Pilot focus

1 year project – extended to 2 years

Three main areas of focus

- Crisis response (including an OOH telephone support line (phone a friend)
- Supervision and guidance support to front line CTLD staff
- Workforce development (including 3rd sector partners)

Achievements so far…

Crisis Response

- Agreed criteria for the service
- Referral process established
- Developed a crisis response model focussed on stabilisation
- RAG rating criteria in place to support CTLD to identify individual's who may be at risk of admission, placement breakdown etc.

Benjamin’s Story – Case Example

Patient Stories – “Benjamin’s Story”

- 22 years old, living with family at the time of crisis.
- Family were unable to cope with the increasing level of aggression
- Unsure whether deterioration of behaviour was due to mental health crisis
- Moved out of area as there was no provision locally
- Several safeguarding alerts and family visiting every other day to ensure basic care needs were being met

“Benjamin’s Story”

Referral made to CCIP, work undertaken included:-

- Rapid response – ability to do so
- Joint assessment completed with Consultant Psychiatrist at point of crisis to consider behavioural factors
- Good external partnership working to facilitate an emergency placement (to prevent inpatient admission)
- Continued liaison with partners and family to review placement and facilitate a transfer back into the local area
- Full co-ordination of transition plan ending in a positive transition

Supervision & Guidance to CTLD

- PBS champions in each CTLD team and also in th inpatient service
- Offer of telephone support to crisis teams (out of hours)
- Embedding of evidence based practice competency framework surrounding PBS
- Development of a structured model of coaching to CTLD staff using case review/case management, peer learning

Tommy’s Story – Case Example

Patient Stories – “Tommy’s Story”

- 79 years old, living in a nursing home
- Undiagnosed ASD
- Lived at the home for the last 4 years. The home has changed significantly in this time i.e. increased number of residents
- Daily incidents of property damage and verbal aggression.
- Evidence of punitive practices and inadequate support

“Tommy’s Story” – CCIP/Team Involvement

- Situational management session completed alongside nurse to build competencies and skills
- Supervision/coaching of the PBS pathway meant it quickly became apparent that the placement was inappropriate. Function of behaviours of concern related to social attention.
- Worked with LA & CHC to identify an alternative provider.
- Tommy moved to a new home within 4 weeks.

“Tommy’s Story” – Feedback

Tommy’s feelings regarding the move

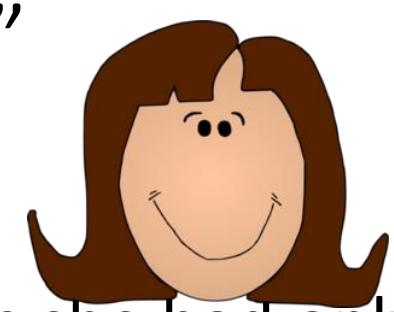
- Referred to his new home as ‘the best place’
- The staff bought him a new plastic gun and a wireless bell that sounds like a bird. These both make him smile
- Tommy repeats that he ‘likes it here’ and wants to stay
- It is quieter
- He is happy that he no longer has a catheter (removed within 2 weeks) and finally has a new wheelchair which is comfy

Workforce Development – (Including 3rd Sector Partners)

- Active support ‘train the trainer’ programme – delivered to a group of clinicians who are currently developing a training package for all clinicians in NYY&S area.
- Provider workforce development – 2 individuals (from one provider organisation) completing a BTEC in PBS, mentored by the CCIP service.
- Innovation – The use of body cameras as an observation technique in an attempt to prevent inpatient admission

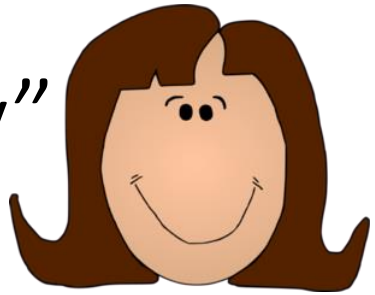
Lilly’s Story – Case Example

Patient Stories – “Lilly’s Story”



- 56 years old, living in a residential home
- Diagnosis of ASD
- Lived at the home for the last 2 years, before this she had only ever lived with her parents who are now very elderly
- Lilly struggles with where she lives as the 4 other residents are non verbal and there is evidence that staff do not always support Lilly in the right way (mainly due to a lack of understanding around ASD and PBS).

