Agenda

Meeting: Care and Independence Overview & Scrutiny Committee

Venue: The Brierley Room, County Hall, Northallerton, DL7 8AD (See location plan overleaf)

Date: Thursday 14 December at 10.00am

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Business

1. Minutes of the meeting held on 28 September 2017

(Pages 6 to 10)

2. Any Declarations of Interest

3. Public Questions or Statements.

Members of the public may ask questions or make statements at this meeting if they have delivered notice (to include the text of the question/statement) to Ray Busby of Policy & Partnerships *(contact details below)* no later than midday on Monday 11 December 2017. Each speaker should limit themselves to 3 minutes on any item. Members of the public who have given notice will be invited to speak:-

- at this point in the meeting if their questions/statements relate to matters which are not otherwise on the Agenda (subject to an overall time limit of 30 minutes);

Enquiries relating to this agenda please contact Ray Busby **Tel: 01609 532655**
Fax: 01609 780447 or email Ray.Busby@northyorks.gov.uk
Website: www.northyorks.gov.uk

- when the relevant Agenda item is being considered if they wish to speak on a matter which is on the Agenda for this meeting.

If you are exercising your right to speak at this meeting, but do not wish to be recorded, please inform the Chairman who will instruct those taking a recording to cease while you speak.

		PROVISIONAL TIMINGS
4.	**Care Standards** a) **Introduction and Agreed line of Enquiry -** Report by the Scrutiny Team Leader **(Page 11)** b) **HAS Perspective and responsibilities –** Presentation by Kathy Clark /Janine Tranmer c) **CQC responsibilities and Briefing** - Kathryn Reid, Regional inspector d) **Independent Care Sector** - Mike Padgham e) **Healthwatch –** Judith Bromfield and Nigel Ayre	***10.05-11am***
5.	**Intermediate Care –** Presentation by Louise Wallace (Assistant Director, Health and Adult Services)	***11 - 11.30am***
6.	**Health and social care workforce planning Task and Finish Group –** Draft Report by the Task Group **(Pages 12 to 38)**	***11.30 -11.45am***
7.	**Director of Public Health Annual Report -** Dr Lincoln Sargeant **(Pages 39 to 50)**	***11.45am -12noon***
8.	**Work Programme** - Report of the Scrutiny Team Leader **(Pages 51 to 56)**	**12noon**
9.	**Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances.**	

Barry Khan
Assistant Chief Executive (Legal and Democratic Services)

County Hall,
Northallerton.

6 December 2017

NOTES:

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

Care and Independence Overview and Scrutiny Committee

1. Membership

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

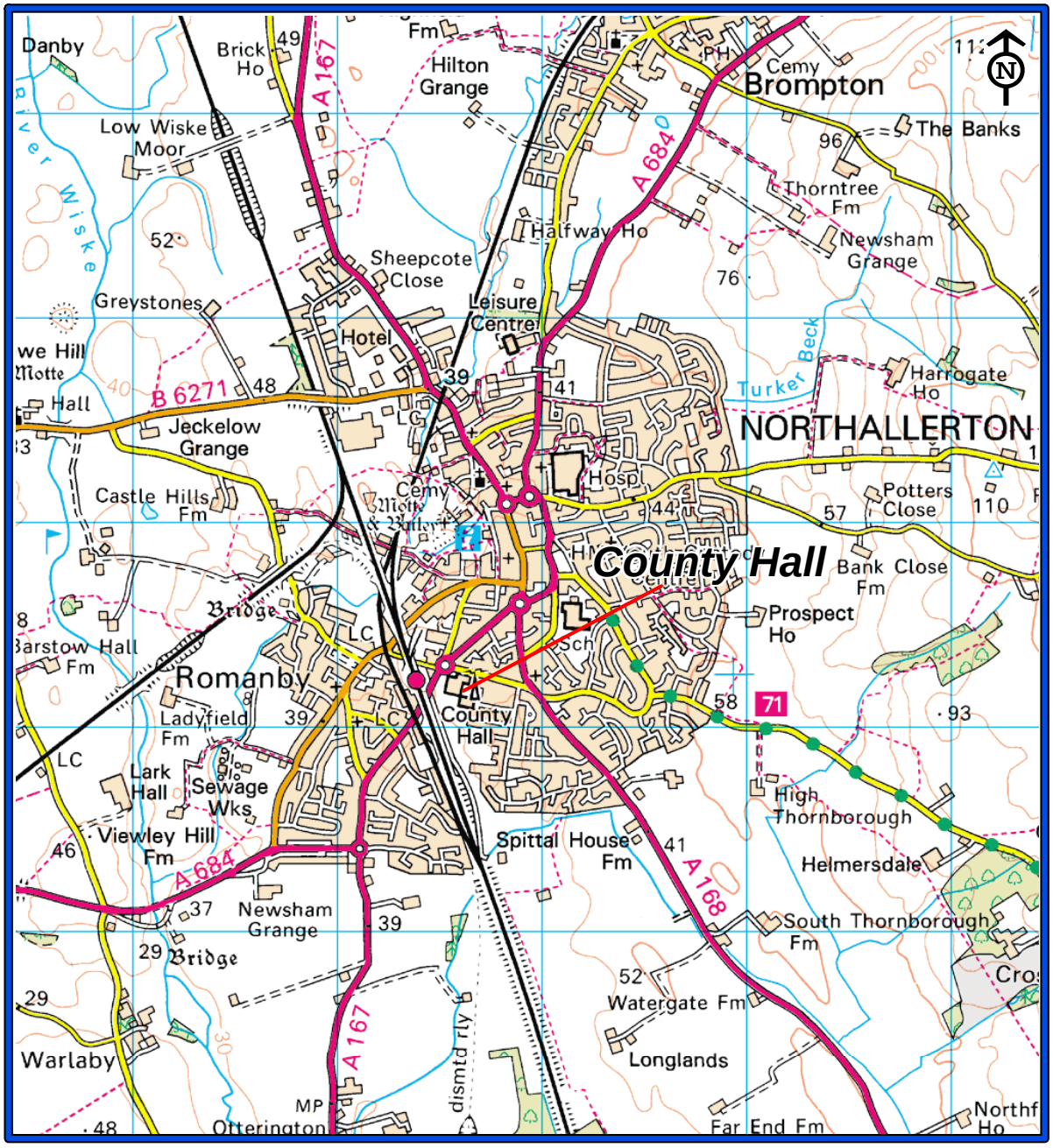
Members other than County Councillors – (3)			
Non Voting			
	Name of Member	*Representative*	*Substitute Member*
1	QUINN, Jill	Dementia Forward	
2	PADGHAM, Mike	Independent Care Group	
3	VACANCY		

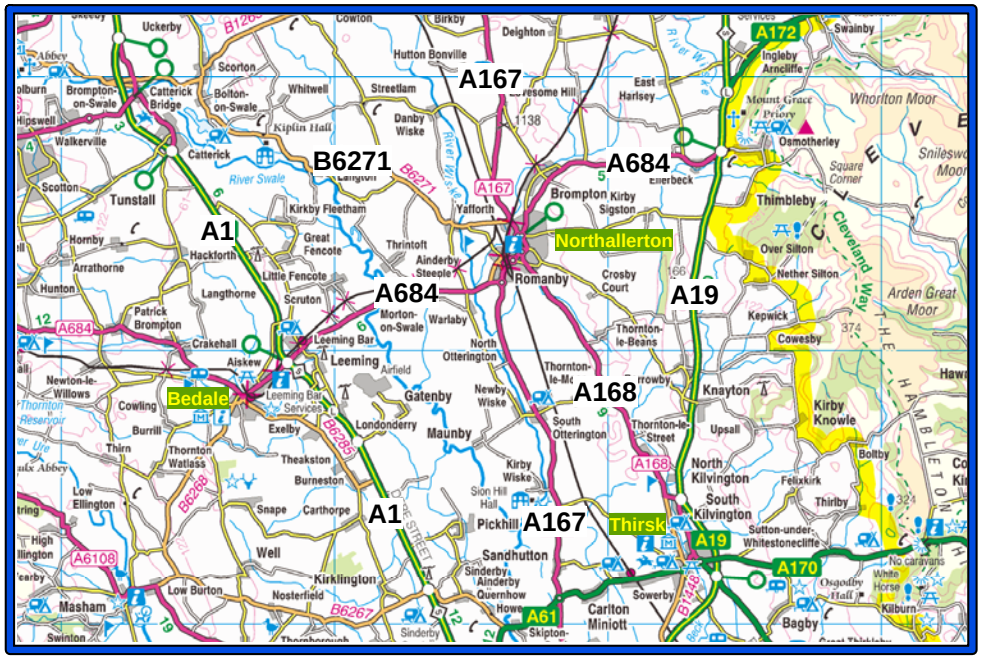
Total Membership – (16)	**Quorum – (4)**

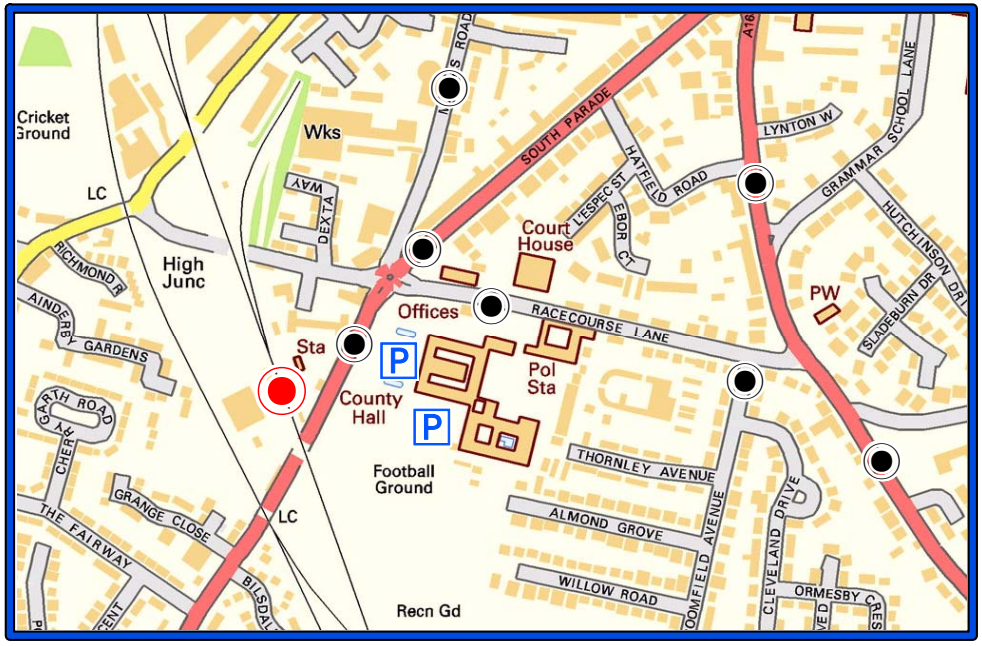
Con	**Lib Dem**	**NY Ind**	**Labour**	**Ind**	**Total**
10	1	1	1	0	13

2. Substitute Members

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







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North Yorkshire County Council

North Yorkshire County Council

Care and Independence Overview and Scrutiny Committee

Minutes of the meeting held on Thursday 28 September 2017 at 10.00am at County Hall, Northallerton.

Present:-

County Councillor John Ennis in the Chair

County Councillors: Philip Broadbank. Eric Broadbent. John Ennis (in the Chair), Caroline Goodrick, Helen Grant, David Jeffels, Andrew Jenkinson, Stanley Lumley, John Mann, Chris Pearson (as substitute for Stuart Martin MBE) and Karin Sedgwick.

In attendance: County Councillor Caroline Dickinson (Executive Member for Adult Social Care Health Integration).

Officers: Ray Busby (Scrutiny Support Officer), Sheila Hall (Head of Engagement & Governance, Engagement & Governance HAS), Avril Hunter (Locality Head of Commissioning Craven and Harrogate, Commissioning (HAS)), Stephen Miller (Senior Strategy & Performance Officer (CYPS)) and Claire Robinson (Health Improvement Manager HAS.

Apologies:
County Councillors Michael Chambers MBE, Stuart Martin MBE and Nicola Wilson.
Voluntary and Community Sector: Jill Quinn (Dementia Forward).
Independent Sector: Mike Padgham (Independent Care Group).

