RURAL ENGLAND
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Issues Facing Providers of Social Care at Home to Older Rural Residents

Rural England research project

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Issues Facing Providers of Social Care at Home to Older Residents in Rural England

Index

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Key Messages

In this research we have sought to examine the issues facing providers of domiciliary care to older people in rural areas. Whilst there has been a considerable amount of recent research about social care, specifically rural dimensions have generally been overlooked. At the more local level, we found scant regard to rural proofing in the Sustainability and Transformation Plans that we have read. Moreover, published statistics seldom provide, or even readily facilitate, any rural analysis. This paucity of rural research and of relevant rural statistics is not only disappointing but also indicates that the rural dimension is widely neglected. However, our research shows that rural areas are facing some specific, or particularly acute, challenges related to demographics, service provision and costs.

Demographics

As examined in Chapter 2, older people make up a significantly higher percentage of the total population in rural areas. In some rural counties over 20% of the population is already aged over 65 years. The percentage of the population aged over 85, the group most likely to need care, is also markedly higher in rural areas than in urban (3% in predominantly rural areas compared to 2% in predominantly urban.) Defra[1] 2016. Projections (ONS [2]) suggest that, nationally, the number of people aged over 85 will more than double between 2014 and 2034 compared to an increase of 49% in the 65+ age range and just under 14% for the population as a whole for the same time period.

Moreover "It has long been the case that increases in life expectancy have outpaced improvements in disability free life expectancy, however the gap is now growing faster….. As a result, more of us are spending more time in later life with multiple long-term conditions, frailty, dementia and social care needs." (Age UK[3]). Therefore, "although rates of ill-health from common causes are on average lower [in rural areas], the prevalence of these conditions will be higher with concomitant pressures on health and care services."(LGA/PHE [4]).

The sparsity challenges

From an economic perspective, research carried out for Defra [5] identified 'two key challenges' for rural service delivery:

- Lower population density impeding economies of scale resulting in higher per unit costs for service delivery.
- The penalty of distance. The distance from providers to rural service users involves higher travel costs, opportunity costs and unproductive time for staff.

The same report observed that those challenges are compounded by the acute pressure on Local Authorities to achieve cost savings and "the perception by service providers that government funding models are not sensitive to rural services."

The 'two key challenges' were very evident in our case studies. In all three areas many of the care provider businesses are small scale, and two local authorities specifically referred to weak local markets for home care. The penalty of distance was most frequently articulated in terms of travel

costs and time with specific problems, including the mismatch of staff locations and those of clients and the difficulty presented by the lack of clustering of clients (which is much easier to achieve in more urban areas). Even where small clusters of clients can be achieved, the loss of just one client can tip the balance between viability and unviability.

Our interviews indicate that home care staff are typically employed on zero hours contracts, receiving payment only for actual contact time. Travel costs are reimbursed, but time spent travelling is time when they are not earning thus presenting an opportunity cost for them.

An analysis of hourly rates paid for externally provided home care[6] shows that rural councils, on average, pay significantly more than do urban councils. In 2015/16 predominantly rural councils averaged £15.61, some 13% higher than predominantly urban Councils (£13.78). Despite paying more than the England average, service providers and commissioners reported particular issues in serving clients in deeply rural locations. Several home care businesses commented that they did not feel Councils paid enough and this seems to be reflected in the problems two of the Councils experience in the handing back of contracts.

Other pressures facing rural councils are illustrated by our case studies. Two of the Councils reported pressures relating to carrying out timely assessments of need. All three faced difficulties in relation to delayed transfers of care from hospital (which is described by the Kings Fund[7] as being "the most visible manifestation of pressures on health and social care budgets"). Although it is difficult to assess how far hospital discharge practices may influence the figure, it is notable that DoTC rates attributable to social care (and also those attributable to health care) are much higher in rural areas than urban.

The financial context is extremely challenging. Age UK[3] calculate that "by 2020/21 public spending for older people's social care would need to increase by a minimum of £1.65 billion to £9.99 billion in order to manage the impact of demographic and unit cost pressure alone." It also notes that Local Authorities face additional pressures on their Care budgets arising from Implementation of the Care Act, National Living Wage and the costs of new requirements for care services.

The impacts on individual rural Council budgets from the growing demand for funded social care were described by one interviewee as "terrifying"

Recruitment and retention issues

In all three areas we looked at businesses providing domiciliary social care and reported issues relating to recruitment and/or retention. Contributory factors were frequently thought to include:

- A small pool of potential employees locally
- Dislike of zero hours contracts
- Low pay
- No career/ upskilling opportunities
- Increasingly complex needs of clients
- Competition from other employment sectors
- A mismatch between the locations of carers and that of rural clients

Other factors

In many rural areas the demographic and sparsity challenges of providing home care are compounded by other factors including:

- Difficulties for clients in accessing health services which are likely to be further away and often inaccessible to them by bus. This may result in first contact with social services being at a 'moment of crisis'
- An older housing stock, which may be of inappropriate design (e.g. entrance steps, narrow staircases)
- Fuel poverty which is more prevalent in rural areas due to the characteristics of the housing stock (older and often single skinned) and where mains gas is frequently unavailable
- A shortage of suitable housing options, both in terms of house types (such as small bungalows) and support (e.g. sheltered housing, supported living and extra care)
- Older people are often geographically separated from family
- Potentially hidden need
- Isolation

There are questions too about the extent to which genuinely integrated approaches across home care, health, and housing provision are hampered by the pressures on individual budgets.

In conclusion, it is, sadly, difficult to disagree with the King's Fund's[7] assessment that "collaboration and innovation are taking place despite the odds, but no one was very optimistic about the future"

References

1. **Defra (2016)** 2001 to 2015 rural urban population data https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565810/2001_to_2015_rural_urban_population_data_v2.csv/preview

2. **ONS (2015)** 2014 based principal projection. Table A2-4 England Population by Age Groups https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea24principalprojectionenglandpopulationinagegroups

3. **Age UK (2017)** Briefing: Health and Care of Older People in England 2017 http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

4. **LGA and PHE (2017)** Health and Wellbeing in Rural Areas https://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

5. **TNS BMRB with the International Longevity Centre (2013)** research for Defra. Rural Ageing Research Summary Report of Findings http://www.ilcuk.org.uk/images/uploads/publication-pdfs/11690_DEFRARuralAgeingReport.pdf

6. **NHS (2016**) Personal Social Services: Expenditure and Unit Costs, England 2015-16. Hourly rates for home care

http://content.digital.nhs.uk/searchcatalogue?productid=23352&topics=1%2fSocial+care%2fSocial+care+expenditure&sort=Relevance&size=10&page=1#top

7. **The Kings Fund (2016)** Social Care for Older People
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf

Chapter 1. Introduction

This paper explores the extent to which older people in rural areas have the opportunity to access high quality social care at home, supporting them to live independent healthy and fulfilling lives. It focuses in particular on the challenges presented to council commissioners of home care and to providers in both the public and private sectors.

The paper is arranged in sections which cover the following areas:

- Analysis of the current and future home care needs of older people in Rural England in the context of demographic and health trends;
- Summarising some of the key elements of The Care Act and other selected legislation relating to Social Care;
- Exploring the perspectives of Local Authorities and other care providers in the context of case studies of three contrasting rural areas (Cornwall, Shropshire and North Yorkshire). These studies look at a variety of issues and challenges affecting service delivery. These include: demographic , economic and geographic characteristics of the area; financial aspects of provision relating to rurality; economic constraints on Councils and service providers; functioning of the Social Care 'market' including staffing issues; and problems causing delayed transfer of care from hospitals.

This paper references evidence from a variety of existing reports and refers to relevant available data sets, but the authors have been disappointed to find so little research or statistical information with a specifically rural 'cut'.

This report defines 'older people' as those aged 65 and over, and the 'oldest old' as those aged 85 and over, although evidence sources sometimes use different definitions.

The definitions of 'rural' most commonly used in this report are:

1. The ONS-Defra rural-urban classification which identifies settlements with fewer than 10,000 residents as rural (and further sub-divides these into rural towns, villages, and hamlets/isolated dwellings).

2. The ONS Defra rural urban classification of Local Authority Areas with three categories of Mainly Rural, Predominantly Rural and Urban with Significant Rural.

The authors acknowledge that this research has a number of limitations including often inadequate rural data, the comparatively small number of interviews that it proved possible to conduct, and, not least, the lack of any direct input from service users themselves. However we hope that it identifies the key issues affecting the provision of home care to older people in rural areas and, through three case studies of diverse rural areas, illustrates a variety of local challenges and responses.

Chapter 2. Analysis of current and future needs

1. Demographics and the demand for social care.

The English population is ageing. Between the census in 2001 and that in 2011 the number of older people (65+ years) in England increased from 7.83m to 8.66million and that their percentage share of the total population increased from 15.8% to 16.3% of the population. Projections[1] suggest that this age group comprised 9.54m (17.5% of the total population) in 2014 and will rise to 11.48m (19.7%) in 2024, 14.24m (23%) in 2034 and 15.66m (24.2%) in 2044.

Older people already form a disproportionate share of the overall rural population and this gap is expected to widen in the future.

Usual resident population of urban and rural areas by age, 2001 and 2011
England and Wales

	2001 Percentage		2011 Percentage	
Age	Urban	Rural	Urban	Rural
0-14	19.1	17.9	18.0	16.2
15-29	19.8	14.7	21.1	14.8
30-44	22.9	21.3	21.2	17.7
45-59	18.1	22.4	18.8	22.3
60-74	12.7	15.4	13.6	19.6
75+	7.4	8.3	7.4	9.4