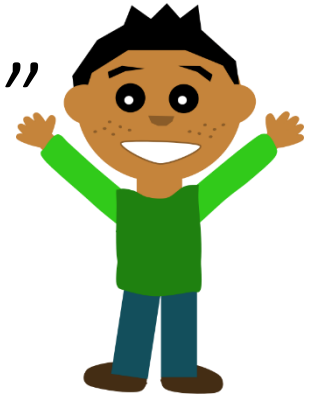
Patient Stories – “Lilly’s Story”



- The principles of Active Support were introduced to the staff team
- After just one week both Lilly and staff were seeing improvements and are much more positive going forward.

Sammy’s Story – Case Example

Patient Stories – “Sammy’s Story”



- 22 years old, living with his mother
- Diagnosis of ASD and Schizophrenia
- Lived at home for the last 4 years with limited services
- Increased incidents of self-harm and property damage.
- Safeguarding alert and request for CTR made after serious incident happened within the home. Team unsure whether current presentation is due to MH or is behavioural

“Sammy’s Story”

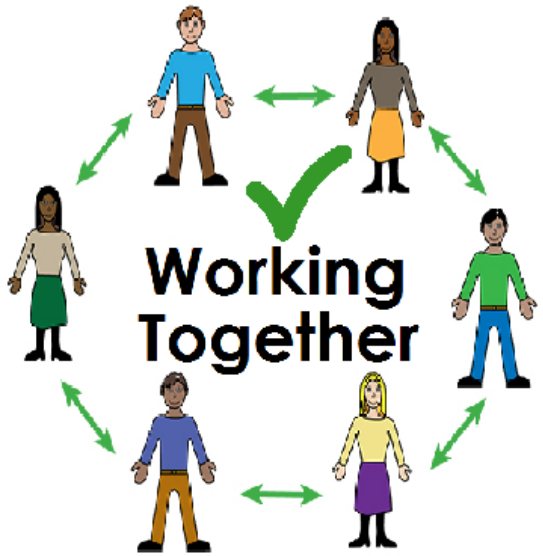
Consideration given to hospital admission

- Three previous admissions – all detrimental
- No LD bed locally
- Due to increased anxiety/distress admission would be unlikely to be a true representation of the Sammy’s normal presentation.
- No resources for intensive observations in the Sammy’s home and Sammy would be unlikely to cope with unfamiliar people being in his home environment.

Body Camera’s as an alternative – pilot

What's gone well

- Positive outcomes for patients
- Successfully find alternatives to hospital admission
- Continued investment in upskilling the CTLD workforce
- Investment from providers in meeting the standards of PBS frameworks and delivery
- CCIP role becoming established within all NYY&S teams



Next Steps…

- Agree additional commissioned funding to sustain and establish the CCIP service model
- To work with commissioners in developing robust contracts around quality placements and skilled workforce – are services fit for purpose?
- Develop a wider understanding of 3rd sector skills and future requirements

Any Questions???

Public Health in North Yorkshire

Ruth Everson: Health Improvement Manager
Jenny Loggie : Health Improvement Manager
Natalie Smith: Health Improvement Officer

North Yorkshire County Council

Purpose of attending Learning Disability Provider Forum

- Provide an overview of Public Health and local priorities
- Provide a summary of the local picture
- Update on local strategies and commissioned services
- Understand the needs of the local population
- Increase the connection between services
- Understand how Public Health team can support Learning Disability Providers

North Yorkshire County Council

OUR VISION: Public health describes our collective organised efforts to improve and protect the health of everyone in North Yorkshire by putting wellbeing at the heart of everything we do to enable each person to live healthier, happier lives.

OUR PURPOSE: The public health team provides leadership, advice and support to partners and communities for collective efforts to shape, facilitate and inspire everyone in North Yorkshire to live healthier, happier lives. This is done through influencing strategic policies and actions and ensuring delivery of services that improve healthy life expectancy and reduce the variation in health outcomes between communities in North Yorkshire.