Copies of all documents considered are in the Minute Book

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134. Minutes

Resolved –

That, the Minutes of the meeting held on 29 June 2017, having been printed and circulated, be taken as read and be confirmed and signed by the Chairman as a correct record.

135. Declarations of Interest

There were no declarations of interest to note.

136. Public Questions or Statements

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

137. Independent Advocacy

Considered –

a) Report by the Corporate Director of Health and Adult Service providing an overview of the Independent Advocacy service that the Council has a statutory duty to provide, including how the service was commissioned, how the service is monitored and a summary of advocacy activity.

b) Presentation by Suzi Henderson, Chief Officer of Cloverleaf accompanied by Helen Beevers from Advocacy Alliance in Scarborough

Avril Hunter explained how the directorate has followed good commissioning practice when seeking in 2015 a provider for this service.

Under the Care Act, the category "Statutory Advocacy" was widened to include individuals who would experience substantial difficulty in being involved with care and support 'process' or safeguarding, and does not have an appropriate individual to support them. Where someone is unable to fully participate in these conversations and has no one to help them, local authorities will arrange for an independent Advocate. Other statutes place specific requirements for advocates where someone may be deprived of their liberty, and where they do not have the capacity to make a particular decision about their health and care, or living arrangements and have no close family or friend able to act on their behalf, through for example Lasting Power of Attorney. Discretionary advocacy can also be provided for people who do not necessarily fall into the Care Act or more specialist advocacy requirements.

Avril talked though the detailed data used to monitor the performance of the service. In terms of service reach, the successful lead provider, Cloverleaf, working with Advocacy Alliance and York Mind under the banner "Total Advocacy", provided effective and timely support to around 1000 people a year. Specialist advocacy continues to increase, comprising 60% of advocacy activity in 2016/17. This has increased steadily since 2012/13 in line with a doubling of Deprivation of Liberty assessments, with a need for both one-off assessments and longer term advocacy support. 25% of referrals for advocacy were for the non-statutory or discretionary independent advocacy. As the demand for Care Act advocacy has not been as high as expected, the capacity has been there to provide more of this.

Suzi Henderson and Helen Beevers described how advocates are working effectively on a one-to-one basis with people to help them to continue to enjoy an active and independent life for as long as possible, that they are improving people's quality of life, promoting their independence and helping them to plan and to maintain or widen their social networks.

Advocates provide an independent support to people, who through vulnerability or lack of capacity need support to help them make a decision, or express what they want to say, or someone to act on their behalf and represent their best interests. This is if there is no family of friend who can undertake this.

A good advocate:

- listens to a person's views and concerns;
- helps explore options and rights (without advising in any particular direction);
- give information to help make informed decisions;
- helps people contact relevant people, or contact them on his/her behalf; and
- accompanies and supports people in meetings or appointments.

An advocate will not:

- give their personal opinion;

- solve problems and make decisions for the person supported;
- nor will they make judgements about that person

Members expressed satisfaction with what they saw as the many positives associated with the commissioning and running of the service. They found it rewarding to learn, from the very moving case studies looked at, the real difference having an advocate can and is making to people's lives.

Resolved –

Members concluded from the evidence they saw and from the comments they heard, that:

- Contracting processes and subsequent communication with providers is transparent and fair.
- There is constructive information sharing.
- Contract terms are flexible enough to allow changes to be made, for example to priorities and targets, in the light of experience and changing circumstances.
- The impact the service is having is kept under proper review.
- Regular and productive dialogue between commissioner and provider is helping shape thinking about future provision before the end of the contract period.

138. NY Safeguarding Adults Board: Annual Report 2016/17

Considered -

Introduction by Colin Morris, Independent Chair to the Annual Report of the North Yorkshire Safeguarding Adults Board for the financial year 2016/17.

Colin and Sheila highlighted a number of headline issues in this year's report.

The Board has reviewed its governance arrangements. As an example, the introduction of the Learning and Improvement Group is helping to break down historical barriers between partner agencies, and thus reduce the bureaucracy that previously may have deterred service users from accessing appropriate help at a time when they may have most needed it.

This year has witnessed many additional changes and challenges to the safeguarding "agenda", many of which do not fit the traditional profile of work that the Board has previously been involved in. These new areas highlight how vulnerable people, be they adults, young people or children, are being targeted and placing them increasingly "at risk". Modern day slavery, human trafficking, sexual exploitation, and forced marriage are all very real examples where an individual's vulnerabilities are taken advantage of and exploited. Advances in technology have brought about liberating opportunities for people, but at the same time opened up huge opportunities for exploitation - cyber bullying, on-line fraud, sexual exploitation and grooming are all examples of this.

Some examples which underline what has been achieved, in partnership terms, include:

- Working in partnership with representatives from West Yorkshire, and York to review the Multi-Agency Safeguarding Policy and Procedure.
- Partnership working with City of York Council to share good practice and look at where closer joint working is possible.
- Participation in initial multi-agency meetings to develop a partnership approach to Modern Slavery and Human Trafficking.

Resolved -

a) That the report and subsequent discussions be noted.
b) Taking into account all the above and all the other initiatives and activity outlined in the report, the evidence suggests the Board is in a healthy state - governance arrangements are sound; partnership commitment is good; work on community prevention and awareness is robust, and strategic links with other partnerships in localities are working well.
c) So that members can be confident they are properly aware of national developments and best practice, it was agreed that arrangements be made for an extra, workshop type session.

139. North Yorkshire Joint Alcohol Strategy: Update

Considered -

Report by Claire Robinson, Health Improvement Manager, Health and Adult Services updating progress against the Alcohol Strategy Annual Report 2016.

The report described the three priority areas underpinning the alcohol strategy. It includes the main developments against these outcome areas, and the impact of increased investment in the alcohol strategy including new investment in Identification and Brief Advice (IBA) to assess changes in people's behaviours and contribute to reducing alcohol related harms.

In January 2015 North Yorkshire County Council (NYCC) published a joint alcohol strategy, the aim being to galvanise partners to collectively reduce the harms from alcohol. The key achievements included:

- Commissioning by the Public Health Team to deliver free Identification and Brief Intervention (IBA) training to target professional (but non-alcohol specialist) groups across North Yorkshire. To date over 900 people have been trained.
- The increased provision of IBA in GP settings and pharmacies.
- As a response to the change in licensing legislation Public Health has been working with colleagues to influence reviews of districts Statement of Licensing Policy and also developing local profiles which include health and police data to support the licensing process and provide alcohol related data for districts.
- The successful work by Trading Standards

Resolved -

a) That the report be noted.
b) From what members saw of the published annual report and the presentations at the meeting, they agreed that experience appears to bear out the decision to

identify three outcome areas: establish responsible and sensible drinking as the norm; identify and support those who need help into treatment through recovery and to reduce alcohol related crime and disorder. By selecting these, the strategy strikes a realistic and prudent balance between promotion, awareness raising, and intervention and treatment.

140. Suicide Audit

Considered -

Report by Claire Robinson, Health Improvement Manager, Health and Adult Services updating on activity and prevalence information in relation to the Suicide Audit. Stephen Miller (Senior Strategy & Performance Officer (CYPS)) highlighted the significance and relevance of some data.

Resolved -

That the report and presentation be noted

141. Work Programme

Considered -

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

Resolved -

That the Work Programme be agreed.

NORTH YORKSHIRE COUNTY COUNCIL
CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE
Thursday 14 December 2017
Care Standards

"How we can be confident that North Yorkshire care providers, particularly those who operate residential establishments, are satisfactorily meeting appropriate quality standards and requirements". Connected to the work on state of the market, "What makes a good care home and a good care provider?"

What are the issues that can influence standards of care - for example fee levels (subject to the usual, inevitable caveats about scrutiny's role etc.), staff recruitment, retention and training, commissioning for quality, contract compliance, and so on.

If members agree to go ahead, the likelihood is the greater part of the morning will turned over to this issue – possibly with some short term focused work afterwards

1. Introduction HAS

- Regulation and inspection and directorate responsibilities, how directorate monitors the quality of services provided
- The state of the market.
- Care Act responsibilities around Market shaping and Provider Failure.

2. CQC representative

How the Care Quality Commission (CQC) regulates, inspects and rates health and social care services.

3. Stakeholders perspective

ICG, Voluntary and Community Sector, Healthwatch

4. Role of Members and information requirements

5. Discussion

Are arrangements in place to protect the public and ensure that residential care and domiciliary care services are of a quality that people would expect?

Ray Busby,
Scrutiny Support Officer,

County Hall
NORTHALLERTON,
Background Docs - Nil

North Yorkshire County Council
Care and Independence Overview and Scrutiny Committee
14 December 2017

Joint Scrutiny by the Scrutiny of Health Committee and the Care Independence Overview and Scrutiny Committee

Health and social care workforce planning Task and Finish Group – draft report for comment

Purpose of Report
This is the draft report of the Joint Scrutiny by the Scrutiny of Health Committee and the Care Independence Overview and Scrutiny Committee, which has scrutinised health and social care workforce planning, over the course of three meetings since September 2017.

Members are asked to review and agree the draft report. In doing so, identifying any gaps, omissions or inaccuracies, and assuring themselves that the recommendations are specific, realistic and relevant to the evidence base presented in this report.

Background

1. At the Scrutiny of Health Committee meeting on 23 June 2017 and the Care and Independence Overview and Scrutiny Committee meeting on 29 June 2017, the initial framework for this piece of in-depth scrutiny was agreed by Members. Since then, over the course of three meetings in September, October and November evidence has been gathered from a wide range of sources to better understand the challenges faced in health and social care workforce planning and to identify any areas where improvements could be made.

Draft report to review and agree

2. The draft report is presented today for the committee to review and agree, subject to the completion of any necessary amendments and updates.

3. The report has been through a peer review process and has been sent to all those people who have contributed to it for comment.

4. Following the discussions at this Committee meeting, the meeting of the Care and Independence Overview and Scrutiny Committee on 14 December 2017 and the completion of any necessary amendments and updates, the intention is to take the final agreed version of this report to a future meeting of the North Yorkshire Health and Wellbeing Board.

Recommendation

5. Members are asked to review and agree the draft report. In doing so, identifying any gaps, omissions or inaccuracies, and assuring themselves that the recommendations are specific, realistic and relevant to the evidence base presented in this report.

6. That the final agreed version of this report is presented to a future meeting of the North Yorkshire Health and Wellbeing Board.

Daniel Harry
Scrutiny Team Leader
North Yorkshire County Council
22 November 2017

Health and social care workforce planning – joint scrutiny by the Scrutiny of Health Committee and the Care and Independence Overview and Scrutiny Committee

Executive summary

The objective of this piece of scrutiny work is to engage with a broad range of commissioners and service providers to better understand the causes of workforce shortages, what the short term and long term impacts are, what actions are being taken to mitigate them and how successful these actions are or likely to be.

Key findings from this piece of joint scrutiny include:

- A great deal of work is already underway to help address workforce shortages across health and social care. This work, however, is often undertaken in silos or unilaterally.

- Workforce planning over anything but the short term is extremely difficult as there are a number of variables that are very difficult to predict.

- National shortages in social care staff are due to increasing demand for social care for older people, the social care role being poorly perceived, perceived lack of career progression, pay rates being low, a rising cost of living, competition with other sectors (hospitality and retail), difficulties in retaining staff, shortages of affordable housing and falling levels of unemployment.

- Workforce pressures in the NHS have arisen from pay restraint, increasing numbers of patients and the complexity of their health needs, the introduction of safe staffing policies and guidance following the Francis report, and the uncertain impact of the UK exit from the EU.

- Recruitment and retention of skilled medical staff in North Yorkshire and the North East is more difficult than elsewhere in the country. In general, the further a hospital is away from the A1/M corridor, then the less attractive a place is to work. Also, NHS staff shortages in England become more acute as you go north of Nottingham.

- Shortages in permanent staff in health and social care mean that employers fill gaps with agency, locum and other temporary staff. This creates additional expense and is inefficient.

- The large amounts of unpaid care provided by family members, who often have care needs of their own, helps relieve pressure upon the health and social care system.

- In addition to general nursing, a number of medical specialties are significantly more difficult to recruit to at Consultant level. There are also GP shortages in all areas. These are particularly acute in poorer, coastal and more rural areas of the county.

- The challenge is to reshape the workforce, changing the skills mix and developing new roles that reduce the dependence on traditional and hard to fill roles, such as GPs.

- Closer working between NHS providers would help: reduce competition for specialist medical roles; share best practice in recruitment and retention; gather accurate workforce data to inform the work of Health Education England.