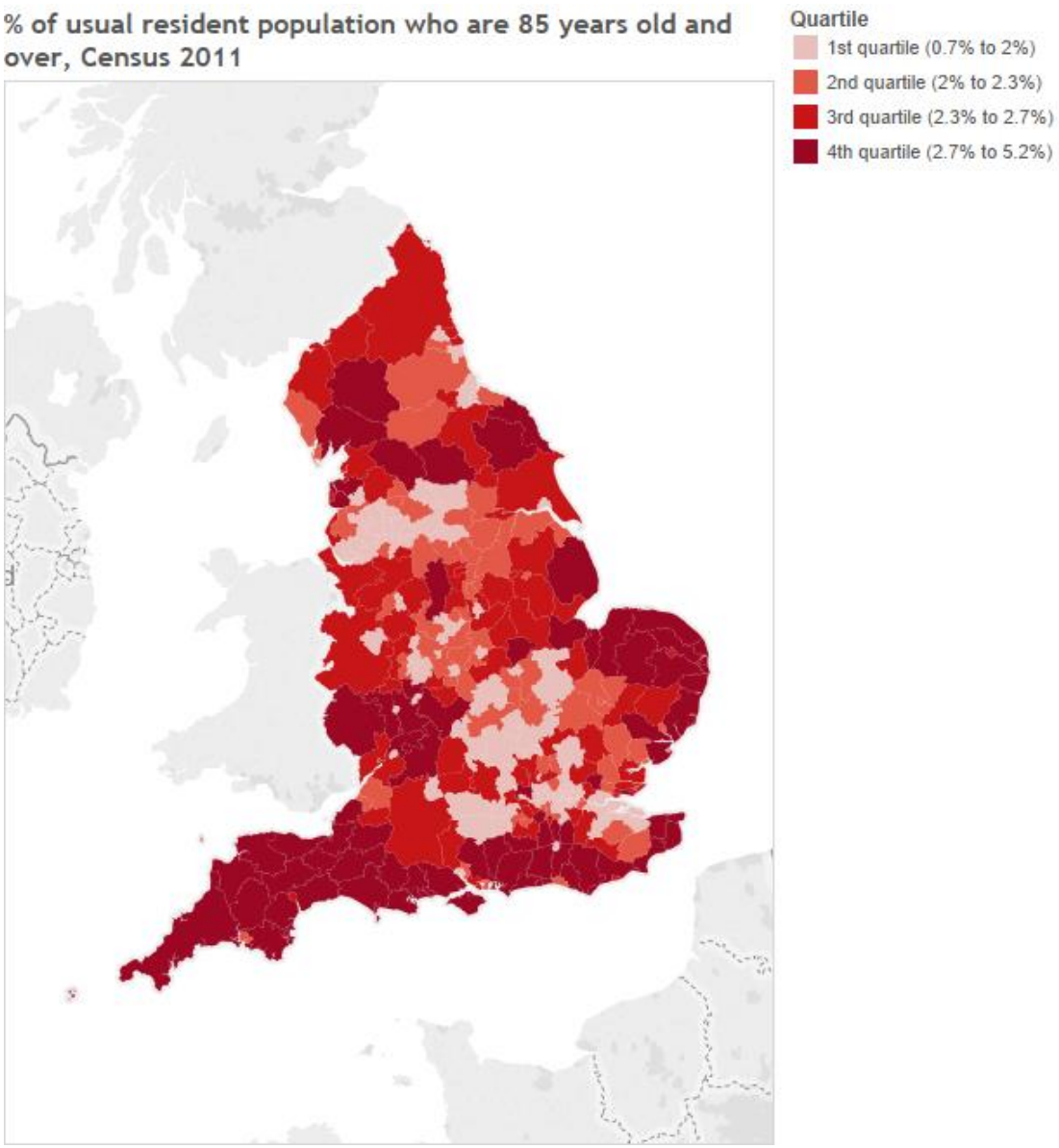
Source: 2001 and 2011 Census - Office for National Statistics

There are significant geographical variations in the current distribution of older people in England. Areas with the highest proportions of older people include Cumbria, Devon, Dorset, Lincolnshire and Somerset, where more than 20% of the population is 65 years and older.

The 'oldest old', over 85 years, are of particular significance as health problems and the likelihood of disability increase with age. This age group comprise a much high proportion of the population of rural areas than urban areas as shown in the table below.

Rural Urban Classification	% of population aged 85+ (2015)
Predominantly Urban	2.08
Urban with Significant Rural	2.78
Predominantly Rural	3.00
England	2.36

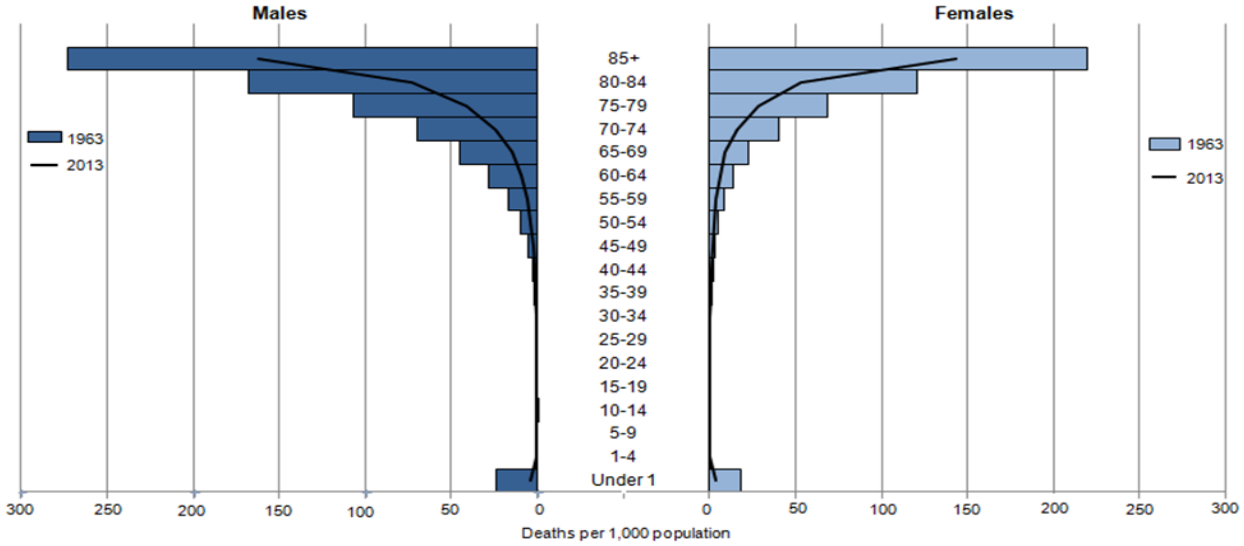
Source : Defra 2016[2]



The Office for National Statistics[1]projections suggest that the number of people aged over 85 will increase from 1.28m in 2014 (when that age group comprised 2.3% of the population) to 1.70m in 2024 (2.9%), 2.68m in 2034 (4.3%) and 3.38m in 2044 (5.2%). Their numbers are expected to more than double in the two decades to 2034, compared to an increase of 49% in the 65+ age range and just under 14% for the population as a whole.

Population ageing in the UK is caused by a combination of rising longevity and medium fertility. Both these factors have implications for social care with increasing longevity increasing demand and medium fertility limiting the supply of family care. As the solid line on the graph below illustrates, the number of deaths per 1000 people within each of the over 60 age groups has dropped markedly in the 50 years between 1963 and 2013.

Age-Specific Mortality Rates, 1963 and 2013. England and Wales

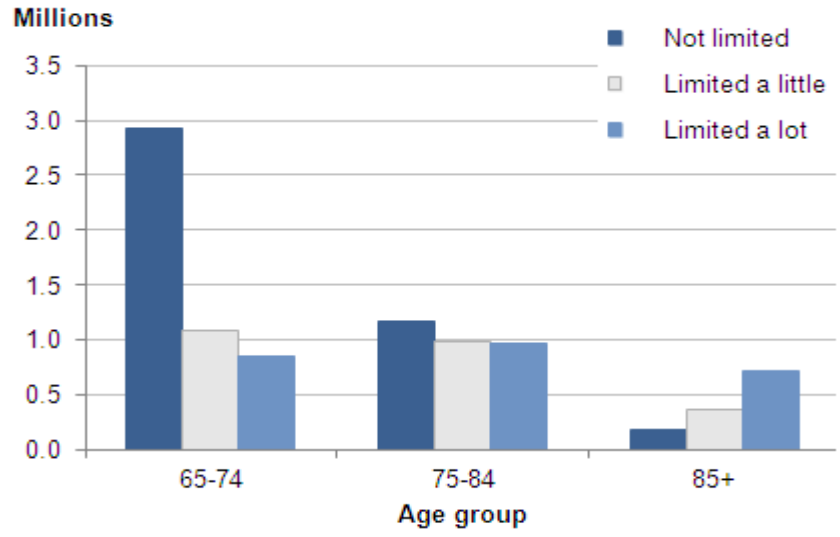


Source: Hoff, A[3] (using ONS data)

Rising longevity will have significant implications for social care provision, especially as "increases in life expectancy have outpaced improvements in disability free life expectancy" (Age UK)[4]. As illustrated in the table below, for most people in the 65-74 age group, their ability to carry out activities of daily living is not limited by long term health problems or disability. For those age 75-84 there are still slightly more people in the not limited category than either the 'limited a little' or 'limited a lot'. However for those aged 85+ 'limited a lot' is the most common category.

The age structure of rural areas is older than urban. Therefore, "although rates of ill-health from common causes are on average lower [in rural areas], the prevalence of these conditions will be higher with concomitant pressures on health and care services."(LGA/PHE)[5].

Table 1 Impact of long-term health problems or disability on the ability to carry out daily activities, by older age groups, 2011, England & Wales. Source: Census - Office for National Statistics



"By their late 80s more than one in three people have difficulties undertaking 5 or more tasks of daily living unaided, and between a quarter and a half of the 85+ age group are frail."(Age UK)[4] This age group is notably over-represented in South West England, Southern England and East Anglia. This is also the fastest growing age group in England numbering 1.22m (2.28% of the total population) in 2012 and projected to rise to 1.88m (3.22%) in 2025 and 2.9m (4.78%) in 2035. [5.] Much of this increase is a result of a projected rise in male life expectancy.

Looking to the future it is evident that the needs of an ageing population will place increasing demands on social care providers, and that these pressures are likely to be felt most acutely in those rural areas with the highest proportions of older people.

The following projections for the period 2005-2041 from PSSRU [6,]and Parliamentary research[7] provide some indication of the potential scale of increasing demand:

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- The numbers of disabled older people, unable to perform at least one instrumental activity of daily living (IADL) or having problems with at least one activity of daily living (ADL), would grow by 108% , from around 2.4 million to around 4.95 million.
- The number of older people with moderate or severe disability, needing help with one or more ADL tasks, would increase by 122% from around 950,000 to around 2.1 million.
- The numbers of disabled older people in households receiving informal care would increase by 102%, from approximately 1.75 million to over 3.5 million.
- Care by children will still need to increase by approximately 90% if the proportion of disabled older people receiving care from their children is to remain the same today.
- The numbers of users of non-residential formal services would need to rise by 102%, from 1.5 million to 3.1 million, to keep pace with demographic pressures

2. Accessibility of social care

Overall the proportion of older people aged 65 and over in receipt of local authority supported social care services decreased sharply from 15.3% in 2005/6 to 9.2% in 2013/14 (Age UK). [4] Although data from 2014/15 onwards is not directly comparable Age UK conclude "the new data gives no reason to suppose that there has been any significant change in long term trends towards fewer people receiving care".[4]

Age UK[4] also calculates that the cut in public spending on older people's social care over the 5 years to 2015/16 amounts to £160million in real terms. Their analysis suggests that there are "now nearly 1.2 million people aged 65+ who don't receive the help they need with essential daily living activities….nearly 1 in 8 older people now live with some level of unmet need". "696,500 people who need help with at least one ADL receive no help at all". In 2015/16 of some 1.31m requests for support from new clients only 608,825 (46.5%) received some form of social care assistance.

The King's Fund [8] concludes that "no one has a full picture of what has been happening to older people and their carers as local authority-funded social care has taken a battering from austerity. Although it is clear that fewer people are now eligible for social care than in the past, we do not know how well they have managed to put in place support for themselves, or at what cost to their

carers' and family members' health and wellbeing." "The gap in experience between those people who happen to have their own resources, or live in an area with more social care, and those who do not has widened."