OUTCOMES: increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities

North Yorkshire County Council

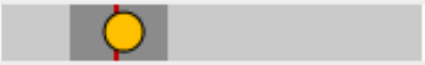
Our priorities

Start Well	A good start to life, building emotional resilience and getting maximum benefit from education are the most important markers for good health and wellbeing throughout life. This enables all children, young people and adults to maximise their capabilities and have control over their lives.
Live Well	By working in partnership to create fair employment and good work for all we encourage a healthy standard of living and enable all working age people to live healthy, active and engaged lives fulfilling their ambitions and aspirations.
Age Well	Strengthening the role and impact of ill health prevention and promoting independence will enable older people and carers to enjoy life, continue to make positive contributions in their communities and make informed choices about their future as they age.
Connected Communities	Creating, developing and maintaining healthy and sustainable places and communities where people shape services and have control of their lives are necessary for North Yorkshire to remain a special place for everyone to live, work and visit.

Local Picture

Approximately 2,300 people with a LD are registered with GP practices across North Yorkshire

Public Health Indicators

Indicator	Period	N Yorkshire		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence	2013/14	2,491	0.5%	0.5%	0.5%	0.1%		0.7%
Adults with learning disabilities in settled accommodation	2013/14	1,385	75.7%	79.2%	74.9%	47.6%		94.4%
Adults with learning disabilities in employment	2013/14	130	7.1%	6.2%	6.7%	0.8%		22.5%
Adults with learning disabilities supported throughout the year per 100,000	2013/14	1,675	477.4	432.0	414.0	0.0		800.6
Gap in employment: % gap between employment rate of those with mental health disorders or learning disabilities & overall population	2016 Q4	-	21.7%	33.4%	31.8%	-10.7%		74.9%
Proportion of people who use services who feel safe	2015/16	-	67.9%	69.9%	69.2%	55.1%		80.4%
Proportion of people who use services who say that those services have made them feel safe and secure	2015/16	-	86.0%	85.9%	85.4%	69.4%		98.6%

Public Health Indicator

Indicator	Period	N Yorkshire		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Prevalence of learning disabilities	2014/15	2,768	0.47%	0.50%	0.44%	0.07%		0.78%
Children with Profound & Multiple Learning Difficulty known to schools	2017	97	1.09	1.35	1.27	0.00		4.06
Children with learning disabilities known to schools	2017	2,144	24.0	39.6	35.0	3.4		86.7
Contact with mental health or learning disability services: rate per 1,000 patients on GP practice list aged 18+	2014/15	19,675	40.9	42.0*	38.7	20.1		83.5
Proportion of supported working age adults whose accommodation status is not known to LA (%)	2015/16	0	0.0%	4.5%	5.0%	43.6%		0.0%
Proportion of supported working age adults with learning disability in paid employment (%)	2015/16	160	10.6%	6.3%	5.8%	0.0%		22.0%
Adults receiving long term learning disabilities support from local authority per 1,000 people on GP learning disabilities register	2015/16	1,705	59.2	53.5	54.5	32.0		300.0
Learning disability: QOF prevalence (All ages)	2016/17	2,906	2.71%	2.95%	2.63%	1.12%		4.53%
Individuals with learning disabilities involved in Section 42 safeguarding enquiries per 1,000 people on the GP Learning Disability register	2016/17	165	56.8	53.5	54.3	0.0		100
Proportion (%) of eligible adults with a learning disability having a GP health check	2016/17	1,221	42.0	44.3	48.9	26.4		100

Health Needs

- People with learning disabilities are more likely to:
    - have higher rates of gum disease
    - Be obese
    - not eat a balanced diet with sufficient intake of fruits and vegetables
    - have CVD problems
    - have higher rates of respiratory disease
    - have higher rates of gastrointestinal cancer