- Public health work and 'Make Every Contact Count' offers an opportunity for a broad range of agencies and personnel to promote healthy lifestyles and become involved in preventative work, reducing GP and hospital attendances in the short term and also the need for more complex and expensive social and medical interventions in the long term.

- Whilst the impact of the UK Exit from the EU and the end of student bursaries for nurse and midwifery training is uncertain at this stage, it is likely that both will create additional pressures upon health and social care workforce shortages.

- More could be done to maximise the UK workforce and reduce the reliance on overseas workers.

The recommendations in this report will be presented to the North Yorkshire Health and Wellbeing Board.

Section 1 – Background, objectives and methodology

Background
A theme that has arisen from the scrutiny of health and social care over the past 18 months has been one of shortages of health, mental health and social care staff. Some of the concerns that have been raised are as follows:

- A large number of GPs are expected to retire in the next 5 years. These are not always being replaced by newly qualified GPs, leading to shortages in GPs particularly in rural practices
- There are shortages of consultants in hospital settings, particularly in smaller hospitals that tend to serve rural areas and which have a large catchment area
- There are shortages in social care staff, which is affecting the ability of social care providers to offer a comprehensive service
- There are shortages in community-based health and social care staff, which is affecting the ability of commissioners to develop out-of hospital services
- There are shortages in out of hours nursing, which can generate demand for more specialist and costly hospital based services
- Individual health services are being re-designed to compensate for or mitigate the existing workforce pressures with the potential for significant unintended consequences.

Some of the questions that have been raised include:

- What workforce planning is underway?
- How does it fit with strategic commissioning planning?
- Is it system wide?
- How do we address the short term and immediate workforce shortages whilst planning for the medium and long term?
- How well-equipped is the workforce to meet future health and social care needs?
- Are there variations in recruitment and retention across North Yorkshire and surrounding areas?
- How are work patterns changing and how does this impact upon the availability of workers?
- What is the impact of the UK leaving the EU?
- What impact will technology have, particularly in remotely provided/monitored care and diagnosis and consultation?
- Is there a further role for volunteers?

Objective
The objective of this piece of scrutiny work is to engage with a broad range of commissioners and service providers to better understand the causes of workforce shortages, what the short term and long term impacts are, what actions are being taken to mitigate them and how successful these actions are or likely to be.

Methodology
The approach to this piece of joint scrutiny included: desktop research into national guidance, policy and best practice; written reports and presentations to the sub-group; briefings by expert witnesses.

Membership of the task and finish group

Cllr Val Arnold	Cllr Mel Hobson
Cllr Philip Broadbank	Cllr David Jeffels
Cllr Eric Broadbent	Cllr John Mann
Cllr Jim Clark (Chair)	Cllr Heather Moorhouse
Cllr Liz Colling	
Cllr John Ennis	Ray Busby, Scrutiny, NYCC
Cllr Caroline Goodrick	Daniel Harry, Scrutiny, NYCC
Cllr Helen Grant	Louise Wallace, HAS, NYCC

Work plan

Date	Action	Comment
Care and Independence OSC – 29 June 2017 Scrutiny of Health Committee – 23 June 2017	Work plan taken to committee	Agree TOR, sub-group nominations/membership and arrangements for Chairing
7 September 2017	First meeting of the sub-group	Context setting - social care and identification of lines of enquiry
11 October 2017	Second meeting of the sub-group	Context setting – health and identification of lines of enquiry
10 November 2017	Third and final meeting of the sub-group	Drawing conclusions and developing recommendations
27 November 2017	Final report and recommendations to sub-group	Circulated by email for comment
Care and Independence OSC – 14 December 2017 Scrutiny of Health Committee – 15 December 2017	Final report and recommendations taken to committee meetings	
January 2018	Final report and recommendations taken to the North Yorkshire Health and Wellbeing Board and Executive	As appropriate

Section 2 – Literature review

Introduction

There is a wide range of research, policy, strategy, guidance and best practice on the subject of workforce planning in health and social care. The literature review summarises the key issues identified in a range of documents that have been identified as the most significant.

Social care

House of Commons, Communities and Local Government Committee, Adult social care, Ninth Report of Session 2016–17
https://publications.parliament.uk/pa/cm201617/cmselect/cmcomloc/1103/1103.pdf

The Committee looked at the funding pressures on adult social care and their consequences. The key findings that relate to social care workforce planning, are as summarised below:

- The turnover rate for nurses working in social care is 35.9%
- 47.8% of care workers leave within a year of starting
- The median hourly pay for a care worker is £7.40
- 160,000 to 220,000 care workers in England are paid below the national minimum wage
- 49% of home care workers are on zero hour contracts, compared with 2.9% of the workforce nationally
- 27% of care workers received no dementia training and 24% of those who administer medication were not trained to do so
- Between 2010–11 and 2013–14, the number of unpaid carers increased by 16.5%, while the general population grew by 6.2%
- One in five unpaid carers providing 50 hours or more of care each week receives no practical support from the local authority.

International Longevity Centre UK (2015) Moved to care: the impact of migration on the adult social care workforce
http://www.ilcuk.org.uk/images/uploads/publication-pdfs/IA_Moved_to_care_report_12_11_15.pdf

The International Longevity Centre – UK (ILC-UK) is a futures organisation focussed on some of the biggest challenges facing Government and society in the context of demographic change.

The report provides an overview of the make-up of the social care workforce, identifying the countries of origin of non-UK workers. The key statistics referred to are as follows:

- 1.45 million people work in the adult social care sector in England (2014)
- 266,000 of these workers were born outside of the UK
- 191,000 of these workers were non-EU migrants
- Among migrants who arrived in the UK over the last eight years (between
- 2007 and 2014), the top five countries of birth were: India (13%), Poland (12%), Philippines (11%), Romania (11%), and Nigeria (7%)

There are regional variations in the adult social care workforce with the highest proportion of migrant workers being in the South East. By contrast, in the North East over 95% of care workers are UK born.

Migration policy may have an impact upon the number of non-EU migrants that can work in adult social care (non-EU migrants are judged on a points-based system). The UK exit from the EU may also have an impact upon the number EEA migrants that can work in adult social care.

The report recommends that:

- UK migration policy is amended to retain existing and promote the recruitment of more non-EU adult social care workers
- An intensive Postgraduate Diploma for adult social care is introduced
- More care apprenticeships are introduced
- There is a national campaign to attract male care workers
- Greater support is given to unpaid carers
- More national funding is given to support adult social care.

Care Quality Commission (2017) Adult Social Care: Quality Matters
https://www.gov.uk/government/publications/adult-social-care-quality-matters

The report sets out a commitment from a broad range of agencies and organisations to creating shared understanding of what high quality adult social care is and then implementing the necessary changes and improvements to achieve it.

In terms of workforce planning, the following are identified:

- Promote the social care role and career and what it can achieve
- Target and attract 'non-traditional' workers into adult social care
- Stronger focus on the development of integrated roles, largely through the Sustainability and Transformation Partnership planning process
- Increase uptake of NICE guidance, NICE quality standards and Skills for Care's workforce resources.

Skills for Care (2017) Recruitment and retention in adult social care: secrets of success
http://www.skillsforcare.org.uk/NMDS-SC-intelligence/Research-evidence/Our-research-reports/Our-research-reports.aspx

Skills for Care is an organisation that provides practical tools, support and help to adult social care organisations and employers on the recruitment and development of their workforce.

The report is based upon research amongst adult social care employers with a turnover of less than 10% to explore what it is that they do that they feel contributes to their success in relation to recruitment and retention.

The key findings are as follows:

Attracting more people

- Recruitment planning needs to be based upon a strong understanding of local need
- Pay above the National Living Wage and also highlight the range of benefits associated with working in adult social care
- Support and value staff and invest in their ongoing professional development
- Build a local reputation of being a good employer
- Be honest about what the job entails.

Taking on the right people

- Find staff with the right values and behaviour, as skills can be taught
- Willing to learn and life experience can be as important as previous work experience
- Use of taster shifts
- Adoption of value based interviews.

Developing talent and skills

- Use external funding that is available to help with investment in staff skills
- Become more adept at identifying learning and development needs
- Wider use of mentoring and buddying.

Keeping your people

- Respect and value staff, investing in learning and development
- Involve staff in decision making
- Pay competitively
- Flexibility around work hours and shifts
- Ensure that staff are mentally and physically fit for work
- Measure staff satisfaction.

Kings Fund and Nuffield Trust (2016) Social care for older people - Home truths
https://www.nuffieldtrust.org.uk/files/2017-01/social-care-older-people-web-final.pdf

This report focuses on services for people over 65 years of age. It has four key lines of enquiry: the response of local authorities to the pressures that they face; the impact upon the social care market; the impact upon the NHS; and the impact upon the quality and sustainability of services for older people.

The report suggests that the combination of low pay, low levels of skills and training and increased difficulties around recruitment mean that the quality of care being provided, at a time when there is rising need, is in doubt.

The report identifies a number of issues relating to workforce planning, as follows:

- Problems with recruitment and retention of staff in residential and nursing care homes
- An increased reliance on migrant workers to bridge gaps
- Competition with the NHS for nursing staff, with the social care offering lower pay and less clear career paths
- Some non-compliance with the minimum wage in some areas of the sector.

Social Care Institute for Excellence (2017) Building the future social care workforce: a scoping study into workforce readiness, recruitment and progression in the social care sector
https://www.scie.org.uk/files/future-of-care/care-workers/building-the-future-social-care-workforce-a-scoping-study-into-workforce-readiness.pdf

The Social Care Institute for Excellence is an improvement and support agency for adults', families' and children's care and support services across the UK.

The report provides an overview of key issues affecting the social care workforce in England, with an in-depth review of the situation in East London.

Recruitment and retention of staff was identified as a key issue. In particular the apparent lack of an obvious and achievable career pathway. A number of examples of innovative practice were identified, as follows:

- The 'I Care Ambassador' programme that was launched by Skills for Care in 2014. This programme recruits staff working in social care roles as sector 'ambassadors' and supports them in promoting and publicising social care work as a viable employment option. Take up of this programme is highest in the North West and South West.

- The 'Getting Started Collaborative' in Northern Ireland. This pilot project gave unemployed people the opportunity to participate in values-based training to become support workers for people with a learning disability. There was then the opportunity to achieve qualifications and then apply for a job.

- The 'Timewise' approach, also known as compatible flexibility', promotes open and honest discussions with employees and potential employees about their non-work commitments and responsibilities. In that way, flexible working patterns that benefit both the employer and employee can be negotiated.

- The 'Supercarers' scheme aims to empower families and give them choice and control over who comes into their home. The Supercarer team match clients and carers and arrange for them to meet before they are confirmed in role.

- The large, independent care provider HC-One has created a new role called a nursing assistant that sits between a senior carer and a qualified nurse. This helped improve quality of care by reducing the use of agency nurses, up-skilling existing staff and providing career progression.

Anecdotal evidence cited in the report suggested that ongoing professional development was often used by social care staff to skill them up to the point where they could work in the NHS.

The main recommendations of the report are:

- Local, regional and national initiatives and campaigns are undertaken to change the public perception of the social care sector

- Greater use of apprenticeships and similar schemes to increase the number of young people entering the social care sector
- Use of pre-employment training, in conjunction with JobCentre Plus, to encourage people who are unemployed to take up roles in the social care sector
- Greater flexibility of shifts and rotas to enable people with non-work commitments to manage their time effectively.

Health

NHS England (2017) Next steps on the NHS Five Year Forward View
https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

The section on 'Strengthening our Workforce' refers to the workforce pressures in the NHS that have arisen from pay restraint, increasing numbers of patients and the complexity of their health needs and the uncertain impact of the UK exit from the EU. It also highlights the geographic variations in recruitment and retention.

A number of key improvements are highlighted for 2017/18 and 2018/19, including:

- An increase in the number of registered nurses of at least 6,000 to be achieved through: an expansion of the education and training programmes; reducing turnover; encouraging nurses back into practice; a fast track programme for mental health and learning disability nursing; development of Advanced Clinical Practice nurse roles; and more effective management of rotas.

- An increase in the overall medical workforce to be achieved through: an expansion of undergraduate medical training and GP training; tackling the pressures on junior doctors in training; and address specific shortages in Emergency Medicine, Endoscopists, Ultrasonography, Radiology.