There are some 5.8 million informal carers in England and Wales.(ONS) [9] "Most care for older people is not provided by the state or private agencies but by family members, at an estimated value of £55 billion annually." [10] The importance of informal carers is illustrated by The Alzheimer's Society [11] which puts the annual care costs of dementia in the UK amount at £26.3 billion – of which £17.4bn is met by those with dementia and their families and just £8.8bn by the state

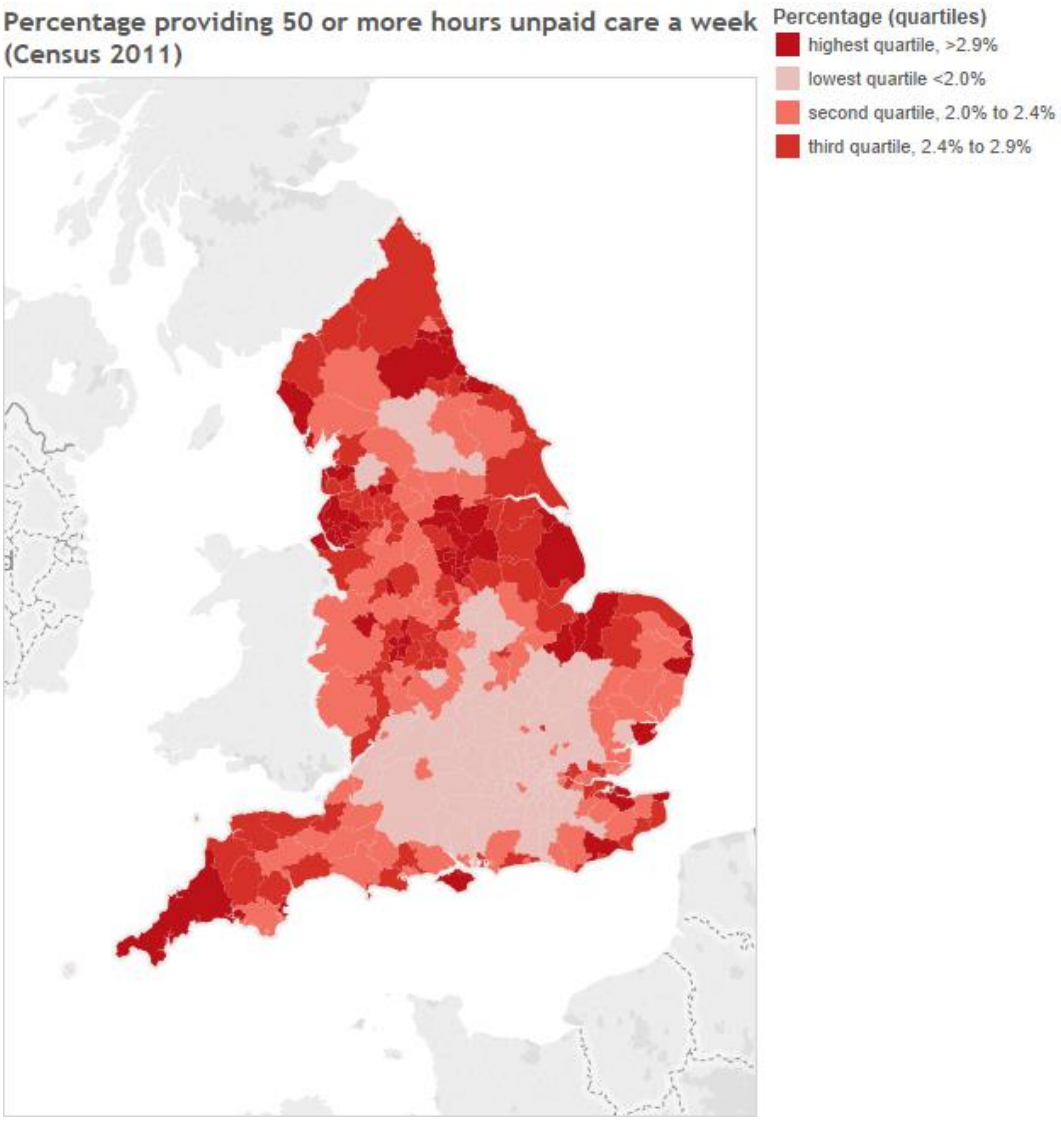
The proportion of usual residents providing unpaid care of all kinds increased between 2001 and 2011 and there was little difference between urban and rural areas in the percentages providing more than 20 hours of care a week.[9] Residents in sparse areas were however identified as being more likely than residents of non-sparse areas to be providing 20 or more hours care. By contrast, there was a difference between urban and rural areas in the proportion of residents providing 1 to 19 hours of care. In urban areas this figure decreased from 6.6 per cent to 6.2 per cent. This compares with a figure of 7.9 per cent in rural areas in 2011.

England and Wales, 2001 and 2011

Classification	Census	Provides no unpaid care	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
Urban	2001	90.2	6.6	1.1	2.1
	2011	90.0	6.2	1.4	2.4
Rural	2001	89.2	7.8	1.0	2.0
	2011	88.3	7.9	1.3	2.4

Source ONS 2001 and 2011 Census

"Older rural residents are much more likely than their urban counterparts to provide some form of care to one another, 24% in rural areas compared to 18% in urban locations" The following map shows the geographical distribution of people of all ages providing more than 50 hours of care per week



The geographical distribution shown above shows a marked similarity to the distribution of people aged 85+.

Growing need will arise due to the increasing numbers of older people, particularly those aged over 85, and increasing constraints on Council social care budgets. However, whilst researchers may assert that "caregiving by adult children will have to rise in order to cope with the increasing demand for informal care" (Hoff)[3], it is far from clear that this is a realistic expectation. "Indeed there are now serious questions as to whether we are approaching the practical limit of this informal capacity for caring."(Age UK)[4]

The family care gap is growing as the number of older people in need of care is predicted to outstrip the number of family members able to provide it. "In England alone, although the number of children providing care to their parents for more than 20 hours a week is projected to increase by 20 per cent to 485,000 by 2032, there is likely to be a shortfall of 160,000 caregivers, because demand will increase by 60 per cent over the same period." [10] That unmet demand is likely to be disproportionately located in rural areas with the highest proportion of older people.

A number of factors contribute to this informal care gap, including:

- Increases in female employment.
- Smaller family sizes resulting in both a reduction in the potential number of adult children-to-parent carers and also an increased proportion of older people who have no adult children who might be asked for help.
- Increased geographical mobility and separation between family generations. These impacts may be particularly acute in rural areas where limited housing and employment opportunities often encourage re-location of young adults and also in those rural and coastal areas experiencing significant in-migration of older people
- Increasingly complex needs
- Reliance on older carers (often spouses) who often experience poor health themselves

Age UK[4] suggest "that the provision of informal care has not been able to expand significantly to fill the gap left by declining provision of formal care services… In many cases it is likely to be the sufficiency of care that has suffered as a result- families who are providing support but are simply unable to provide enough to meet all of an individual's needs".

Cuts in funding have also impacted upon the voluntary sector. Research by the King's Fund [8] found that:

- Where the voluntary sector delivered services to older people directly, reductions in local authority grants were particularly difficult to manage.
- A number of their interviewees felt that the public sector tended to assume that volunteers were cost free, ignoring the costs of training, support and supervision
- One common theme was the need to charge users for services that might once have been free.

Voluntary and community sector organisations were felt to be facing threats to their sustainability similar to those experienced by commercial providers.

The King's Fund's[8] overall conclusions include "In our conversations with local authorities, social care providers, the voluntary sector and the NHS, we heard an amplification of messages that will be familiar to those who have watched the social care sector over the past five years: social care providers under pressure, struggling to retain staff, maintain quality and stay in business; local authorities making unenviable choices about where next to wield cuts; NHS providers scrambling to get older people out of hospital before they deteriorate; and the voluntary sector keeping services going on a shoestring. Collaboration and innovation are taking place despite the odds, but no one was very optimistic about the future"

The same research concludes that "Local authorities' vision of an enabled, independent older citizen, supported at home by family and community, turning to the state for care only in extremis, requires a vibrant voluntary and community sector, family members able and willing to play that role, and health and care services fully geared up to support people in their homes. We have not found evidence of these things being in place." [8]

References

1. **ONS (2015)** 2014 based principal projection. Table A2-4 England Population by Age Groups https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea24principalprojectionenglandpopulationinagegroups

2. **Defra (2016)** 2001 to 2015 rural urban population data https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565810/2001_to_2015_rural_urban_population_data_v2.csv/preview

3. **Hoff, A. Government Office for Science (2015)** Current and future challenges of family care in the UK https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454514/gs-15-18-future-ageing-family-care-er09.pdf

4. **Age UK (2017)** Briefing: Health and Care of Older People in England 2017 http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

5. **LGA and PHE (2017)** Health and Wellbeing in Rural Areas https://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

6. **PSSRU (2008)** Future demand for social care, 2005 TO 2041: Projections of demand for social care for older people in England. Report to the Strategy Unit (Cabinet Office) and Department of Health http://www.pssru.ac.uk/pdf/dp2514.pdf

7. **Parliament.uk (2010)** online. The ageing population: key issues for the 2010 Parliament http://www.parliament.uk/business/publications/research/key-issues-for-the-new-parliament/value-for-money-in-public-services/the-ageing-population/

8. **The King's Fund (2016)** Social Care for older people. Home truths https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf

9. **ONS (2013)** 2011 census Analysis- Comparing Rural and Urban Areas of England and Wales

10. **McNeil, C. and Hunter, J (2014)** The generation strain: Collective solutions to care in an ageing society. IPPR

11. **Alzheimer's Society (2014)** Dementia 2014 Infographic http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2761

12. **Life Opportunities Survey quoted in ONS (2013)** 2011 census Analysis- Comparing Rural and Urban Areas of England and Wales

Chapter 3. A Brief Overview of the Context for the Provision of Home Care to Older People.

3.1 The Care Act

The Care Act 2014, which came into effect on 1 April 2015, sets out what care and support people should expect. "The driving principles of the Care Act are the promotion of wellbeing and the prevention, delay and reduction of the need for care and support." (SCIE) [1] "There is a shift away from providing services to meeting needs."(SCIE) [2]

Some of the main elements of the Care Act include:

- A focus on preventing or delaying the need for support. This can include investment in preventative services and utilising existing community resources
- Local Authorities have a responsibility to provide information and advice to all residents, not just those eligible for funding or support from the Council. This information and advice should be made available in accessible ways and should include rights and entitlements and how they can access them
- A consistent national criteria of eligibility for support based on the individual's ability to achieve certain outcomes.
- Eligible people have a legal right to a personal budget and direct payment to support their wellbeing
- New rights of support for carers aimed at enabling them to maintain their caring role
- Local Authorities have a duty to assess an adult's needs for care and support, whether or not that individual is eligible for funding.
- Local Authorities have a duty to promote the integration of care and support provision with health provision.
- Local Authorities "must facilitate a diverse, vibrant and sustainable market for care and support services". "Good commissioning….should focus on wellbeing, workforce development, pay and appropriate pricing of services. It should support sustainability and ensure choice" (SCIE [2])
- Adult Safeguarding requirements are defined.