North Yorkshire County Council

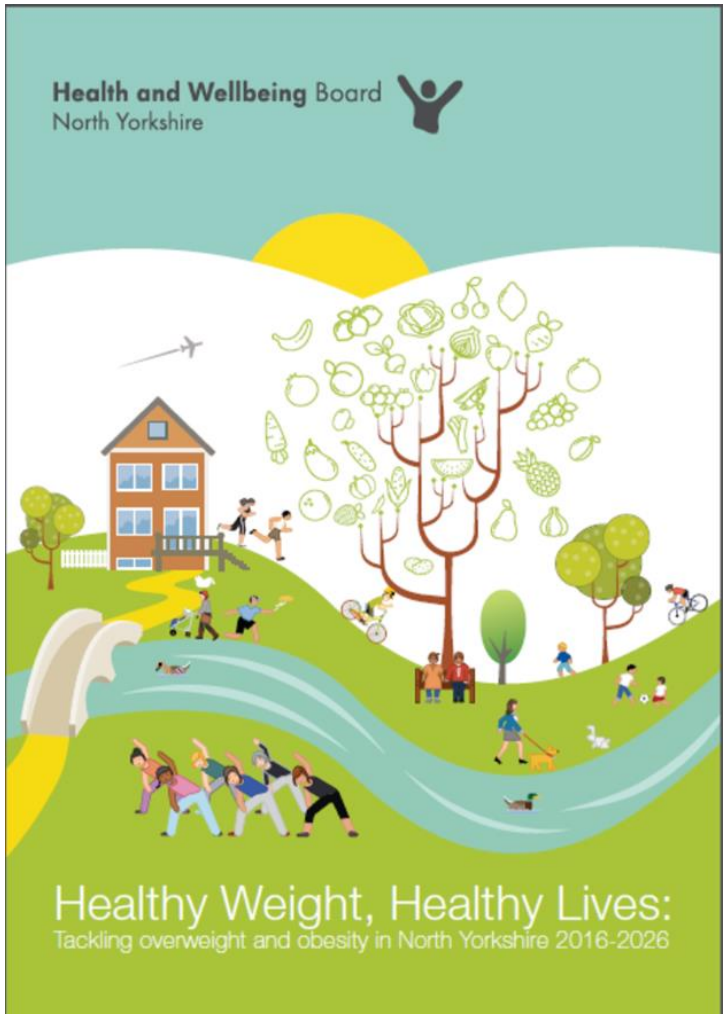
Mandated services

Statutory duties transferred from PCTs to Local authorities on 1 April 2013

- Sexual health services
- Health protection planning and assurance
- Health care public health advice service
- National Child Measurement Programme
- NHS Health Checks
- Elements of Healthy Child Programme

North Yorkshire County Council


Health and Wellbeing Board
North Yorkshire
"Live Well,
Live Longer"
Learning Disabilities Strategy
for North Yorkshire 2017 - 2022


Health and Wellbeing Board
North Yorkshire
Healthy Weight, Healthy Lives:
Tackling overweight and obesity in North Yorkshire 2016-2026


A Weight off Your Mind
Healthy
Juice
A Weight Management Plan for people with Severe Mental illness and/or a learning disability
Easy Read version
Northumberland, Tyne and Wear NHS
NHS Foundation Trust
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

North Yorkshire Joint Alcohol Strategy 2014-2019

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

Health and Wellbeing Board
North Yorkshire

North Yorkshire Tobacco Control Strategy 2015-2025
Smoke-Free North Yorkshire

Working together to reduce the harm caused by tobacco to individuals, families, communities and businesses in North Yorkshire.

Health and Wellbeing Board
North Yorkshire

Smoke-Free North Yorkshire

North Yorkshire
County Council

Stronger Communities
Inspire, Achieve, Innovate

Investment Prospectus

Central Services

Aim: to identify those at risk of serious, but potentially avoidable, conditions. The NHS Health Check is an important step for many people towards

- improving their lifestyle
- becoming more aware of what they can do to minimise health risks.

The NHS health check can help lower people's risk of developing

- heart disease,
- stroke,
- kidney disease,
- type 2 diabetes and
- some types of dementia

Receiving an NHS Health Check

Currently, 70 General Practices are offering the programme across North Yorkshire.

Having an NHS Health Check is both quick and straightforward. The GP will invite adults to attend for a Health Check via an invite letter. It's free of charge, including any follow-up tests or appointments.