- A stronger focus upon staff health and wellbeing.

Health Education England (2016) Workforce Plan for England
https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%20180516_0.pdf

Health Education England is an NHS body that is responsible for the education, training and workforce planning for all NHS staff. Health Education England work in partnership across Yorkshire and the Humber through the Local Workforce Action Boards.

The NHS England Five Year Forward View (2014) has identified a number of priority areas for improvement that Health Education England will support through focussed workforce planning and delivery. These are: Primary Care; Mental Health; Maternity; Cancer; Prevention; Health and Care Integration; Urgent and Emergency Care; and Seven Day Services.

The Workforce Action Boards have identified the following as priority areas: Nursing; Emergency Medicine; Paramedics; General Practice.

Safe staffing policies and guidance, introduced as a result of the Francis report (2013) into the failings at the Mid Staffordshire Foundation Trust, have increased the demand for nursing staff. Another significant driver in demand has been the increase in hospital attendances.

Many of the workforce shortages that have been experienced and which are predicted could be overcome through the development of a multi-professional workforce, better use of technology, and through organisational changes to the NHS primary care system. Best practice examples of new ways of working piloted in the various Vanguard programmes will need to be rapidly upscaled and applied across the NHS and social care.

The retention of existing GPs is being addressed by the NHS England, the Royal College of General Practitioners and the British Medical Association through the '10 Point Action Plan'.

Around 400 pharmacists are being recruited to work in general practices to provide clinical consultations that enable patients, particularly those with long term conditions, to optimise medicines use.

Carter Review (2015) identified significant variation in costs and practice which, if addressed, could save the NHS £5 billion each year by 2020 to 2021. Of these savings up to £2bn comes from the workforce budget, through: better use of clinical staff; reducing agency spend and absenteeism; adopting good people management practices.

Forecasts of future supply suggest that more people are being trained and entering the NHS system than are leaving the system in every profession. This includes people leaving NHS employment to work in the independent and care sectors.

NHS Provider forecast increases in workforce demand 2015 to 2020 suggest that there will be an increase in demand for nursing roles of 16,860 or 4.9% and an increase in demand for Allied Health Professionals of 5,946 or 7.1%.

The medical workforce divides into more than 60 specialties.

Health Education England views the Sustainability and Transformation Partnerships as key vehicles for the creation of a shared, local view on the shape, size, and characteristics of the workforce required to deliver NHS services in the future.

The NHS electronic staff record is not used consistently or to its optimum. This then reduces the quality and the impact of the data that is collected. This creates a barrier to identifying, diagnosing, and solving shortage problems.

See also the Health Education England (2016) Yorkshire and the Humber Delivery Plan 2016/17
https://hee.nhs.uk/hee-your-area/yorkshire-humber/about-us/delivery-plan

King's Fund Rachael Addicott et al. (2015) Workforce planning in the NHS
https://www.kingsfund.org.uk/publications/workforce-planning-nhs

- The NHS workforce is estimated to be 1.4 million people and accounts for around 70% recurring NHS provider costs.

- There are substantial gaps in the available data on workforce numbers, measures of demand and workload, and estimates of the workforce numbers required to address this demand. These gaps are particularly acute in the following areas: primary and community care; agency and bank staff; vacancy rates; and independent and voluntary sector providers.

- Although Health Education England is responsible for training the workforce of the future, day-to-day workforce issues are responded to by individual employers. Decisions made about the current workforce will impact upon the workforce needs in the future. The link between individual employers and Health Education England is not always made.

NHS Improvement (2016) Evidence from NHS Improvement on clinical staff shortages – a workforce analysis
https://improvement.nhs.uk/uploads/documents/Clinical_workforce_report.pdf

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. It offers support to these frontline providers to ensure that they give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

The key points from the report are as summarised as below:

- The increased demand for nursing staff that resulted from the Francis Inquiry Report on the Mid Staffordshire NHS Foundation Trust, has been partially offset by recent productivity improvements across the NHS

- The focus of NHS Improvement workforce initiatives is upon: supporting providers on workforce planning and improving co-ordination at a national level; building on the work of the Carter Review to improve provider productivity; and reducing providers' agency costs.

- The supply of UK trained nurses is slow to respond to changes in demand. International recruitment has helped to fill emergent gaps, as has the use of agency nurses. In 2015/16, agency nursing accounted for 31% of total spending on clinical agency staff by all NHS foundation trusts.

- There has been an expansion in the consultant workforce over the past 10 years but there are shortages in key specialities, including: emergency medicine; acute general practice; diagnostic services; and psychiatry.

- Do more to ensure that the existing NHS workforce is being used effectively, taking into account the recommendations in the Carter Review.

British Medical Association (2015) Building the Workforce – the New Deal for General Practice
https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-current-issues/workforce-10-point-plan

NHS England, Health Education England, Royal College of General Practitioners and the British Medical Association worked together to produce a 10 point plan to address workforce planning in general practice, as below:

- Promote careers in general practice
- Improve the breadth of training
- Training hubs for primary care staff
- Incentives for GP trainees
- Investment in retainer schemes
- Incentives to remain in practice
- New ways of working to support general practice
- New induction and returner scheme
- Investment and incentives to attract GPs back into practice.

General

Reform (February 2017) Work in progress - Towards a leaner, smarter public-sector workforce, Alexander Hitchcock et al.
http://www.reform.uk/wp-content/uploads/2017/02/Reform-Work-in-progress-report.pdf
Reform is an independent, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity.

The report outlines the problems currently facing people trying to develop a public sector workforce that is fit to meet future public service needs, whilst also suggesting ways in which workforce planning could change. The key issues arising from the report are summarised below:

- There are too many administrative posts in the public sector. For example, in primary care there is estimated to be 10 receptionists for every 14 clinicians and almost one receptionist for each GP. In secondary care about 18% of the workforce are in administrative roles.

- A leaner workforce could be achieved through a flattening of existing hierarchies and the greater use of technology. For example, one GP has a clinician-to-receptionist ratio of 5:1. If this ratio were applied across the NHS as a whole, then there could be a potential reduction of 24,000 roles across the NHS (based upon 2015 workforce statistics).

- A number of clinical roles could also be automated. The report refers to work done by McKinsey which estimated that 30 per cent of nurses' activities could be automated and a similar proportion of doctors' activities could also be automated (in some specialisms but not all). This would then free up clinical capacity.

- The greater use of apprenticeships is identified as providing a more skilled and diverse public-sector workforce, reducing levels of over-qualification and offering better value for money.

Lord Carter of Coles (2016) Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

The review looked at productivity and efficiency in English non-specialist acute hospitals. It found that there was significant unwarranted variation in productivity and efficiency across all of the main resource areas. The report estimated that the variation was worth £5bn in terms of efficiency opportunity.

Variations included:

- Inpatient treatment ranging from £3,150 to £3,850 (a 20% variation)
- Care provided by registered nurses and health care support workers per patient day ranging from 6.33 to 15.48 hours
- Deep wound infection rates for primary hip and knee replacements ranging from 0.5% to 4%
- Costs of pathology services as a percentage of operating expenditure ranging from 1.1% to 2.4%.

In terms of workforce, the focus of the report is upon making better use of the existing workforce through initiatives and approaches.

For nursing:

- Adoption of Care Hours per Patient Day metric as the standard means by which nursing and care staff deployment is measured
- Use of e-rostering systems
- Standardised approach to the management of enhanced care demands.

Section 3 – Organisations giving evidence

At the Task and Finish Group meetings on 7 September 2017 and 11 October 2017, a number of organisations gave evidence. A summary of the responses received and presentations given are as below:

Cath McCarty, Health and Adult Services, North Yorkshire County Council and Liz Beavan, Human Resources and Organisational Development, North Yorkshire County Council

- National shortages in social care staff are due to increasing demand for social care for older people, the social care role being poorly perceived, perceived lack of career progression, pay rates being low, a rising cost of living, competition with other sectors (hospitality and retail), difficulties in retaining staff, shortages of affordable housing and falling levels of unemployment.
- The importance of social care work has been acknowledged nationally but it will always be in competition with nursing.
- National organisations tend to provide strategic direction. Local authorities are expected to lead the work on social care workforce planning.
- There are not large numbers of EU workers in social care. In Harrogate and Selby, however, restrictions on EU workers in hospitality and retail may increase the pressure on social care as more UK workers are drawn into that occupation, as opposed to social care.

- There are low levels of unemployment, particularly amongst young people and young adults.
- The age profile of the social care workforce is relatively high at present, with 70% of the existing workforce due to retire in the next 20 years.
- Average hourly pay rates for entry level care roles in North Yorkshire in 2017 ranged from £7.84 to £9.03. The NYCC average hourly pay rate is £7.97. However, this does not take into account the full range of benefits associated with working with a local authority.
- There could be opportunities to encourage recent retirees to work in social care.
- There is a drive to attract young people and young adults into social care, with work already underway.
- People on Job Seekers Allowance can do 16 hours of work per week. Could more be done to encourage people on JSA to take on part time social care work?
- There are areas of the county where packages of care could be more easily provided if workers could be recruited locally or if workers could be transported to the work.
- People could be encouraged to become self-employed social care workers and provided services to those people in the community who received Direct Payments for their social care.
- Men and young people are currently underrepresented in the social care workforce both nationally and locally.
- Social care work can be flexible as it tends to involve working shifts. As such, it may be attractive to students and young people, who could 'earn while they learn'.
- The implementation of the Living Wage and Workplace Pensions will only increase the pay baseline for all employers. It won't necessarily lead to a surge in recruitment into social care.
- Schools and Higher Education (HE) providers all have a role to play in promoting social care as a viable career.
- NYCC has linked with HE providers on work experience in social care but with mixed results.
- The Make Care Matter website (www.makecarematter.co.uk) has been developed by NYCC with partners which includes sector-wide material such as employment opportunities, career progression routes, staff case studies and blog posts, a student hub and positive news stories. Users will be signposted from existing campaigns and initiatives including roadshows, careers fairs, open days and social media activity.

Dr Lincoln Sargeant, Health and Adult Services, North Yorkshire County Council and Chris Sharp, Public Health England

- The public health workforce is far larger than just people who have a formal public health qualification. Many different people can have an impact upon promoting health and wellbeing and helping to prevent diseases with some support from public health practitioners. The 'Make Every Contact Count' approach embodies this.
- Whilst public health training is a core part of curriculum for doctors, nurses and many allied health care professions, it is often not maintained after the initial training.

- The public health consultant capacity in the county has decreased since the move of public health from the NHS to the local authority. The consultants now work over a much larger footprint.
- As in other areas of health, it can be very difficult to find enough learning placements to support training and ongoing professional development.
- The reduction in the number of environmental health officers in district councils and also changes to their roles and responsibilities creates a gap in public health delivery.
- Work is underway to raise awareness of the public health role and the career that can be had.
- There needs to be a focus on creating a new, integrated workforce that can support people in the community and manage health conditions outside of the hospital setting.

Chris Mannion, Associate Director, Workforce Transformation (West Yorkshire and Harrogate Local Workforce Action Board) and Dr David Eadington, Deputy Dean in Health Education England and a Consultant at Scarborough Hospital

- Shortages in permanent staff mean that employers fill gaps with agency, locum and other temporary staff. This creates additional expense and is inefficient.
- The reliance upon locums and employment agencies to provide the staff needed to continue to offer a safe and effective service. NHS Improvement (regulator) has been working with Trusts to help reduce their agency costs, with some success.
- Jobs and careers in the NHS are not promoted as effectively as they could be. There are a broad range of interesting and well paid roles that people could do but which are not well publicised. Such as, Operating Department Practitioners.
- The delivery of health training has become more complex, with a number of larger (hospital) providers offering their own schemes with a variety of incentives and tie-ins.
- Local Workforce Action Boards have a key role to play in trying to co-ordinate training activity across their area.
- Any expansion of healthcare training is dependent upon clinical placement capacity.
- Most medical specialisms have a long production time. Of recent medical school graduates, only about 50% are moving into training immediately – young doctors are seeking more flexibility in how they plan their career. Many take career breaks and time out. Most return to training within the next two years. Tracking of GMC numbers suggests that 5% do not come back. Their destination is unknown but most are probably still working in health, but not in a training pathway.
- At present in the North, there is particularly low take up in General Practice, Psychiatry, Medicine, and growing difficulty in Paediatrics. The current focus of the government is upon recruitment and retention of GPs.
- Often newly qualified GPs are working as locums rather than joining a practice as a permanent GP. An increasing number of GPs are saying that they are planning to retire early, which means that there are pressures at both ends of the pipeline, less GPs coming in and more leaving.
- Encouraging and supporting NHS staff to retire 2 to 3 years later than planned may help bridge some of the shorter term gaps in workforce.