3.2 Related Social Care Services

Whilst this research specifically focuses on the provision of domiciliary care to older rural residents there are certain related areas which merit some mention.

Preventative services.

Whilst moving towards prevention and early intervention is seen as a way to make savings, the ADASS budget survey 2017 report [3] notes the "tension between prioritising statutory duties towards those with the greatest needs and investing in services that will prevent and reduce future needs." The same report suggests that 6.3% of adult social care budgets was spent on prevention in 2016/17, a decrease from 7.1% the previous year. Possibly this reduction might also reflect the difficulties in quantifying the benefits of particular preventative services.

Context of change in the NHS.

"Cuts to social care should not be viewed in isolation from overstretched general practice and community nursing and the uneven distribution of intermediate care beds; these are all factors identified by our interviewees. Under-investment in primary and community NHS services threatens to undermine the policy objective of keeping people independent and out of residential care." (Kings Fund [4])

"Over the past three decades the number of hospital beds has been declining. This is a result of medical advances (leading to shorter stays in hospital) and a shift in policy towards providing treatment and care outside hospital". "Over the last 29 years the number of available hospital beds in England has more than halved" (Kings Fund [5])

NHS statistics online show a 7.9% reduction in the six years to the end of 2016/17 and the trend is continuing. With just 5.5 hospital beds per 1000 population and the UK is now the fourth lowest out of 22 European Countries (OECD figures quoted in Bate[6]).

The Better care Fund.

The Better Care Fund (BCF) is the Government's primary funding mechanism specifically for the integration of health and social care. It was first announced in the 2013 Spending Round, with the aim of "delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays." (Bate[7]). "The BCF is a pooled budget between the NHS and local authorities, which is intended to shift resources away from hospital care and towards care in the community and at home."

The four national Better Care Fund conditions for 2017-19 are:

1. Plans to be jointly agreed. Plans should be signed off by the Health and Wellbeing Board and by constituent Councils and CCGs
2. NHS contribution to adult social care is maintained in line with inflation.
3. Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care.
4. Managing Transfers of Care

(Department of Health and DCLG [8])

Delayed Transfers of care

A recently published House of Commons briefing paper about delayed transfers of care from the NHS (Bate[7]) defines a transfer of care (DToC) as "where a patient is ready and safe to leave hospital care, but is unable to do so, and remains occupying a hospital bed"

The same paper tells us that:

- "in 2016/17 there were 2.3 million delayed transfer days in England, an average of around 6,200 per day. The average number of delayed days for 2016/17 was 25% higher than the previous year. (The Kings Fund [4] describes this rapid rise in DoTC as "the most visible manifestation of pressures on health and social care budgets.")
- It is estimated that delayed transfers cost NHS providers £173 million for the previous year, up 19% from 2015/16.

- "Although the majority of delayed days are still attributable to the NHS, delays attributable to local authority social care have risen by 85% over the past two years.. "
- In 2016/17 'Awaiting a care package in own home' accounted for 456,447 delayed days out of a total of 2.3m. Not only was this the largest single reason category for DToC, but it had increased by 45.3% from the previous year, more than any other reason. Whilst this category includes both health care and social care only approximately 25% of these care package delays were attributed to the NHS.
- DToC are estimated to have cost providers some £173m in 2016/17 up 19% from the previous year.
- The impacts are not solely financial but can cause detriment to the patient in terms of morale, mobility and the risk of infection (Bate 2017[7]).

In addition to possible patient detriment there are potential financial penalties of £130 per day for Local Authorities if they are unable to assess a patient awaiting discharge or to put in place measures to meet his/ her care and support needs following receipt of a discharge notice from the NHS. Although the Local Authority must be given a minimum of 3 days from the assessment notification or one day after proposed discharge date(whichever is later), it is not difficult to see how challenging that timescale can be to meet.

A House of Commons report 'Discharging older people from acute care' [9] quotes a National Audit office estimate of around £800m gross cost for the NHS arising from older patients being delayed in hospital. It criticises the Department of Health, NHS England and NHS Improvement for "failing to address long-standing barriers to health and social care sectors sharing information and taking up good practice" and states that "the result is an unacceptable variation in local performance"

Statistics contained in that report state that emergency admissions of older patients have gone up by 18% between 2010/11 and 2014/15, faster than the rate of increase in the older population. Delayed transfers of care increased 31% between 2013 and 2015.

The report's conclusions are that:

- There is a poor understanding of both the scale and the cost of the problems of delays in discharging older patients from hospital
- There is an unacceptable variation in local performance in discharging patients
- The fragility of the adult social care provider market is clearly exacerbating the difficulties in discharging older patients from hospital
- Good practice on discharging patients is patchy across local areas
- Absence of widespread and effective sharing of patient information is a barrier to discharge.
- There is a fragmented accountability structure.
- Local health and social care not working together effectively, with organisational boundaries getting in the way
- Financial incentives are not encouraging all organisations to work together to reduce delays.

Analysis of the NHS statistics [10] for the average daily rate of delayed transfers of care per 100,000 population aged 18+ shows a distinct variation by rural urban classification.

Delayed Transfer of Care. Monthly average days per 100,000 population aged over 18 years, 2016/17

Local Authority Classification	All reasons	Social Care and both*
Predominantly Rural	19.2	8.4
Urban with Significant Rural	16.7	7.1
Predominantly Urban	13.0	5.5
England (average)	15.0	6.4

*This category includes those discharges delayed due to social care reasons and also those discharges delayed due to both health and social care reasons

The above figures are not limited to the discharge of older people but do nonetheless illustrate the greater difficulty in achieving the timely discharge of patients from hospital in rural areas.

Our discussions with commissioning authorities and providers in selected rural areas gave a variety of reasons why this may be the case in the context of providing social care at home to older people. Those reasons include:

- The increasingly complex needs that must be catered for.
- Logistics of serving scattered rural clients in terms of travel costs and time.
- The capacity of local care provider businesses
- Concerns about the availability of health care support, including GP and pharmacy availability, particularly at weekends.

Part of the rationale for additional targeted funding in the Spring Budget 2017 [11] was "to support authorities which are struggling, and to ensure more joined up working with the NHS." It is too early to comment on the effectiveness of that funding.

3.3 Commissioning and Funding Challenges and Market Sustainability

On average, adult Social care accounts for almost 37% of whole net budgets of provider Councils and that percentage has been rising steadily from 30% in 2010/11 (ADASS [3]). However, Council budgets as a whole have been reducing and the 2016 ADASS report [12] noted a £1bn gap between the funding available and the amount needed to keep up with demand and cost pressures on adult social care services. ADASS [3] calculate that between 2010 and 2017 adult social care savings have increased each year and now cumulatively amount to £6.3bn.

The two most significant pressures in recent years relate to the increased numbers of older people needing care and support and changes to the National Living Wage affecting Council costs and provider fees. "Quite apart from past cuts – over £5 billion less in local authority social care budgets over the last five years – it is demography-defying that spending is set to fall further when the number of over 85s will double over the next two decades.."[13]

Additional funding was made available during 2017:

- The 2016/17 Local Government Finance Settlement permitted Councils to set an Adult Social Care Precept to raise an additional 2% per annum for three years starting 2016/17. It also included the Improved Better Care Fund payable for three years from 2017/18
- The 2017/18 Local government Finance Settlement provided a one-off £241m Adult Social Care Grant and gave the option for Councils to re-profile their adult social care precepts to 3%, 3%, 0%,) over 3 years (as opposed to 2%, 2%,2%). ADASS (2017) figures indicate that some 70% of Councils took the 3% option in 2017/18
- The Spring Budget 2017included an additional £2bn in grant monies from DCLG to councils for the period 2017/18-2019/20, with half that sum available in the first year. There is however a requirement that this money must be pooled into the Better care fund and spent on adult social care needs, reducing pressures on the Health service including reducing delays in transfer) and stabilising the social care provider market.

Despite the additional funding, ADASS [3] still identify a serious gap in funding. In response to their 2017 survey 53% of Directors said that identified reductions to services will directly affect older people. Three frequently listed concerns relating to failure to meet statutory duties related to market sustainability 79%, and prevention and wellbeing 44%, and providing services/ personal budgets sufficient to meet eligible needs 25%. Over three quarters felt that providers are facing financial difficulties; providers are facing quality challenges; and that the NHS is under increased pressure.

22% of responding councils said that their home care fees for older people had risen by over 5% in the last year and a further 42% had risen by over 3%, key drivers of this increase being National Living Wage, other pay pressures and local market issues (including capacity and competition).

The higher costs of provision in rural areas is illustrated by the wide variations in the costs to Local Authorities of externally provided home care. A simple analysis of NHS statistics shows that there is a distinct pattern of more rural Councils facing higher costs. As illustrated in the following table those differences are considerable with predominantly rural Councils paying £1.83 per hour or 13.3% more than predominantly urban Councils and £1.33 per hour or 9.3 % than the England average.

Average Hourly Rates for Externally Provided Home Care 2015/16

Local Authority Classification	**Average Hourly Rate**
Predominantly Rural	£15.61
Urban with Significant Rural	£14.87
Predominantly Urban	£13.78
England	£14.28

Calculated from NHS statistics [14]

These figures are well below the minimum costs calculated by UKHCA [15] which for 2015/16 were £16.16 per hour based on the National Minimum Wage.

Consequences for those seeking home care

The Kings Fund [4] examines in detail the impacts of changes in local authority spending on social care for older people. Extracts from their key findings include:

- "The social care system in its current form is struggling to meet the needs of older people.
- Six consecutive years of cuts to local authority budgets have seen 26 per cent fewer people get help. No one has a full picture of what has happened to older people who are no longer entitled to publicly funded care.
- The past six years have also brought huge pressures on the social care market. Central government grant reductions to local authorities have been passed onto care providers in the form of reduced fees, or below inflation increases. Combined with shortages of nurses and care workers, higher regulatory standards and the introduction of the National Living Wage, this has put many social care providers under unprecedented pressure.
- Local authorities have sought to protect the most vulnerable older people with the highest needs, while at the same time encouraging others to be independent, drawing on the resources of their families and communities, and to reduce dependence on support from the state.
- For many people the experience of needing to find and pay for care comes as an unpleasant surprise for which, in general, they are unprepared."

Whilst unmet needs are hard to quantify, Age UK [16] estimate that, of the 2.8 million people aged 65-89 in England with care related needs, 900,000 currently do not receive any formal support.

Provider failure

The ADASS report [3]informs that 39% Councils had providers of home care that have closed or ceased trading in the past 6 months and 37% had been 'handed back contracts' over the same time period. Also that some 79% of Better care Fund funding to maintain provision of adult social services had been spent on avoiding cuts to services and not for any additional activity.