Individuals can ask at their GP surgery for more information. Additional detail about what happens at the NHS Health Check and how to lower your risk is available from the national NHS Health Check website:

http://www.healthcheck.nhs.uk/

North Yorkshire Horizons

- Adult specialist drug and alcohol service across North Yorkshire
- For anyone aged 18 years+ if misusing illicit drugs or illicitly obtained prescription drugs, or if a potential dependent drinker (i.e. have AUDIT score 20+)

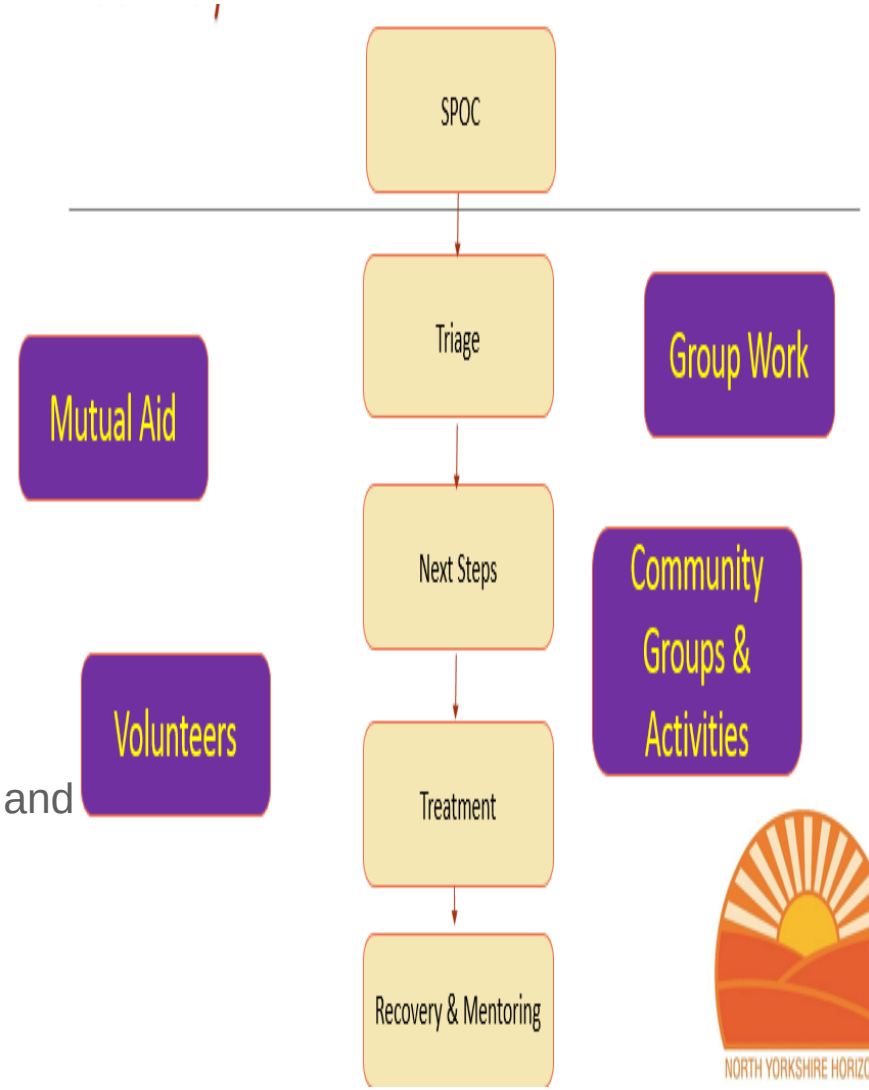
County wide service

- Hubs in Skipton, Selby, Northallerton, Harrogate, Scarborough
- GP and pharmacy based services
- Clinics and recovery groups in community venues
- In-reach in police custody
- Home visit provision where appropriate

Evidence based treatment and recovery offer available – 1:1, group based and peer support

Ambition is to support as many people to recover as possible, including abstinence. Harm reduction central feature of service delivery.

Anyone can refer via the Single Point of Contact – please include up to date contact details for the individual being referred and information on potential risk



www.nyhorizons.org.uk

Smokefreelife North Yorkshire

- North Yorkshire's local Stop Smoking service.
- FREE, open access service for people who live or work in North Yorkshire, aged 12+.
- Providing intensive behavioural support and stop smoking medicines.
- 1:1, drop ins, group support, telephone and text based support available across North Yorkshire.
- Call 01609 663023 or text QUIT to 66777.
- Visit: www.smokefreelifenorthyorkshire.co.uk