- Newly qualified medical staff, such as GPs or pharmacists, often stay near where they trained or head to larger urban areas. It can be difficult to attract them to rural areas, areas with higher level of deprivation and smaller hospitals and practices.
- For GPs there are financial incentives that may help with recruitment and retention in rural areas.
- The creation of local training is seen as a way of increasing recruitment and retention. The Coventry University Scarborough Campus is commencing local nurse training.
- The further you are away from the A1/M corridor, the less attractive a place is to work in for junior doctors, as a general rule of thumb. Also, difficulty recruiting medical trainees becomes more acute as you go north of Nottingham.
- More work could be done to encourage all NHS employers to share good and best practice around recruitment, retention and the development of new roles.
- The challenge is to reshape the workforce, changing the skills mix and developing new roles that reduce the dependence on traditional and hard to fill roles, such as GPs. For example, advanced clinical practitioner roles and nurse associates. Although, skilling up existing nurses to take on more specialist or technical roles means that there are less people to do the day to day patient care on hospital wards.
- There is also a need to increase recruitment to Bands 1 to 4 and to improve training for these staff. Apprenticeships may help here. The government levy creates a strong financial incentive to make apprenticeships work.
- The long term impact that the end of student bursaries for many health professions and the introduction of a repayable loan will have is uncertain. Early indications are that it may be deterrent, particularly for mature students changing their career and people from less affluent backgrounds.
- The impact of the UK Exit from the EU is uncertain at this stage. Whilst a significant number of nursing staff come from the EU, most non-UK consultants come from outside of the EU.
- More could be done to maximise the UK workforce and reduce the reliance on overseas workers.
- The lesson that has been learnt from previous attempts at long term workforce planning is to not make any radical changes. There are simply too many variables and too many events that are unforeseen to accurately predict future demand for all specialisms.
- There are currently 26,000 more clinicians in the NHS compared to 5 years ago. However, there are still workforce gaps because during the same period it is estimated that the number of established posts that the NHS wants to fill grew by 62,000.
- All NHS providers contribute data on workforce to HEE and LWABs but this can be incomplete, difficult to access and sometimes not informative.
- Some of the Royal Colleges are moving towards a more multi-professional view of the workforce and are working in new ways through the Academy of Medical Royal Colleges, rather than uni-professionally.
- Alignment of roles and consistent pay banding across NHS providers may help reduce competition.
- NHS providers are being encouraged to look for ways to enable their staff to access work in different providers. This would be cheaper and more effective than using locums and agency staff.

- NHS provider exit interviews could be improved. Need to understand why people are leaving and make changes accordingly.

Pete Summerfield, Yorkshire Ambulance Service, Locality Manager, North Yorkshire Dales

- Retention initiatives tend to focus upon training and development opportunities that offer career progression and make the job more interesting. For example Emergency Care Assistants wishing to progress their career and qualify as Paramedics.
- In the North Yorkshire part of YAS, there is currently a full complement of A&E Operations staff (Paramedics and Emergency Care Assistants). However, staff can be attracted away from rural areas, like the Upper Dales, to urban areas, like Leeds, due to the increased number and type of calls that they will deal with and the related opportunities for career development. This is attrition within YAS.
- There are a number of private health providers, who use qualified paramedic staff in GP surgeries and for Out of Hours services in neighbouring areas (Sunderland, Durham, North Tees, and Darlington), who attract staff away from YAS with seemingly better terms and conditions. However, a large proportion come back to YAS, over time (two thirds).
- Military paramedics at Catterick Garrison work with YAS locally to maintain and develop their skills and expertise. This increases the number of people available for a rota. Some also stay with YAS when they leave the military.
- YAS promote flexible working and do their upmost to enable staff to have a work/life balance. This helps with retention and fosters good will.
- Noted that advanced and different skills are needed to work with a patient on the longer ambulance journeys that you have in rural areas. This may help make some of the rural work more attractive.
- Rotation of staff through different clinical settings can help with training and development and also retention. This risk is, however, that these more highly skilled workers become attractive to other employers.

Janet Probert, Hambleton, Richmondshire and Whitby Clinical Commissioning Group

- The CCGs have a strategic role to play, as health commissioners, in workforce planning.
- Increasingly, decisions about where people receive the care and interventions that they need are being influenced by workforce pressures and shortages.
- Workforce planning over anything but the short term is extremely difficult as there are a number of variables that are very difficult to predict. For example, technological innovations, developments in pharmacology, behaviour of leading pharmaceutical companies, changes in disease profiles, increases in survivability, the state of the economy and political changes. As such, the projected needs identified at Day 1 and the consequential changes to workforce training and recruitment over the next 5 to 10 years is often wrong.
- Medical training now has high levels of specialisation. Whilst this can help improve patient outcomes, it also creates difficulties as more staff are needed to cover all of the specialisms. This is particularly problematic in smaller hospitals, like the Friarage in Northallerton. For example, increasing specialisation in anaesthesia has meant that instead of one anaesthetist being able to cover all

medical events, specialist anaesthetists are required to work in Accident and Emergency, Intensive Care and High Dependency, and Operating Theatres.

- Instead of trying to recruit and fill existing gaps, a more sustainable and effective response is to consolidate specialist roles, interventions and treatments in a small number of sites. The creation of specialist trauma centres has led to a 50% increase in survival rates.
- There are a wide range of different agencies and organisations, commissioners and providers engaged in workforce planning. They do not always have a system-wide view of what actions are required, as they have pressing workforce issues of their own to solve in the short term.
- Gains could be made by health and social care through a new way of working with frail elderly people. Frail elderly people are best looked after in the community and not in hospital. Ending the dependence on hospital services would help release capacity in the hospital workforce and improve outcomes for frail elderly people.
- Public expectations need to be managed. People want every site to have every service with all the specialist staff that would be needed to sustain those services. This is no longer viable.

Wendy Nichols, Unison

- Social care has one of the highest levels of staff turnover in the whole economy. Therefore, need to focus upon retention.
- Lack of support, training and low pay can impact upon retention and the quality of care that people are able to give.
- The adoption of the Ethical Care Charter by Local Authorities is seen as key. The Charter is a set of commitments that councils make which fix minimum standards that will protect the dignity and quality of life for those people and the workers who care for them.
- The adoption of the Residential Care Charter by care providers also seen as key. The Charter sets out the minimum standards and employment conditions required to deliver decent care. Employment levels, pay, conditions and training directly impact the quality of care.
- Social care is always in competition for staff with other occupations, which often pay better and are perceived as having better terms and conditions, like catering, hospitality and retail.
- Lifting the public sector pay cap will have a negative impact upon the NHS and local authorities unless additional funding is given to pay it. If it comes from existing funding streams, then it will impact upon care.

Maureen Goddard, Bradford District and Craven – Health and Care Integrated Workforce Partnership

In Bradford District and Craven, workforce partnership at a system wide level is conducted through the Integrated Workforce Programme (IWP). The IWP is an overarching and enabling programme that aims to work collaboratively to identify and work towards developing a system wide integrated workforce that is fit for the future.

The IWP workforce strategy has been co-created and co-designed by partners within and across the health and care system. It brings together the common challenges, key priorities, good practice and potential workforce solutions from a wide range of

health and care sectors and patient pathways. The strategy, which has been shaped, tested and refined over time by a wide range of stakeholders, has four delivery programmes focused on:

1. attracting and recruiting people to the health and care system (particularly developing the concept of 'growing our own')
2. developing the health and care workforce together
3. retaining people in the system
4. working to a shared culture of integration.

As an example of taking of taking a longer term approach to our shared workforce challenges, a key piece of work within work programme 1 has been in developing a health and care Industrial Centre of Excellence (ICE). This builds on the four ICE programmes that were already being delivered across Bradford District (ie Business and Finance, Science & Environmental Technologies, Advanced Manufacturing and Engineering and the Built Environment). An ICE provides industry led programmes for 14-16 year olds who want to learn skills, gain experience and develop a career in a particular sector.

The development of a health and care ICE in the Bradford District aims to build strong and lasting partnerships between employers, schools, colleges and universities; creating career pathways that will transform the way young people think about working in health and care and developing the skills required by in the system.

The ICE programme will provide a platform for apprenticeships, routes into further and higher education and professional training within and across the local health and social care system.

Other key pieces of work include developing and agreeing common competences and quality standards, particularly within statutory and mandatory training; delivering joint leadership programmes and developing an agreed and shared set of values for integrated working.

Will Thornton, Workforce Utilisation, York Teaching Hospital NHS Foundation Trust

Workforce planning takes place at departmental and Trust level, and informs the Local Workforce Action Board for the Humber Coast and Vale region (Sustainability and Transformation Partnership) and workforce planning by NHS England.

Like in many NHS organisations, attention in the Trust has focussed on workforce planning and redesign to mitigate shortages in the supply of doctors and registered nurses. There are also recommendations from the Carter Review into productivity in NHS Hospitals which will impact the future make-up of our workforce.

A forecast of workforce shortages in nursing, based on current rates of turnover, hiring and forecasted retirements, has indicated that by 2024 the Trust could have a workforce gap of 735 full-time equivalent staff.

To address shortages, the Trust is taking a number of actions, including:

1. Recruitment programmes, including open events, attendance at university events, rolling advertisements and digital marketing
2. Retention initiatives (e.g. re-opened the Associate Specialist grade to Middle Grade doctors and signed SAS Charter to uplift annual leave entitlement for this grade)
3. Development of new roles and programmes (e.g. Senior Foundation Doctor – Trust Grade (F3), rotational programmes to allow nurses to work across different specialties)
4. Increasing numbers of trained Advanced Clinical Practitioners and Nursing Associates, to enable the re-allocation of work and allow a smaller number of doctors and registered nurses to concentrate on tasks commensurate with their training and registration.

Simon Cox, Scarborough and Ryedale Clinical Commissioning Group

There are just over 100 GPs in practices in the Clinical Commissioning Group (CCG) with about 70 whole time equivalent posts. There are currently 12 vacancies with several posts being vacant for more than 2 years. A recent survey of GPs in practices in the CCG found that in the next five years 21% of GPs intend to retire. The CCG has been working to deliver our General Practice Forward View plan which includes workforce development.

The CCG has supported the national plan to recruit international GPs and is working across Humber, Coast and Vale Sustainability and Transformation Partnership (STP) CCGs with NHSE and has engaged a recruitment agency to work with local clinicians to finalise recruitment, induction and training plans.

The CCG has worked closely with Coventry University Scarborough Campus to bring nurse training back to Scarborough after a gap of over 20 years for local people having an opportunity to take up a nursing career with local training offered. It is hoped that the first intake of student nurses will be in February 2018. All GP practices now have nurse mentors and all students will have placements in local general practices which has not always been the case in previous years.

Locally, the CCG has been working with practices over the last 3 years to develop the primary care workforce and introduced new roles to support the GPs. In two practices we have paramedics who are seeing patients at home and in nine practices we have pharmacists to provide medicines management advice to patients. This is in addition to Advanced Nurse Practitioners who see patients with minor injuries and minor ailments and are able to prescribe medicines.

Section 4 - summary of key findings from literature review and evidence from organisations

There are a number of themes that have been identified, as below:

- A high percentage of care workers, 47.8% leave within the first year of work. This high rate of attrition could be reduced through the introduction of: taster sessions and shifts; wider use of mentoring and buddying; increased flexibility around shifts and rotas; and pay incentives.

- There is a reliance upon unpaid carers, often family members with care needs of their own, to provide care for older people. Without this care being provided, local government social care and the NHS would face a significant increase in demand for services. As such, there is a question as to whether more support could be given to carers.

- The UK exit from the EU creates a risk that health and social care workers from the EU who currently work in the UK may leave to return to their home countries, as their immigration status and standing in the community is placed in doubt. In terms of health, the risk is most acute in the hospital setting. In social care, the risk is associated with EU staff leaving the retail and hospitality sectors and those vacant jobs (which may offer better terms and conditions) being filled by people who would have otherwise worked in social care.