The Kings Fund [4] also found a number of pressures on home care services, noting that:

- "The past six years have also brought huge pressures on the social care market. Central government grant reductions to local authorities have been passed onto care providers in the form of reduced fees, or below inflation increases. Combined with shortages of nurses and care workers, higher regulatory standards and the introduction of the National Living Wage, this has put many social care providers under unprecedented pressure.
- Many social care providers are surviving by relying increasingly on people who can fund their own care, but those dependent on local authority contracts are in difficulty.(Kings Fund 2016)
- Unpaid carers will also be expected to do even more."

The gap between what local authorities are able or prepared to pay and the costs of provision are illustrated by United Kingdom Home Care Association's research. [15] They have calculated the realistic

minimum price for home care in 2015/16, based on modelled costs, to be £16.16 per hour based on the National Minimum Wage and £19.03 based on the National Living Wage. Given that their modelling makes only a modest assumption about travel distances it seems fair to assume that the minimum price in rural areas would be even higher. However, as noted above the actual amounts paid by English local authorities average just £14.28.

The rural dimension

Recent research and available statistics rarely consider the specific challenges of home care provision in rural areas. We consider this an important omission.

Differences between the provision of social care at home in rural areas and provision in urban areas can be considered under three headings: Needs; costs and logistics of delivery; and accessibility.

Needs

Chapter 2 of this report details the different demographic characteristics of rural and urban areas. Whilst there are, of course, local variations the rural population is typically older with those aged over 65 and over 85 making up a significantly higher proportion of the overall population. Accordingly, "although rates of ill-health from common causes are on average lower [in rural areas], the prevalence of these conditions will be higher with concomitant pressures on health and care services." LGA/ PHE [17]

The lack of suitable housing in many rural communities is an additional factor contributing to higher social care needs. Not only is there a shortage of specialist housing for older people but the general housing stock is characteristically older and more difficult to heat.

It also cannot be assumed that the social care needs of older people living in rural areas are necessarily evident. Research (defra 2013) has identified evidence that older people often avoid seeking help until 'moments of crisis'. Amongst the reasons for this are a 'make do' attitude, reluctance to make a fuss, and explicit or implicit fear of emerging health or frailty issues.

Costs and logistics of provision

From an economic perspective, research carried out for Defra [18] identified two key challenges for rural service delivery:

Lower population density impeding economies of scale resulting in higher per unit costs for service delivery.

The penalty of distance. The distance from providers to rural service users involves higher travel costs, opportunity costs and unproductive time for staff.

These challenges are compounded by the acute pressure on Local Authorities to achieve cost savings and "the perception by service providers that government funding models are not sensitive to rural services"

Many rural areas also face a shortage of care staff an issue which is explored in more detail in Chapter 5. A number of factors contribute to recruitment and retention problems including;

- Smaller numbers of potential employees in rural areas
- Low status and lack of a career structure
- Low pay and particularly zero hours contracts
- Competition from other employment sectors and sometimes also within the sector
- Receiving only expenses, rather than pay, for travel to and between clients.

The difficulties of finding suitable staff, combined with the additional costs associated with services to rural areas has led to a number of home care businesses ceasing to trade. Others have sought to move away from Council contracts in favour of clients who self-pay. As a result, Councils are finding it ever more difficult to let contracts, especially it seems for clients in remoter locations, and the handing –back of contracts is becoming more common.

Accessibility

Older rural residents are more likely to face difficulties in accessing care. The few, and still reducing, rural bus services makes it more difficult for many older people to gain face-to-face advice and poor digital connectivity is more likely to be an issue (even if the older person has access to an internet connection and has the skills and confidence to utilise it).

Geographic separation from any close family and the closure of local shops, pubs and meeting places can all contribute to isolation. Those who live in remoter rural locations and those who have moved in retirement may also be less well-connected to any community provision or informal support.

As recent research (LGA/PHE [25]) recognises, rural areas have a unique set of circumstances that can exacerbate the social isolation of older residents in particular, leading to poor health, loss of independence and lower quality of life.

> "Access to care depends increasingly on what people can afford – and where they live – rather than on what they need" (Kings Fund, 2016)

References

1. **SCIE (2014/15)** Care Act 2014 Key Messages: Commissioning independent advocacy. http://www.scie.org.uk/care-act-2014/advocacy-services/commissioning-independent-advocacy/key-messages.asp

2. **SCIE online (2014)** Care Act Presentation Transcript http://www.scie.org.uk/care-act-2014/video.asp

3. **ADASS (2017)** Budget Survey 2017 https://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf

4. **The Kings Fund (2016)** Social Care for Older People http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf

5. **The Kings Fund (2015)** The number of hospital beds https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/hospital-beds

6. OECD figures quoted in **Bate, A (2017)** Delayed transfers of care in the NHS. House of Commons Briefing Paper Number 7415 http://researchbriefings.files.parliament.uk/documents/CBP-7415/CBP-7415.pdf

7. **Bate, A (2017)** Delayed transfers of care in the NHS. House of Commons Briefing Paper Number 7415 http://researchbriefings.files.parliament.uk/documents/CBP-7415/CBP-7415.pdf

8. **Department of Health and DCLG (2017)** 2017-19 Integration and Better care Fund Policy Framework https://www.adass.org.uk/media/5994/adass-budget-survey-report-2017.pdf

9. **House of Commons Committee of Public Accounts (2016**), Discharging older people from acute hospitals , 22 July 2016, HC 76 2016-17, https://publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/76/76.pdf

10. **NHS (2017)** https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/ Local Authority ASCOF Performance Indicators 2016-17

11. Spring Budget 2017: Philip Hammond's Speech https://www.gov.uk/government/speeches/spring-budget-2017-philip-hammonds-speech

12. **ADASS (2016)** Budget Survey 2016 https://www.adass.org.uk/budget-survey-2016

13. **LGA (2016)** Adult Social Care Funding: 2016 State of the Nation Report. Quoting Richard Humphries (The King's Fund) https://www.local.gov.uk/sites/default/files/documents/adult-social-care-funding-c17.pdf

14. **NHS (2016**) Personal Social Services: Expenditure and Unit Costs, England 2015-16. Hourly rates for home care http://content.digital.nhs.uk/searchcatalogue?productid=23352&topics=1%2fSocial+care%2fSocial+care+expenditure&sort=Relevance&size=10&page=1#top

15. **United Kingdom Home Care association (UKHCA) (2015)** A minimum price for home care http://www.ukhca.co.uk/pdfs/AMPFHC_150719.pdf

16. **Age UK (2017)** Later Life in the United Kingdom http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

17. **LGA and PHE (2017)** Health and Wellbeing in Rural Areas https://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

18. **TNS BMRB with the International Longevity Centre (2013)** research for Defra. Rural Ageing Research Summary Report of Findings http://www.ilcuk.org.uk/images/uploads/publication-pdfs/11690_DEFRARuralAgeingReport.pdf

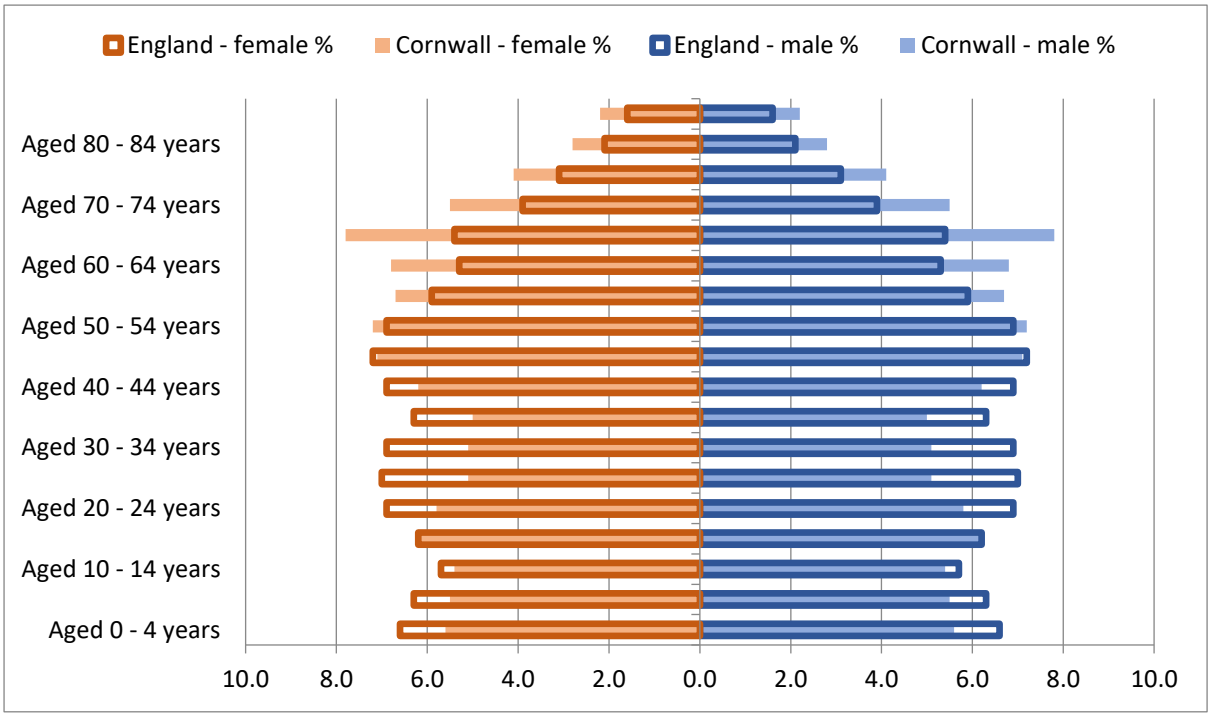
Chapter 4. The Case Study Areas

Cornwall

1. Characteristics of Cornwall

Cornwall is a sparsely populated rural area, with a population of approximately 549,400 (mid year 2015), located in the extreme South West of England. It has a population density under 1.5 people per hectare and is geographically isolated, being surrounded by sea except for its eastern border with Devon and Plymouth. There are only 5 towns with a population of over 20,000 and none exceeding 30,000. Of a total population of 545,350 in Mid - 2014, over 40% of the population lived in the countryside or in small settlements with fewer than 3,000 population (Cornwall Council [1]).

The population of Cornwall contains a higher proportion of older people than the national average. About 131,800 people in Cornwall, 24% of the population, is aged over 65 and nearly 17,000 (or 3%) is over 85 (Cornwall Council [2]). Comparative figures for England are 17.6% and 2.3% respectively.



2014 population estimate. Source: ONS [3]

It is estimated that there will be an increase of some 5725 people aged over 85 in Cornwall during the decade to 2025 by which time they will comprise 3.9% of the total population. Looking ahead to 2039 it is expected that some 6.5% of Cornwall's population will then be aged over 85.

Population Projections (000s)

	England			Cornwall		
	All Ages	65+	85+	All Ages	65+	85+
2017	55,640	10,063	1,370	558	137	19
	100%	18.1%	2.5%	100%	24.6%	3.4%
2025	58,770	11,727	1,785	593	158	23
	100%	19.9%	3.0%	100%	26.6%	3.9%
2039	63,282	15,184	3,029	642	197	42
	100%	24.0%	4.8%	100%	30.7%	6.5%

Source: ONS [3]

The Council[1] describes the local labour market and economy thus: "low economic output (per capita), low wages, low productivity, a lack of big companies have been persistent challenges"." 97% of businesses employ fewer than 10 people. The specific characteristics of the local economy have implications for the provision of home care as explored in more detail below.