Yor Sexual Health Services

Free open access service providing contraception & STI services

YSH YorSexual Health

Free and confidential services across North Yorkshire and York

- Face to face clinics in all districts
- Virtual STI and HIV testing available
- Free condoms for target groups via the
- Condom Distribution Scheme
- Clinical outreach team provides 1:1 work with
- vulnerable young people and adults
- Targeted outreach with at risk groups e.g. MSM,
- sex workers, LGB&T young people
- Support service for people living with HIV & their carers
- Free training for professionals to increase sexual health knowledge & skills

All GP Practices also provide wide range of contraception

Many Pharmacies provide free ‘morning after’ pill to 13-24 year olds

Single point of contact via www.yorsexualhealth.org.uk or 01904 721111

Tier 2 Adult Weight Management Service

The service is an evidenced based programme designed to tackle the rise in excess weight in the adult population of North Yorkshire.

The service is available in all 7 districts and offers;

- A free multicomponent 12 week programme including nutritional advice, weigh ins, physical activity and behaviour change aimed at achieving a 5% weight loss
- A further free 12 week maintenance programme for adults who have achieved a 5% weight loss, aimed at maintaining the weight loss at the end of the programme

Eligibility criteria

- Aged 18 or over
- Have a BMI of 25 or over
- Registered with a GP practice in North Yorkshire or
- Working for an organisation based in North Yorkshire

Clients can self refer or be referred by their GP or other health Professional. Website: https://www.northyorks.gov.uk/healthy-weight

North Yorkshire County Council

Breastfeeding and Healthy Start

- Almost three quarters of women begin to breastfeed but this drops to less than half by 6-8 weeks. Initiation rates vary across the county from 84.4% in Harrogate to 60.3% in Scarborough.
- HDFT and NYCC have jointly achieved stage one of Unicef Baby Friendly Initiative. Currently working towards stage two
- A county wide infant feeding strategy has been drafted and action plan is being developed
- Breastfeeding support groups have been established across North Yorkshire
- Priorities include better links between antenatal and postnatal infant feeding support services, targeting areas with lower breastfeeding rates and developing a breastfeeding welcome scheme
- Healthy start vitamins available for pregnant women and children through children's centres free of charge to those eligible and others can purchase at cost

Stronger Communities

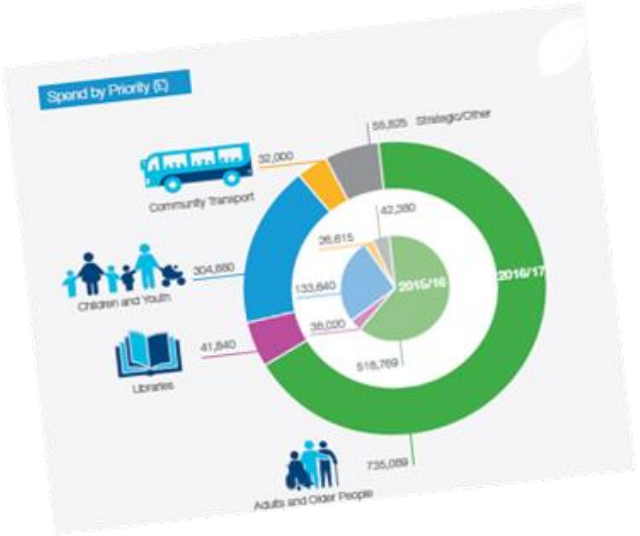
Aims: To work in partnership with the voluntary and community sector to achieve some key community objectives.

Objectives

- developing communities to look after themselves to a greater degree than they already do,
- reducing demand on statutory services and mitigating some of the cuts in public services.

Set within a framework of priority Council service areas (Libraries, Children, Young People & Families, Community Transport, and Adults and Older People) Programme investment and strategic partnerships will focus on three clear outcomes:

- Reducing inequalities – health, access, civic participation.
- Improving social connectedness – reducing loneliness and social isolation, enhanced community capital.
- Improving well-being – social, emotional, physical.



Find Out More

You can find out more information about the Programme and read the full Prospectus on our webpage (https://www.northyorks.gov.uk/stronger-communities) or by searching 'Stronger Communities' on the intranet. There is a team of Delivery Managers in place (one per district) able to work with local groups

Questions

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North Yorkshire County Council