- There is a role for national government to promote social care work as a career and put in place measures that aid long term retention of staff. This includes: the development of undergraduate and postgraduate diplomas for social care; national campaigns to raise awareness of what opportunities exist in social care; and targeting and attracting 'non-traditional' workers into social care.

- Social care is in competition for staff with the NHS, as NHS based social care roles are seen as more attractive with better pay, terms and conditions and a more defined career path.

- There are currently 26,000 more clinicians in the NHS compared to 5 years ago. However, there are still workforce gaps because during the same period it is estimated that the number of established posts that the NHS wants to fill grew by 62,000.

- The ability of Health Education England to address workforce issues is dependent on cooperation of other health and care organisations including NHS Foundation Trusts, GP providers, the 3rd sector and the private sector.

- The NHS has over 60 different medical specialties. Increased specialisation has improved quality and patient outcomes, but the reduced commitment to generalism that has come in parallel has created operational difficulties – effects of this are most difficult to mitigate in smaller hospitals, which can only recruit to the mainstream secondary care specialties.

- There may be scope for a fresh look at key roles (which are difficult to recruit to) across health and social care to see whether there is scope create new, integrated roles, such as such as care navigators, social prescribers, physician associates, and pharmacy assistants.

- There could be opportunities for aspects of an existing role to be delegated to another professional. For example, elements of a GPs current role could be performed by a nurse practitioner, a paramedic and a community pharmacist.

- Future workforce needs, in 5, 10 and 15 years' time, are not yet clear.

- The NHS staff record is not fully utilised, which makes it difficult for Health Education England and the Local Workforce Action Boards to access the data that they need to identify and respond to current and future workforce shortages.

- The Sustainability and Transformation Partnerships that cover North Yorkshire (x3) are providing leadership on NHS workforce planning, largely through the Local Workforce Action Boards. Whilst local authorities are engaged in the discussions, the focus appears to be upon addressing shortages in staffing in NHS provided care.

- The use of agency medical staff is a significant cost burden upon the NHS. NHS Improvement, which oversees NHS providers, is working to drive this expense down. If the workforce shortages that have led to the use of agency staff cannot be addressed, then workforce shortages are likely to become a more significant factor in discussions about some service reconfigurations.

- The Carter Review identified that there was a significant variation in productivity across similar NHS services, which if reduced would release significant savings that could then be used elsewhere in the system.

- Apprenticeships and schemes aimed at the long term unemployed can help increase recruitment into social care work. Taster sessions and mentoring and support can help retain workers past the first 12 months.

- Any expansion of health, social care and public health training is dependent upon the availability of placements and mentors/supervisors.

- Medical technology (use of remote diagnosis and prescribing) has not developed at sufficient pace to make a significant difference to the way in which services are offered.

- Alignment of roles and pay across NHS providers may help reduce the competition for specialisms and the inflation for market rates as providers attempt to out-bid each other.

- NHS providers could be encouraged to: share their staff more, using a bank system where additional shifts could be offered by those providers facing staff shortages; improve the quality of workforce data; to share best practice around recruitment, retention and the development of new roles.

- People do not always enter the health and social care system at the right point. Evidence suggest that 1/3 of people who go to see a GP could have gone elsewhere for treatment.

- Public health work and ‘Make Every Contact Count’ offers an opportunity for a broad range of agencies and personnel to promote healthy lifestyles and preventative work, reducing the need for more complex and expensive social and medical interventions further down the line. This then can reduce the burden upon medical services and staffing.

- Gains could be made by health and social care through a new way of working with frail elderly people.

Section 5 – Recommendations

Recommendations

In making these recommendations, it is recognised that there is already a great deal of work underway and that long term planning of the health and social care workforce is often impeded by the need to respond to immediate shortages in staff that threaten the sustainability of services. Without a move away from traditional roles and traditional workforce training, however, the problems that are currently being experienced will only worsen.

National

1. The committees write to HM government to request that measures are put in place as quickly as possible that help ensure that existing workers from the EU in health and social care roles are not disadvantaged in any way by the UK exit from the EU.

2. The committees write to HM government to request a review of the financial support that is offered to people seeking training in health and social care. In particular, consider reinstating bursaries for nursing, midwifery and allied health professionals training.

3. The committees to write to HM Government to request that additional funding is made available to the NHS and local authorities to enable increases in pay rates to be met, when and if the public sector pay cap is lifted, without the need to find money from within existing budgets.

4. The LGA and ADASS to work with HM Government to promote social care work as a career, support structured training and development and put in place measures that aid long term retention of staff.

Sustainability and Transformation Partnerships (x3)

1. The NHS and local authorities (through the Local Workforce Action Boards) to increase the number of integrated health, social care and public health professional roles in the community, attached to a GP practice or similar community hub, which enable a more efficient use of the existing workforce, avoid duplication of roles and release capacity in some of the more difficult to recruit to roles.

2. The NHS and local authorities (through the Local Workforce Action Boards) to look at new ways of working with frail elderly people that reduce hospital admissions and provide integrated support in the community.

3. NHS providers to work together through the Local Workforce Action Boards to: encourage workforce mobility; improve the quality of workforce data provided to Health Education England (NHS staff record), including the greater and consistent use of exit interviews; and to share best practice around recruitment, retention and the development of new roles.

4. Health Education England and the Local Workforce Action Boards to work with local authority public health services and Public Health England to promote public health interventions by a wider workforce of associated practitioners and workers.

5. Health Education England, the Local Workforce Action Boards and the County Council to support the ongoing development of local medical training, through educational institutions in Yorkshire and Humber, such as the Coventry University Scarborough Campus and the Hull York Medical School.

6. Health Education England and the Local Workforce Action Boards to explore whether more could be done to promote and develop the self-employed social and health care workforce that provides services to people in the community who receive Direct Payments for their health and social care.

County

1. The County Council to continue to promote social care careers to a broad-base of non-traditional workers, such as: retirees; young people; students; men; ex-military; long term unemployed; and people on Job Seekers Allowance or Universal Credit.

2. The CCGs and the County Council to work together to promote a greater understanding and awareness of where people should go to get the health and social care interventions that they need. Also, to work with other community services, such as community pharmacies, to ensure that there is capacity to cope with any resulting increase in demand for their services.

3. The CCGs and the County Council to review the findings of local and regional Vanguard programmes to see what lessons can be learned and applied.

4. The CCGs and the County Council to work together to explore technological solutions that help reduce the demand upon health and social care services (diagnostic tools and remote prescribing and consultations), support flexible working (e-rostering) and increase automation.

Ongoing monitoring

There are also a number of areas in which impact monitoring is suggested:

1. Monitor the impact of the emergent shortage in clinical, social care and public health placement capacity upon training and development
2. Monitor the local impact of the end of student bursaries for nursing, midwifery and allied health professionals
3. Monitor the local impact of the UK exit from the EU upon the health and social care workforce.

Acknowledgements

In addition to the County Councillors from the Scrutiny of Health Committee and the Care and Independence Overview and Scrutiny Committee who worked together on the joint scrutiny task and finish group, I would like to thank all those people who contributed to this piece of work:

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- Liz Beavan, Human Resources and Organisational Development, North Yorkshire County Council
- Dr Lincoln Sargeant, Health and Adult Services, North Yorkshire County Council
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- Mark Inman, Leaf Mobbs and Pete Summerfield, Yorkshire Ambulance Service
- Chris Mannion, Associate Director, Workforce Transformation (West Yorkshire and Harrogate Local Workforce Action Board)
- Dr David Eadington, Deputy Dean in Health Education England and a Consultant at Scarborough Hospital
- Wendy Nichols, UNISON
- Maureen Goddard, Bradford District and Craven Integrated Workforce Programme
- Will Thornton, Workforce Utilisation, York Teaching Hospital NHS Foundation Trust
- Jack Davies, Community Pharmacy North Yorkshire
- Simon Cox, Scarborough and Ryedale CCG.

North Yorkshire County Council

Care & Independence Scrutiny Committee

14th December 2017

Annual Report of the Director for Public Health for North Yorkshire 2017

1 Purpose of the Report – Healthy transitions; Growing old in North Yorkshire

i. To present the Annual Report of the Director for Public Health for North Yorkshire 2017, "Healthy transitions; Growing old in North Yorkshire."

ii. C&ISC are asked to receive the report and to consider the actions that members can make to implement the recommendations.

2 Background

2.1 It is the duty of the Director of Public Health (DPH) to write an annual report on the health of the local population. This is my fifth report.

2.2 This year's report describes some of the challenges faced by individuals and communities as they age. It examines services that help and explores opportunities for improving systems across social care, health and wider determinants such as housing. The aspiration is that older people should be recognised as active citizens, not passive recipients of services.

2.3. The report uses information collated from a range of health and social care sources recognising that ageing is a key issue for many partner organisations in North Yorkshire.

2.4 The Main Report is online and can be accessed at

http://hub.datanorthyorkshire.org/dataset/director-of-public-health-annual-report-dphar-2017

3 Executive Summary

3.1 This year's report builds on the two previous years examining life stages by focusing on ageing well and dying well. An initial section describes the ageing population across North Yorkshire.

3.2 The report goes onto explore three transitions through ageing. The first focuses on healthy retirement considering good mental and physical

health as well as financial planning. The second considers need for support as we age using a series of case studies to illustrate the challenges and potential supports. The third transition examines end of life care.

3.3 The recommendations set out key challenges that individuals and the services that support them need to address. The main report will be web-based with a printed executive summary which signposts to the full report.

3.3 For the purpose of the report the older age population are those aged 65 years and over. To illustrate the scale of the challenge in North Yorkshire the report notes that:

- In 2015 there were more people aged 65 and over in North Yorkshire than people aged under 20 (130,000) and as many people aged 75 and over (63,700) as there are children aged under 10 (63,300)
- By 2025 the 65 and over population will rise to over 169,000 (28% of population). This increase will be greatest in those aged over 70, with an expected increase of 44% in the 75-79 age group
- Life expectancy has improved between 2002- 04 and 2012-14 in both males and females. However, the gap between our most and least deprived communities has remained the same (7.7 years) for men and has widened for women (from 4.8 years to 5.5 years)
- Life expectancy at 65 for men was 19.3 years in 2012-14. Of this 10.3 years was free of disability. For women it was 21.7 years with 12.5 free of disability
- There is variation across districts – the largest gap in life expectancy is between men in the most deprived communities in Scarborough (72.5 years) and the least deprived communities in Craven (85.3 years), a gap of 12.8 years (2012-14 data).

3.4 In addition there are groups that are vulnerable and need additional support. These include those living with long term conditions, cancer survivors and people with additional responsibilities such as carers.

3.5 When thinking about the impact of this on North Yorkshire in the future, we can consider how to:-

- promote healthy ageing ensuring the contribution and needs of older people are considered?
- support those wanting to remain part of a productive, growing, thriving economy, sharing lessons with other employers across North Yorkshire?
- demonstrate that we value those who chose to be carers and/or volunteers?
- make retirement planning for wealth, health and wellbeing the norm across North Yorkshire?
- ensure older people are proactively supported when they grow frail?
- promote conversations about end of life care and access to good quality information about available choices?

3.6 This report makes four key recommendations.

4 Summary Annual Report Recommendations – 2017

- **Age-friendly communities**

  As people get older it is important that they live in environments that help them to maintain control over their lives and make a positive contribution to their communities.

  Policies, plans and services should promote healthy ageing by ensuring the contribution and needs of older people are considered, barriers to full participation and inclusion are reduced, and older people feel safe and supported to make choices about their lives.

- **Comprehensive retirement planning**

  Financial security, physical and mental health, and caring commitments are some of the factors that influence the work decisions of people as they get older. Many older people can expect a long period of their lives to be spent "in retirement" and wish to contribute through formal and informal work opportunities after retirement age.

  Employers should facilitate workers to plan comprehensively for retirement including financial planning, ill health prevention, mental and emotional resilience, and social connectedness.

  Employers should consider options that allow workers to manage their transition to retirement and allow "retired" people to maintain formal and informal links with the workplace.

- **Identifying and managing frailty**

  Older people may experience physical and mental decline as they age especially when they have one or more long term conditions. This can affect older people's ability to live independently. However, physical and mental health are not the only factors that influence their ability to function. Social support, health and care services and environmental factors are also important.

  Information should be made available to older people and their carers to help them to identify the factors (physical, mental and social) that predict loss of independence so plans can be made to manage should these arise.