In terms of deprivation, there are marked contrasts between different parts of Cornwall with highest levels concentrated in central and some western and northern Wards. Overall Cornwall compares unfavourably with the National average with some 55% of the population being within the two most deprived national quintiles. The least deprived national quintile is markedly underrepresented. (Public Health England [4])

14.2% of households in Cornwall live in fuel poverty compared to a National average of 11% (DBEIS, 2017). The Council[5] estimates fuel poverty causes 300 excess winter deaths as well as creating additional pressures on both the NHS and Social Care providers.

Cornwall has 1 acute hospital; 12 community hospitals with over 300 beds in total (271 in operation as of May 2017); and 66 GP practices.

2. The challenges facing providers of domiciliary Social Care in Cornwall.

Overview

The emerging Sustainability and Transformation Plan (Cornwall Council[6]) identifies 7 specific challenges facing health and social care in Cornwall. In addition to demographics, deprivation and geography/sparsity considered above, the Plan notes:

- Complex needs with dementia and presentation of depression in the worst quartile and higher than average suicide rates and prevalence of diabetes.
- Risky behaviours. More than half the population's circumstances or behaviours increase their susceptibility to disease.
- Financial. Rising demand and rising costs give a potential deficit of £277m in 20/21

- Structural. Too many organisations and not enough integration of services. Too much reliance on hospital beds instead of care at home or within the community.

In 2015 Healthwatch Cornwall[7] identified a number of key findings in their Care at Home Report These included:

- "A serious shortfall is perceived in the current capacity to provide care at home in Cornwall…"
- "More than 40 care providers said…current conditions in the home care sector are fragile at best and risk serious breakdown…."
- "People in receipt of care desire that it is delivered by trained and experienced staff. Continuity of care is necessary…"

"The case for change is clear and there is an increasing understanding amongst stakeholders, clinicians, practitioners, health campaigners and the wider population that the current health and care system is disjointed, overstretched, outdated, reactive, underachieving and not cost effective. There are many areas of good and outstanding practice but also areas where performance is below national standards with unacceptable variations in health outcomes.

- Right now we are spending per head of population what we will have available to spend in 2020/21. We are predicting a £140m deficit in 2016/17 across the health and social care system and if we do nothing this will grow to £277m by 2020/21. Health and care services are currently fragmented and duplicated with an over-reliance on an expensive bed-based model of care instead of placing the citizen at the centre of an integrated system and offering care at home first." (Cornwall Council [5])

A higher than average level of demand

NHS statistics for 2016-17 show that Cornwall received 14,320 requests for support for new clients per 100,000 of its population over the age of 65 which exceeded the England average of 13,490 (NHS [8]). So, not only does Cornwall have a higher proportion of older residents but also the level of requests for support from within that group is higher than the national average.

The strain that home care is under is reflected in a number of outcomes including delayed transfers of care, delays in providing care needs assessments, and difficulties in arranging and maintaining care contracts.

NHS statistics for delayed transfers of care, sometimes referred to as hospital bed blocking, indicates a much higher incidence of such delays in Cornwall than might be expected on the basis of overall population numbers. 2016-17 figures (NHS [9]) for average daily delayed transfers of care per 100,000 of the adult population attributable wholly to Social Care, or to Social Care jointly with health care, was 15.7 for Cornwall, well over double the 6.4 average for England.

The Cornwall and Isles of Scilly Transformation Board [10] quotes statistics of around 60 people each day staying in an acute hospital bed in Cornwall who don't need to be there and some 35% of community hospital bed days being used by people who are fit to leave

The snapshot figures for a single night in February 2017 show that, of the patient discharge delays, a higher percentage were attributable to Social Care and, notably, the percentage of delayed patients awaiting a social care package in their own home was more than 1.5 times the national average.

Delayed transfers of care (DTOC) February 2017 snapshot.

	Total patients DTOC	Social Care Caused	Awaiting Social Care package in own home
England	6834	2523 (36.9%)	1452 (21.2%)
Cornwall	149	78 (52.3%)	50 (33.6%)

Source: NHS England online.

Despite the Council's considerable investment in 5000 more hours of domiciliary care and an additional 38 residential home places over the year ending November 2016 this has not impacted on delayed transfer levels. Current efforts are concentrating on a timely safer discharge model operated by multi-disciplinary teams and on reducing unnecessary visits to A&E, including those from residential care homes.

We were also told that the hospital conversion rate, the percentage of people presenting to A&E who were admitted, is about twice the national average at 38%-42%.

More positively 2015-16 statistics (NHS [11]) of older people over 65 who are still at home 91 days after discharge from hospital are better for Cornwall 88.3% than the national average of 82.7%.

Worryingly, in the wider community there are typically some 600 people who have been waiting for more than 28 days for an assessment of need "and some 150 people whose care needs the Council is struggling to source". This backlog is clearly of great concern to the Council as "each person waiting for an assessment is at an unknown risk".

Clearly the demand for Home Care is interlinked with many other factors including health care and accommodation (both private homes and residential care and nursing homes). Two of our interviewees mentioned difficulties experienced by some elderly people in accessing GP healthcare which is seen as leading to more acute needs at the time of presentation and a greater dependence on emergency presentations at A&E.

Additional issues which the Council identified as increasing the demand for home care included:

- The lack of extra care housing in Cornwall
- The potential consequences of any reduction in community hospital beds.

Costs

NHS statistics [12] show that Cornwall Council paid an average of £16.13 per hour in 2015/16 for externally provided home. This is significantly higher than the England average of £14.28 and only marginally below the £16.16 rate that the UKHCA [13]) identified as the minimum for the same year.

Despite payment levels above the national average, the Council report that contracts for the provision of home care are frequently handed back -"it's a problem that we face all the time". It was explained that the challenges of serving clients in a sparsely populated rural impose addition costs on providers "it's not just more expensive for us, it's more expensive for everyone. "Those costs include additional costs of travel, time taken travelling between clients, and potentially other unproductive time.

The structure of care provision is a further factor potentially increasing costs. Typically firms providing home care in Cornwall are small and operate over a limited geographical area. There are no large national providers and "there is no real market in the provision of home care" (Council officer). From the providers perspective the level of public funding for home care is insufficient "there's not a penny to be made from home care" (Provider). "Several former providers have closed and others have contracted."

Whilst the Council clearly recognises the additional costs involved in serving rural areas, there are tensions between this recognition and its overall budget constraints. Whilst it is beyond the scope of this research to analyse this factor in detail it should be noted that some social care providers have been critical of the Councils 'Framework' system which was apparently introduced "with the intention to bring about changes in the structure of the market for providers of care at home- a smaller number of consistent larger providers, where quality could be more easily monitored…" (Healthwatch Cornwall [7]). Criticisms are that smaller providers, who could add capacity, were excluded and that companies within the framework have had payments reduced from some £17.50-£18 an hour to £16.15 without the expected compensatory rise in client numbers.

It is uncertain what impacts the increases to the minimum wage and indeed the Government's increased funding for 2017 will have on the situation.

Recruitment and retention.

All three interviewees commented on the difficulty of recruiting carers. This is supported by The Health and Social Care plan 2016-2021 [10] which states that the average annual turnover of care workers, nursing and health visitors is 37%. This was largely seen as due to the competition from other employment sectors, especially in tourism which is a significant local employer. "Whilst we can usually recruit through the winter it is more difficult between Easter and October. We are in a better position than many companies – we are able to offer full-time and part-time contracts because we have the flexibility to offer shifts in our homes - others must find it really hard"(Provider). Competition from supermarkets and within the care sector were also mentioned- "we can't compete with the rates the Council pay for re-ablement (£29 per hour)".

The sector's reliance of zero hours contracts was also seen as a major disincentive to recruitment and retention. "people want to know how much work they can rely on, for security and for things like mortgages" (Provider). Whilst mileage is paid, companies generally only pay wages for actual contact time with clients so if extensive travelling the actual hourly rate of pay can be significantly reduced. "Pay is the key issue. People are forced out of the job they love because they can't afford to keep doing it."(Provider).

The challenges of the job were also mentioned. “We get a lot more people living at home with complex needs now than, say, 10 years ago.” (Provider). Concern was expressed about knock-on issues arising from, for example, the shortage of community nurses, difficulties in accessing GPs, and the potential implications of any reduction in community hospital beds.

Vulnerable groups

There was a general consensus amongst the three interviewees that whilst the whole of Cornwall is essentially rural in character, those clients living in remoter areas, outside the main towns, are the most difficult and costly to serve. It is contracts affecting those clients that are most often handed back.

Whilst those who pay the costs themselves are usually better able to secure care, we were told that it was not unusual for private clients to pay in excess of £20 per hour, thus significantly out-bidding those who are publicly funded. For those wholly or partly publicly funded there are often significant delays in assessment, organisation of care packages and subsequent re-assessment.

The availability of informal help from family of the local community varies greatly from individual to individual. One interviewee suggested that those with family living locally not only often benefited from direct help but also from effective advocacy that could unlock problems with securing care. Conversely, those who have moved to Cornwall later in life with no local family and perhaps fewer close friendship ties often find it particularly difficult to access appropriate care.