  Health and social care practitioners should develop holistic assessments that focus on functional ability rather than physical or mental frailty. This includes data sharing with appropriate consent between all services dealing with the individual's wellbeing that take full account of their circumstances including

the resources available to help them cope with reduced physical and mental capacity.

- **End of life planning**

  Being able to plan with family and friends about the last stages of life ensures that older people remain in control of the choices that affect them and those they love through the end of their life. This means that they should have access to a wide range of information to plan their end of life wishes.

  Services providing end of life care should to be better coordinated across the County, particularly with regards to sharing patient information and examples of good practice.
  Health and social care practitioners should facilitate discussions with older people and their carers on end of life planning and support them to access information to inform their planning.

  All staff involved in end of life care should receive the appropriate level of training to enable them to provide the best possible quality of care in all locations.

5 Next steps

5.1 The annual report is being widely shared amongst partners with a view to inspiring action.

5.2 Capacity to deliver in the NYCC public health team has been increased with the recent appointment of a Public Health Consultant and Health Improvement Manager to drive this agenda forward.

5.3 We welcome a discussion with C&ISC to gather ideas of how to build on existing good work to deliver the recommendations within Local Government Organisations and with partners.

6 Appendices

6.1 Appendix 1 – Report of the Director of Public Health for North Yorkshire 2016 – final pdf.

Dr Lincoln Sargeant
Director of Public Health for North Yorkshire

14th December 2017

Health and Wellbeing Board
North Yorkshire

Enter

Healthy transitions; Growing old in North Yorkshire

Director of Public Health Annual Report 2017 Executive Summary

Transition 1 From working life to healthy retirement
Transition 2 Increasing need for support
Transition 3 End of Life

North Yorkshire County Council

Introduction

A girl born in the UK in 1917 could expect to live for 57 years. Her twin brother could expect to live for 51 years. One hundred years later, girls can expect to live for 84 years and boys for 80 years. The fact that life expectancy has been increasing steadily over the last century should be celebrated as the triumph of public health. Why then is the reference to an "ageing population" so often seen in negative terms?

In this my 5th annual report, I focus on the older population in North Yorkshire. We examine why the achievement of longer lifespans must be matched by societal changes in our attitudes to older people. The pursuit of ever increasing lifespans can come at the expense of quality of life both from an individual and societal perspective. Accepting that life has a beginning, middle and end, and is lived in a specific social context may help us focus as much on the quality of life as the length of life. The notion of a "good life" may once again inform the aims of public health.

For the first time my main report is published online in an interactive format. There you will find the underpinning intelligence which has informed my recommendations.

This report is structured around three transitions that many of our older residents will experience at different ages and in different ways. The first is moving from work into retirement when in addition to planning for economic security and optimising our health, we should also consider how we stay connected.

The second transition concerns the move from independent living to needing support and care. This transition is not the result of a failure of medical science or preventative medicine but a natural consequence of growing older. Improvements in the delivery of health and social care will help but are not the complete answer. This increased need for care does not diminish the importance of contributions that older people make to the community.

The final transition is preparing for the end of life. There is a sense in which ageing itself is a terminal condition – the official cause of death is merely the mechanism. Living with the end in mind, rather than being morbid, can be liberating for older people and their families who can help prepare each other for this final stage of life.

Please visit the website where the full report is presented in an interactive format. We want to provide a positive experience for readers and give the option to link to other sources of information for those who want to explore topics in greater detail than a print only version would allow.

This includes an update on how we have progressed creating healthy workplaces and building healthy workforces from last year's report.

As always I hope this report is a spark for conversation and action. I look forward to hearing from you and working with you to implement the recommendations I am making this year.

Dr Lincoln Sargeant
September 2017

Who is old in North Yorkshire?

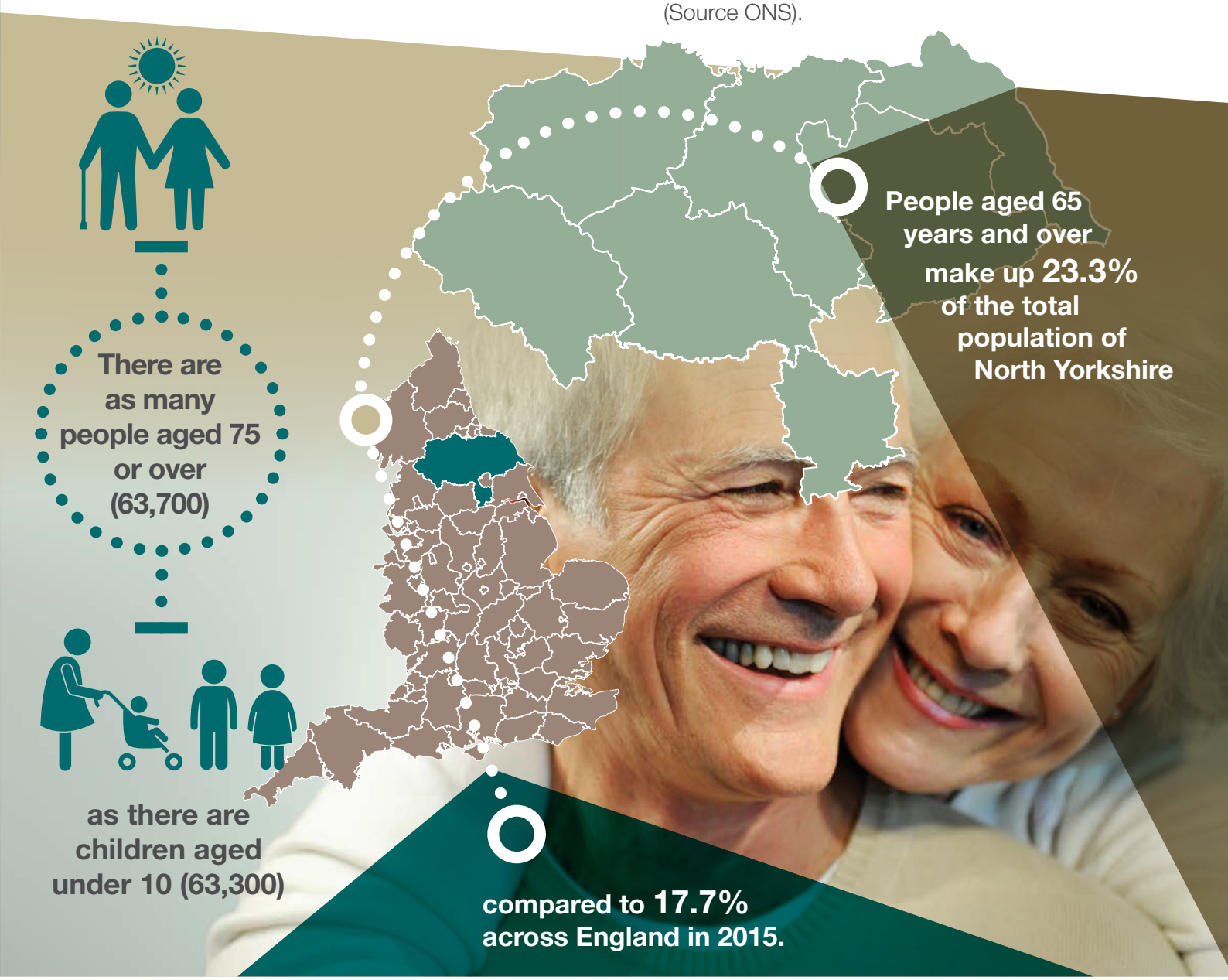
Two thirds of the population growth in North Yorkshire over the last 10 years has been as a result of increased numbers of people aged 65 and over.

In 2015 we had:

- More people aged 65 or over (140,000) in North Yorkshire than aged under 20 (130,000).
- An increase of 27.3% in the older population compared to 2005.
- 54% of the population aged 65 or over are women – rising to 61% among the 80 and over population.

By 2025:

- The 65 and over population will rise to over 169,000 (28% of population).
- This increase will be greatest in those aged over 70, with an expected increase of 44% in the 75-79 age group.
- The proportion of the population aged over 80 is estimated to rise 8% by 2025 (from 6% in 2015). (Source ONS).



Life expectancy

A boy born in North Yorkshire today will live to around 80 years old, of which 66 years will be in good health. A baby girl can be expected to live until around 84 years old, of which almost 67 years will be in good health. This indicates that whilst men and women in North Yorkshire live longer, they also live longer in good health and spend fewer years (and a lower proportion of their lives) in poorer health, compared to the England average.

- Life expectancy has improved between 2002-04 and 2012-14 in both males and females. However, the gap between our most and least deprived communities has remained the same (7.7 years) for men and has widened for women (from 4.8 years to 5.5 years).
- Life expectancy at 65 for men was 19.3 years in 2012-14. Of this 10.3 years was free of disability. For women it was 21.7 years with 12.5yrs free of disability.
- There is variation across districts – the largest gap in life expectancy is between men in the most deprived communities in Scarborough (72.5 years) and the least deprived communities in Craven (85.3 years), a gap of 12.8 years. (2012-14 data).

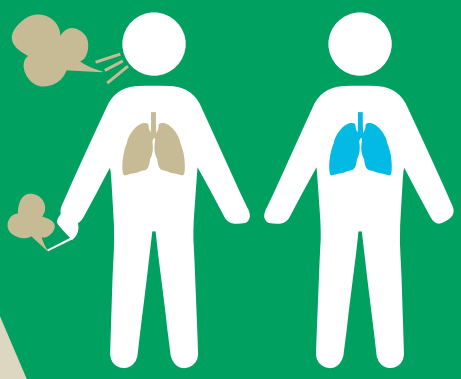
Main causes of death in older people

Among older adults (65 and older), cardiovascular diseases (chronic ischaemic heart disease, heart failure and stroke) are the most common cause of death and account for 32% of deaths. Cancer is the second most common cause of death (25% of deaths). Respiratory conditions accounted for 14% of deaths, whilst dementia accounted for 12% of deaths.

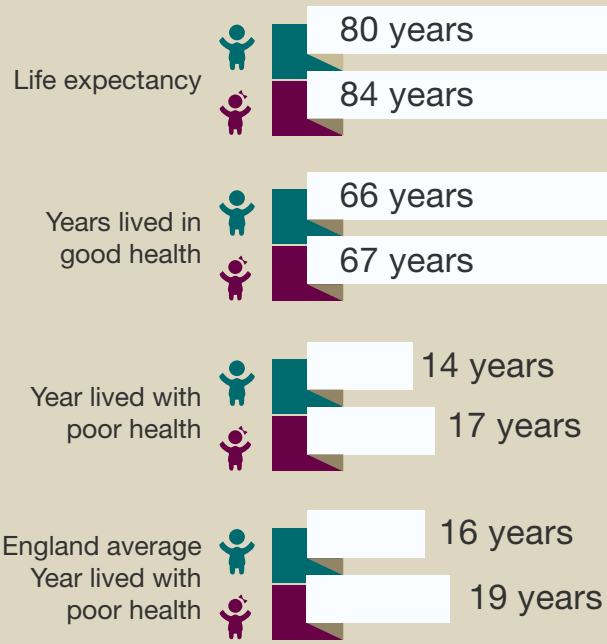
In our very old (over 80) residents, the proportion of deaths attributable to circulatory diseases rises to 34%, followed by cancer (19%) and respiratory diseases (16%). An increasing proportion of deaths are as a result of multiple organ failure and frailty associated with old age.

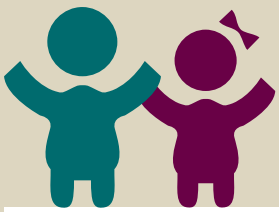
The proportion of deaths attributable to flu or pneumonia in the 65 and over population was 6%, rising to 7% in the over 80 population. (2013-16).

Smokers need social care on average 4 years earlier than non-smokers (ASH 2017).



Born today in North Yorshire





Transition 1 -
From working life to healthy retirement:

Most of us dream about what we will do when we retire. Some plan to spend time with loved ones, seeing children and grandchildren grow up. Others want to travel the world. Some look forward to spending more time on hobbies like cycling, gardening or walking the dog. Some people will continue to work in older age on a full or part-time basis.

To a great extent, having a healthy retirement depends on our choices and behaviours in the years prior to retiring. The full report examines how factors such as what we eat and how active we are affect our health. It also considers good mental health including staying connected to other people by learning, caring and volunteering. In older age more of us are living with one or more long term condition or having survived health concerns such as cancer.

30% of people aged 65 and over were recorded as living in a one person household in 2011.