References

1. **Cornwall Council (2015)** Cornwall: a brief description. http://www.cornwall.gov.uk/media/20392018/cornwall-statistics-infographic-a3_proof3.pdf

2. **Cornwall Council** http://www.cornwall.gov.uk/media/23153642/2014-based-national-population-projections_pyramids.pdf

3. **ONS (2016)** Subnational Population Projections for Local Authorities in England: Table 2 2014 based https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

4. **Public Health England (2017)** Health Profile http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000052.pdf

5. **Cornwall Council** Reducing Fuel Poverty and Improving Winter Warmth http://www.cornwall.gov.uk/media/17610168/warmthhealthinfographic_pr8.pdf

6. **Cornwall Council** A Sustainability and Transformation Plan for Cornwall and the Isles of Scilly: Summary of the draft Strategic Outline Case. Shaping the future of local health and care. (Summary

of strategic case being worked on by Council and NHS)
http://www.cornwall.gov.uk/media/22355677/cornwall-ios-stp-summary-of-strategic-outline-case.pdf

7. **Healthwatch Cornwall (2015)** Care at Home Report

8. **NHS online (2016)** Requests for support for new clients per 100,000 within age band.
http://digital.nhs.uk/pubs/commcaressa1516

9. **NHS England (online) (2017)** Delayed Transfers of Care by Reason
https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/

10. **The Cornwall and Isles of Scilly transformation Board (2016)** Taking control, Shaping our Future. Health and Social Care Plan 2016-21
https://www.cornwall.gov.uk/media/22983857/taking-control-shaping-our-future.pdf

11. **NHS Digital (2016)** Measures from the adult Social Care Framework, England 2015-1016. Disaggregated 0utcome Measures. 2B(1) http://www.content.digital.nhs.uk/catalogue/PUB21900

12. **NHS Digital (2016)** Personal Social Services: Expenditure and Unit Costs, England - 2015-16 [NS] Reference data Tables. Table 16 Hourly rates for home care by External and Internal provision
http://content.digital.nhs.uk/searchcatalogue?productid=23352&topics=1%2fSocial+care%2fSocial+care+expenditure&sort=Relevance&size=10&page=1#top

13. **United Kingdom Home Care association (UKHCA) (2015)** A minimum price for home care
http://www.ukhca.co.uk/pdfs/AMPFHC_150719.pdf

North Yorkshire

1. Characteristics of North Yorkshire

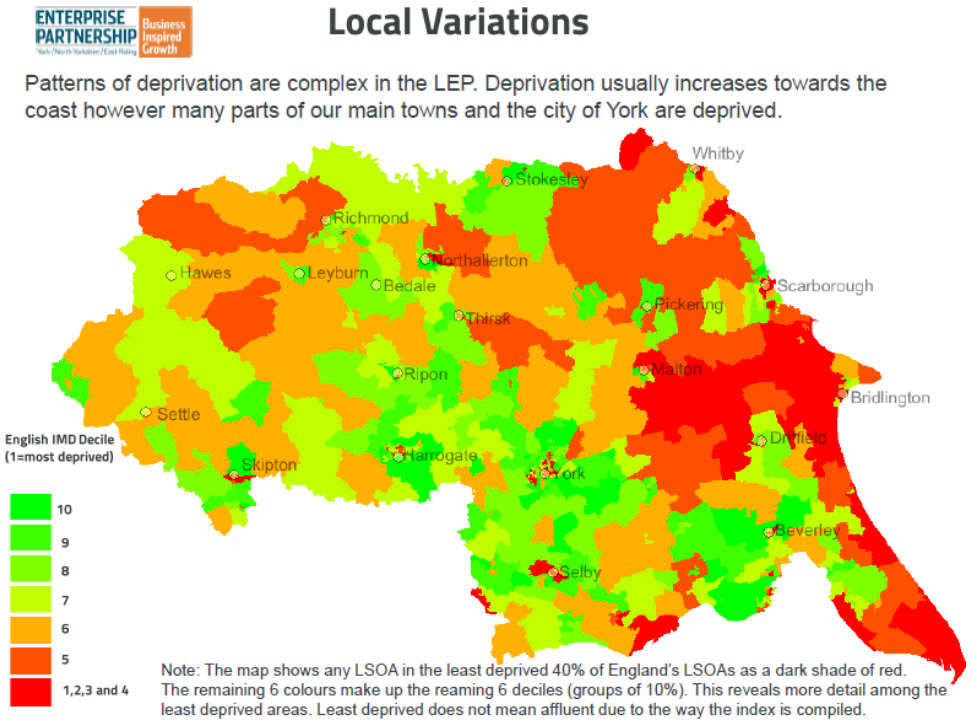
Unlike the other two case studies, North Yorkshire is a two-tier local authority area. It comprises North Yorkshire County Council, which has responsibility for Adult Social Care and seven district and borough councils and two National Parks.

North Yorkshire is classified as a predominantly rural area with 74% of its population living in settlements of 10,000 or less population, 55% living in settlements of less than 3,000 population and only eight settlements with populations of more than 10,000.[1] It has a total population of 598,376, and an average density of 0.75 persons per hectare, with three of the District council areas having a density of less than 0.5 persons per hectare.[2]

The pattern of employment by occupation mirrors very closely that for England as a whole, but with a higher percentage of jobs in the accommodation and food activities, 11% compared with 7% for England.[3] Similarly the numbers who are economically active and unemployed closely reflect that for England. However, there are more people who are self employed, 13.9% compared with the England figure of 10.9%. The most significant difference is the lower level of earnings. In 2016 locally earned median earnings were £498.30 per week compared with £544.70 for England.[3]

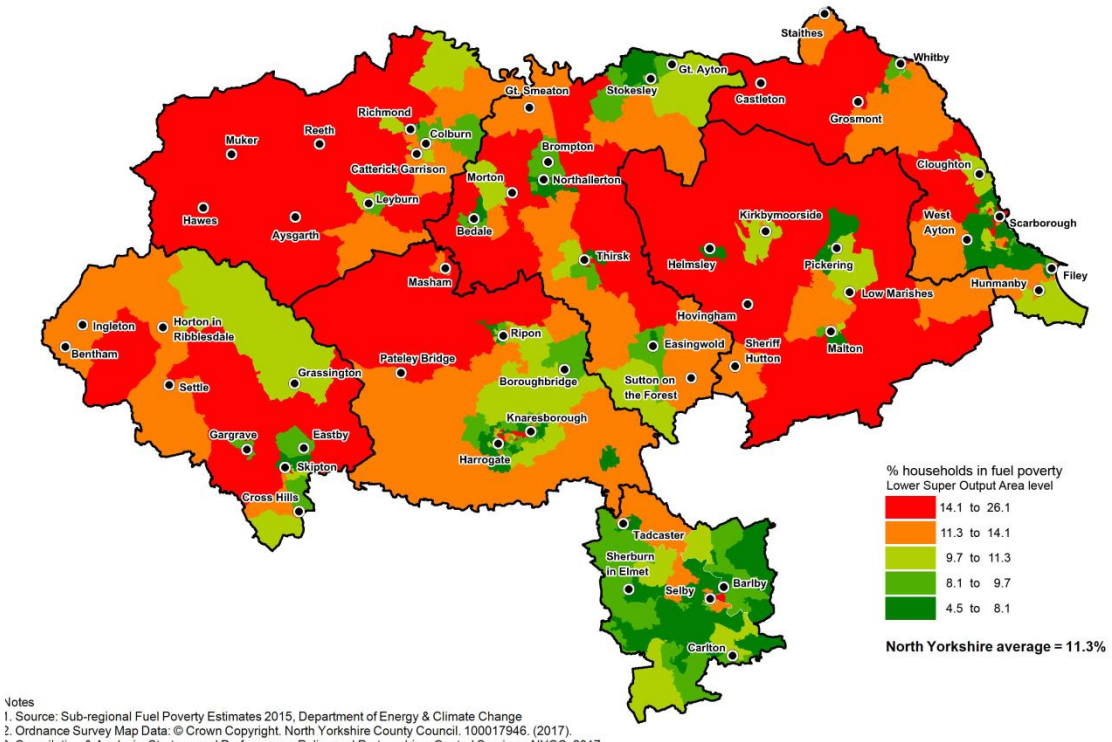
In terms of deprivation, overall North Yorkshire is among the least deprived in England. It is ranked 125th least deprived out of 152 upper tier local authorities for the Index of Multiple Deprivation (IMD), a similar position to 2010 when the county was ranked 129th out of 149 upper tier local authorities. However, there are pockets of high levels of deprivation, with the number of Lower Super Output Areas falling within the most deprived in England increasing from 18 to 23 between 2013 - 2015. These are primarily in the coastal communities of Scarborough and Filey. Map 2 shows the

distribution of deprivation across North Yorkshire and East Yorkshire. It clearly shows these pockets of deprivation, with a marked higher incidence in the coastal and more remote rural communities.



One of the risks to Health and Well Being identified by the North Yorkshire's Winter Health Strategy 2015 - 2020 are high levels of fuel poverty in three of the district council areas. Across the county as a whole there are an estimated 24,699 households in fuel poverty. This figure equates to about 10% of households in North Yorkshire, but in the districts of Craven, Richmondshire, Ryedale and Scarborough this ranges from 12.3 % to 13.3%. At Lower Super Output Area, even greater levels of fuel poverty are evident, as shown in Figure Two, that demonstrates the acute levels of fuel poverty in the more remote rural areas.[4] This is because housing tends to be older and more difficult to make energy efficient. Many homes have solid walls so are more difficult to insulate and a large proportion of homes are off the mains gas network, meaning higher costs for heating fuels. More generally in rural areas, there is a lower take up of benefits and energy advice and grants. These factors, together with North Yorkshire's growing older population, many of whom are living in rural areas with fixed incomes, are identified as the cause of hundreds of Excess Winter Deaths and emergency admissions to hospital.[5]

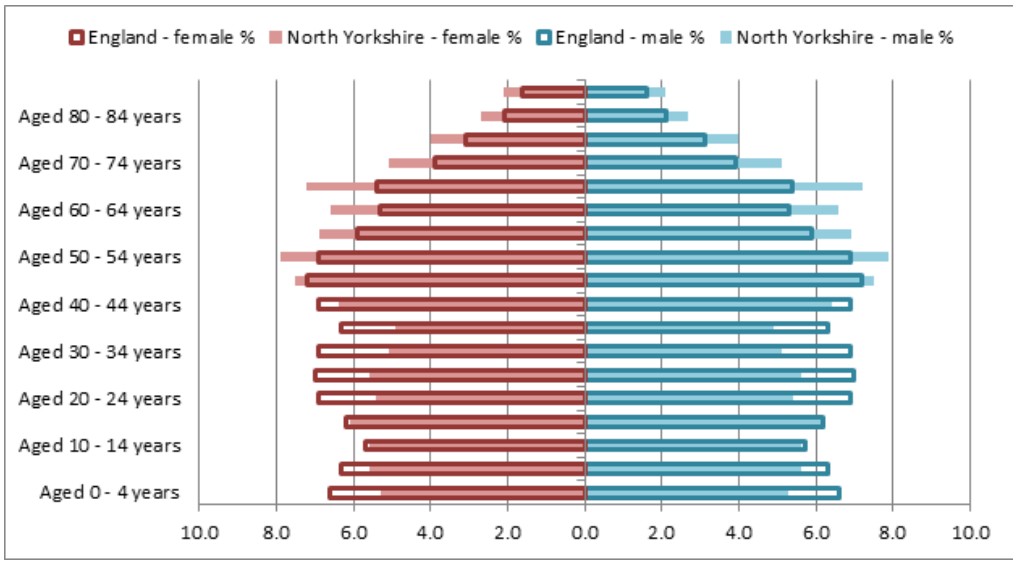
Sub-regional fuel poverty estimates 2015



Notes
1. Source: Sub-regional Fuel Poverty Estimates 2015, Department of Energy & Climate Change
2. Ordnance Survey Map Data: © Crown Copyright. North Yorkshire County Council. 100017946. (2017).
3. Compilation & Analysis; Strategy and Performance, Policy and Partnerships, Central Services, NYCC, 2017
4. For more statistics about North Yorkshire visit www.DataNorthYorkshire.org

Demographic context

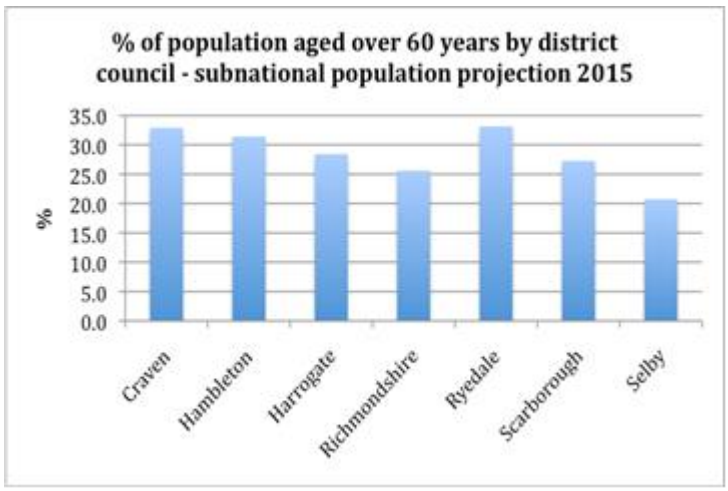
North Yorkshire has an older and rapidly ageing population. Diagram One shows the county's age profile and gender balance.