As a result people play a key role in maintaining their own health by accessing services when necessary.

The report highlights economic wellbeing in older age. Whilst much national press has highlighted the value of the "grey pound" this report notes issues of asset-rich and cash-poor households as well as the inequalities across the population. There is advice for people wishing to plan their financial security, recommending making a will, arranging powers of attorney and guarding against fraud.

It's important to remember that older people make a huge contribution to communities across North Yorkshire by volunteering, being carers, actively participating in society and in many other ways.

See the full report for more on:

- How ageing affects us
- Making healthier choices
- Making best use of health care in old age
- Staying connected
- Financial planning

Transition 2 - Increasing need for support

During 2016/17, 6.6% of the population aged 65 and over in North Yorkshire were in receipt of social care from the council.

Over time most older people will need more support. The rate at which this happens is affected by many factors and support may come from a number of sources. Fundamentally this support must meet the individual's needs whilst maintaining their independence and dignity.

The full report examines issues that may affect older people as they increasingly need support such as safeguarding and fraud, loneliness and social isolation and some common mental and physical health issues. The report also highlights the services such as housing, supportive technology, social care and the Living Well team that are in place to assist them.

North Yorkshire Woman loses 20,000 to fraudsters

Fiona is a 65 year old widowed lady who was defrauded out of 20,000.

North Yorkshire County Council teams, including Trading Standards, Safeguarding and Living Well, have helped her to overcome the stress and anxiety this caused. As her care needs have increased, however, she has moved into an Extra Care Housing scheme where she has settled happily.

Anita phones home

With help from the Living Well team Anita learnt how use Skype. Despite her health problems she now maintains contact with her family more easily.

Legs eleven...

Local bingo enthusiast, Susan, is back playing her favourite game thanks to her befriending service. She also thanked her local hospital for their excellent care for her diabetes and osteoporosis: "If I have a win at the bingo I'll definitely be making them a donation to say thanks!"

With help from his friends Jack's back on track

Jack, who used to be a drinker and has recently been diagnosed with dementia, has taken steps to ensure he can continue to be an active member of his local community. "My friends at the bowls club provide me with transport so that I can continue to go and enjoy myself. Another member helps me with the administration side of my work as social secretary, and I can continue to make suggestions for trips and events."

Marvin's back on his feet

After a fall Marvin, a former engineer, remains an active member of his community with help from local equipment services. He's also benefited from the support of his local falls team who arranged for him to attend an exercise group. Marvin thanked his buddy Jim from the group: "Jim has been great. He's really encouraged me to keep going when I've been a bit tired or worried."

See the full report for more information about the people above and the services that have helped them.

Transition 3 - End of Life

Around 1% of the North Yorkshire population dies each year, with 50% of these dying in their usual place of residence in 2015. The main causes of death in North Yorkshire are cardiovascular disease and cancer.

It is recognised that most (but not all) people would rather die in their usual place of residence. The provision of end of life care has therefore shifted towards a community setting, which is not only preferred by most people but is also more cost-effective than lengthy (and often unnecessary) hospital admissions towards the end of life. The public health approach to end of life care encourages the development of compassionate communities, recognising that all individuals (whether carer, health professional or simply member of the community) have a role to play in caring for people during the last year of their lives.

There remain some areas of end of life care where we need to do better. Services providing end of life care need to be better co-ordinated across the County, particularly with regards to sharing patient information and examples of good practice. All staff involved in end of life care should receive the appropriate level of training to enable them to provide the best possible quality of care in all locations. Finally, it is important to promote and encourage a culture where individuals, carers and staff feel comfortable talking about death, allowing important decisions around end of life preferences to be made in a timely manner.

Recommendations

The aspiration is that older people should be recognised as active citizens, not passive recipients of services.

1. Age-friendly communities

As people get older it is important that they live in environments that help them to maintain control over their lives and make a positive contribution to their communities.

Policies, plans and services should promote healthy ageing by ensuring the contribution and needs of older people are considered, barriers to full participation and inclusion are reduced, and older people feel safe and supported to make choices about their lives.

2. Comprehensive retirement planning

Financial security, physical and mental health, and caring commitments are some of the factors that influence the work decisions of people as they get older. Many older people can expect a long period of their lives to be spent "in retirement" and wish to contribute through formal and informal work opportunities after retirement age.

Employers should facilitate workers to plan comprehensively for retirement including financial planning, ill health prevention, mental and emotional resilience, and social connectedness.

Employers should consider options that allow workers to manage their transition to retirement and allow "retired" people to maintain formal and informal links with the workplace.

3. Identifying and managing frailty

Older people may experience physical and mental decline as they age especially when they have one or more long term conditions. This can affect older people's ability to live independently. However, physical and mental health are not the only factors that influence their ability to function. Social support, health and care services and environmental factors are also important.

Information should be made available to older people and their carers to help them to identify the factors (physical, mental and social) that predict loss of independence so plans can be made to manage should these arise.

Health and social care practitioners should develop holistic assessments that focus on functional ability rather than physical or mental frailty. This includes data sharing with appropriate consent between all services dealing with the individual's wellbeing that take full account of their circumstances including the resources available to help them cope with reduced physical and mental capacity.

4. End of life planning

Being able to plan with family and friends about the last stages of life ensures that older people remain in control of the choices that affect them and those they love through the end of their life. This means that they should have access to a wide range of information to plan their end of life wishes.

Services providing end of life care should to be better co-ordinated across the County, particularly with regards to sharing patient information and examples of good practice.

Health and social care practitioners should facilitate discussions with older people and their carers on end of life planning and support them to access information to inform their planning.

All staff involved in end of life care should receive the appropriate level of training to enable them to provide the best possible quality of care in all locations.

Data quoted in this report correct as at July 2017.

PREVIOUS PAGE

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NORTH YORKSHIRE COUNTY COUNCIL

Care and Independence Overview and Scrutiny Committee

14 December 2017

Work Programme 2017/18

1.0 Purpose of Report

1.1 The Committee has agreed the attached work programme (Appendix 1).

1.2 The report gives Members the opportunity to be updated on work programme items and review the shape of the work ahead.

2.0 Background

2.1 The scope of this Committee is defined as: 'The needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector.'

3.0 Public Health Briefings to Group Spokespersons: 9 November 2017:

3.1 Two public health commissioned providers gave an annual update briefing to your spokespersons at the mid cycle briefing on Thursday 9 November. A number of other members of the committee accepted the invitation to attend.

North Yorkshire Horizons

3.2 North Yorkshire Horizons, which opened on 1st October 2014 is a specialist drug and alcohol service. Individuals who meet the following criteria are eligible for support from the service, in line with national guidelines. Angela Hall from Public health introduced Tracy Edwards from North Yorkshire Horizons (Service Manager for the Recovery and Mentoring Service) and Mark Vidgen (Assistant Director, Treatment Service).

Yorsexualhealth

From April 2013, North Yorkshire County Council became responsible to arrange for the provision of open access sexual health services for everyone present in their area. Two years on, Georgina Wilkinson from Public Health together with Tina Ramsey presented an update on progress.

3.3 As on previous occasions when the committee has talked to commissioners and providers, members have come to some conclusions.

a) They liked how accessible both sets of services are to the community
b) They approved of the strategic approach to substance misuse and sexual health services across North Yorkshire, and note the progress

made by the North Yorkshire Horizons service and Yorsexualhelath during their initial contract term.

4.0 Items emerging out of Mid Cycle Briefing

4.1 Catterick Garrison

4.2 During the above session, the impact of the Catterick Garrison base upon those commissioned public health services repeatedly cropped up during debate. This lead to a wider discussion about scrutiny understanding and assessing how the council's resources are committed to addressing social issues associated with the base. Members asked that a proposal be put to Scrutiny Board about the involvement of the Council in the planning for the expansion, in particular the development of local services and facilities.

4.3 This will go to the next Board meeting on Thursday 15 February 2018. Neil Irving will update on the planned expansion of Catterick Garrison, the role of the Council and details of the associated opportunities and risks.

4.4 Prevent, reduce and delay: March 2018

4.5 This work will focus on an update to the new HAS care and support structure. By the time the item is considered, there will be 12 month or more progress on Strength Based Assessments. The report will also cover trends and actions on Delayed Transfer of Care, and give some case study examples of prevent initiatives (Front Door/Living Well), and reduce/delay (a follow up to the presentation received last time on Reablement and planned care)

4.6 User participation: March 2018

4.7 The committee has asked the question "how confident can we be that services are person centred; are services locally appropriate, have they been planned with individuals to put them and their carers in control to deliver the best outcomes"

4.8 Group Spokespersons have agreed that there will be an initial awareness raising session on our model of engagement at committee but after that a less formal approach will be adopted, possibly meeting in a community or user-led venue. The ambition is to hear directly from user groups about key issues. There are probably four angles to this work: user co-production in own care and support plan, experts by experience as peer mentors and service providers, users shaping services, users feeding back on services

4.9 Community Health Pathways

4.10 This is likely to be early in 2018. Whilst the idea behind this topic was to understand better how community services are organized around the

communities where people live and the GP practices people use, and how partners work together.

4.11 How this will be tackled committee will very much depend on the results of the results of the contract to provide adult community services in the Scarborough and Ryedale area. If North Yorkshire County Council's bid, in partnership with East Coast Health Options (ECHO) is successful, the focus will be on the Scarborough area, if not the content will be more generic in nature.

5.0 Recommendations

5.1 The Committee is recommended to consider the attached work programme and determine whether any further amendments should be made at this stage.

DANIEL HARRY

SCRUTINY TEAM LEADER

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6 December 2017

APPENDIX 1

Care and Independence Overview and Scrutiny Committee

Scope

The needs of vulnerable adults and older people and people whose independence needs to be supported by intervention from the public or voluntary sector

Meeting Details

Committee Meetings	Thursday 14 December 2017 at 10.30am
	Thursday 22 March 2018 at 10.30am
	Thursday 10 May 2018 at 10.30am
Mid Cycle Briefings	Thursday 15 February 2018 at 10.30am

Programme

BUSINESS FOR THURSDAY 28 SEPTEMBER			
SUBJECT	**AIMS/PURPOSE**	**COMMENTS**	**LEAD**
Local Account	Is the account an honest assessment of social care performance, is it accessible.	deferred	
Annual report of Safeguarding Board	Review • Whether safeguarding arrangements are effective. • Board governance is sound; • Partnership strength and commitment • community prevention • strategic links with other partnerships in localities	May be part of a wider analysis of safeguarding trends. May be extended to include safeguarding training	Sheila Hall/Chair of the Board

BUSINESS FOR THURSDAY 14 DECEMBER 2017			
SUBJECT	**AIMS/PURPOSE**	**COMMENTS**	**LEAD**
Care Provider Standards	How we can be confident that North Yorkshire care providers, particularly those who operate residential establishments, are satisfactorily meeting appropriate quality standards and requirements		
Dialogue with Care Quality Commission Representative	Follow up to discussion with CQC about inspection regime.		Kathryn Reid
Intermediate Care	brief overview of intermediate care, discharge to assess, and our step up step down beds.		Louise Wallace
BUSINESS FOR THURSDAY 22 MARCH 2017			
SUBJECT	**AIMS/PURPOSE**	**COMMENTS**	**LEAD**
Resource Management Theme	Prevent Reduce Delay Strength Based Assessments	Trends and actions on Delayed Transfer of Care, and give some case study examples of prevent initiatives (Front Door/Living Well), and reduce/delay (a follow up to the presentation received last time on Reablement and planned care)	Rachel Bowes
Learning Disabilities Service	Changes to the service focusing on user participation and co-design of services. Possible strategy consideration		Joss Harbron
Mental Health Strategy Update		Suggest move to January 2018	Kathy Clark
User Participation	how confident can we be that services are person centred; are services locally appropriate, have they been planned with individuals to	initial awareness raising session on our model of engagement at committee but after that a less formal approach will be adopted,	Sheila Hall

	put them and their carers in control to deliver the best outcomes“ There are probably four angles to this work: user co-production in own care and support plan, experts by experience as peer mentors and service providers, users shaping services, users feeding back on services	possibly meeting in a community or user-led venue. The ambition is to hear directly from user groups about key issues.	
Community Mental Health Pathways	item in relation to Health and Social care Integration Theme	Understand better how community services are organised around the communities where people live and the GP practices people use, and how partners work together	Louise Wallace
Scrutiny Support Annual Older Peoples Champion Report			