2014 population estimates ONS[6]

This high percentage of older residents holds true across the seven district councils, but with some small differences, as shown in Diagram 2

Diagram 2: Percentage of population over 60 years old



Source: 2014 Based Subnational population projections [7]

Using the same data, it is expected that by 2025 the population aged over 60 years will rise to be 35% of the population, with over 8% of residents aged over 80 years old. In the last ten years, two thrids of the county's population growth has been as a result of increased numbers of people aged over 65.[8]

The latest report by the Directof Public Health[8] to the County Council's Health and Well Being Board stated that 54% of the county's population currently aged over 65 are women, rising to 61% amongst those aged over 80 years old. It also quoted the 2011 census that showed that 30% of people aged over 65 years old were recorded as living in single person households.

Overall, life expectancy is higher than the average for England, 80 years for men and 84 for women. They also have longer healthy lives with respectively 67 years and 68 years of these being in good health.[8]

It is, however, evident that there are significant and growing pressures on Social Care resources. The latest draft Better Care Fund Plan report to the North Yorkshire Health and Well Being Board reported that, "There are an increasing number of people with multiple long term conditions, frailty and complex social, emotional, medical and psychological problems in North Yorkshire and too many frail and elderly people are attending emergency departments with conditions that could be managed in the home setting with the right level of support. Furthermore there is often a lack of emphasis on prevention in out of hospital community settings."9

2. Demand for Social Care services

As other reports (e.g. Rural Ageing Report- Defra 2013) have highlighted, we were told that rural residents tend to present and seek social care at a point of crisis. In contrast to many older people in urban areas, there is a strong emphasis in rural communities on self-reliance and drawing on the support of friends and neighbours for as long as possible.

NHS statistics for 2016-17 show that 9650 requests for support for new clients per 100,000 of its population over the age of 65 in North Yorkshire, which is less than the England average of 13,490.[10]However, we were told that there is a mixed picture across the county; with a higher pro rata rate amongst residents aged 85+ living in remote rural communities.

The late presentation and high level of emergency admissions may also be a result of the difficulties older rural residents experience reaching GP and hospital appointments. Recent research by Health Watch North Yorkshire[11] examined the accessibility of hospital and GP appointments in the district of Craven. Its findings are stark. For some rural residents, "there is *no way* a patient can be there without further taxis or an overnight stay outside of these hours if using public transport." Particular problems were noted for residents in Upper Wharfedale. The only appointments that were accessible by public transport in a four-hour window between 10.35 and 3.35 were at the Royal Lancaster. All other hospitals were only accessible within a 2-4-appointment hour window. The nearer hospitals of Skipton and Castleberg are less accessible than the longer journey to the Royal Lancaster. However, to reach an appointment here, within the 4-hour appointment window, still involves a 12-hour round trip leaving at 7am in the morning.

In terms of access to GP appointments, accessibility is better than for hospitals, but the report flags up some significant issues, including the fragility of service when so many rural practices are single GPs. In addition, over two thirds of the electoral wards within the region have no public transport access to a GP surgery outside of normal office hours. For these residents the possibility of access to GPs from 5pm to 8pm would be of no realistic benefit.

We were told that the gap between assessments for care and demand is being managed. Whilst not providing information on those at home waiting for a care assessment, data provided by the NHS shows that North Yorkshire performs better than others in terms of this being a reason for delayed discharge from hospital.

Recognising the pressure on their services, North Yorkshire have changed the way they plan a package of social care for an older resident. The assessment is still undertaken by a social worker, but whereas previously this led to NYCC providing a package of care, today the options are wider and can result in the individual gaining support from the Stronger Communities initiative or the Delivering Well Being initiative.

However, NHS data does reveal that whilst social care assessments are generally being done in a timely manner, there are delays in discharging patients from hospital that are due to problems with social care. For North Yorkshire this was the cause of delay for 41% of patients, compared with 36% for England as a whole.[12] More specifically, lack of a home-based care package is the principle reason for the delay in discharge from hospital. In North Yorkshire this was the reason for delay for 27% of patients, compared with on average 21% for patients across England. Last year the target for delayed discharge days for North Yorkshire was exceeded by 11,246 days (around 12 delays per day).[9]

Further evidence that points to a lack of Social Care support are the numbers of people aged over 65 injured as a result of falls. 213, with a total of 2228 incidences recorded, exceeded the Better Care Fund plan 2016/17 target. Similarly the fact that the reablement target for people remaining in their own home 91 days after discharge from hospital was missed could be explained in part by limited Social Care provision.[9]

From the interviews we undertook it is likely that this is particularly a problem for residents living in rural areas. We were told that the County Council typically provides 200 packages of care in total, involving 7- 10 care assessments a day. Of these they struggle to deliver around 20 - 30 care packages for older people in the remote rural communities. Primarily, this is because the Council has difficulties commissioning care coverage for these areas because of their physical isolation and the associated pressures this puts on time and costs. As a recent North Yorkshire Better Care Fund report to the Health and Well Being Board states, "It is a struggle in many, though not exclusively, very rural areas of the county to secure care at home for people."[9]

Despite this, North Yorkshire County Council puts significant priority on its re-enablement service. It provides for up to six weeks support, paid for by the Council. It assists people discharged from hospital to adapt to their changed physical circumstances and to develop new skills so they are in a stronger position to retain their independence living at home. Recognising that this requires more specialist support, re-enablement carers are paid £1 more an hour (£9.30) than a care assistant.

A particular concern is the increase in demand for Social Care support for people with dementia and their carers. With a growing older population the county faces a significant increase in the number of people with dementia. Currently it is estimated that around 10,000 people are believed to be living with dementia in North Yorkshire, which equates to 0.98% of the overall population, higher than the national figure of 0.74%. The majority of these people are aged over 65. Recognising that almost 17% of the county's population live in super sparse rural communities, the County Council's dementia strategy states, 'The issues of living in a rural area and access can increase people's feelings of social isolation and has an impact on commissioning and provision of support'.[13]

3. Challenges facing delivery of Social Care in North Yorkshire

Providing Social Care and the ability of older rural residents to access it in North Yorkshire is affected by a number of challenges, these relate to the rurality of the area; difficulties recruiting and retaining staff; the complexity of the structure and urban focus for providing health and social care; and cuts in the Social Care budget which impact more severely in an area where costs of provision are higher as a consequence of rurality.

Rurality

Providing Social Care to a small and dispersed population is more costly as shown in Tables One and Two (see costs and Budgetary pressures). This has a direct impact on the availability of social care providers covering rural areas.

Last year the Better Care Fund report to the Health and Well Being Board reported that North Yorkshire's care market was already operating at 90- 97% capacity, five years ahead of nationally projected occupancy levels. Near full employment makes recruitment and retention particularly challenging and the transactional costs and logistical requirements of remote rural and coastal areas means that the normal market assumptions that apply to most of England do not apply in large parts of the County.[14]

We were told that North Yorkshire has two contracts and three provider frameworks, with a list of 110 providers on their list. These tend to be very small organisations that barely cover the geography of the county and are unevenly distributed. Generally, it is always possible to find care for clients in Scarborough. However, even here there are pressures at holiday time when carers leave the sector because of the higher wages from tourist related employment. In contrast it is often problematic to secure agencies willing to cover Craven, the Dales and South Ryedale.

Recently one of the larger national providers pulled out of North Yorkshire, apparently as a consequence of a large-scale business decision. It is also the Council's experience that small-scale providers often hand back contracts for providing Social Care in the more rural areas. For these reasons it retains an in-house care service that can act as a backstop.

We were told that overall result is that choice of provider is more limited in the rural areas for all types of care provision. This is particularly the case for high level domiciliary care because nursing capacity is very limited, in part because the 'market' is very weak, a reflection of the isolated nature of rural communities.

To try and widen the choice, North Yorkshire County Council are considering offering a rural premium to cover the additional costs of travel. In addition, when providers are asked to bid for a service they are asked to provide 3 prices: urban- covering the towns; Rural- covering communities within a 3 mile radius of the towns; and Super Rural - covering the areas outside the first two categories. Unfortunately, even this is not sustainable, so NYCC are looking at whether they could pay an additional rural premium to cover travel times and/or pay on the basis of outcomes.

Recruiting and retaining care workers

It is in part, because of the issues of rurality, that care providers find it difficult to recruit and retain staff. In addition, as the report to the Health and Well Being Board states, "Recruitment and retention is also a key pressure for both health and social care. With near full employment, health and care providers find it hard to attract and retain quality staff. In social care, the workforce is predominantly female and employed on zero hour type contracts. This leads to seasonal capacity issues around school holidays, whilst the scale of local tourism creates additional pressures in coastal areas through the summer." It goes on to report its research that shows that even though some providers are paying more than the national minimum wage, pay levels and the demands placed on care workers from the increasingly complex needs of their clients, means recruitment and retention remains a problem.

The complexity of the structure and urban focus for providing health and social care

Responsibility for planning and providing health and social care in North Yorkshire is through a combination of North Yorkshire County Council, three Sustainability and Transformation Plans, six CCGs, seven district councils, four acute trusts, two mental health trusts and 90 GP practices. As a report to the Health and Well Being Board on integration health and social care states, 'the multiple organizations with multiple services, with North Yorkshire's size and geography, when coupled with this structure makes the journey towards integration more complex than the norm.'[9]

The three Sustainability and Transformation Plans (STPs) include a very diverse range of areas and tend to be dominated by circumstances and solutions that have an urban focus. Two examples were offered to illustrate this point.

First, the closure of local hospitals covering the more rural areas now means that rural residents commonly have a two-hour journey to attend hospital appointments or visit relatives. As noted above, the research for Health Watch North Yorkshire shows this is likely to be an underestimate of the problem.

Secondly, it is considered by commissioners that the STPs do not respond to: the hidden deprivation that exists in some of the rural communities; the high incidence of fuel poverty; and the problems of isolation that can result in depression. All these require higher investment in preventative services and helping people live at home, and access to the services they need, but which are provided beyond their community. Instead the STPs investment and activity is focused where the greatest number of people can be assisted, the urban areas, where different solutions are appropriate.

It is interesting to note that a search for the word 'rural' in all three of the STPs resulted in three references in relation to the diversity and geography of the STP area. Only one mentioned a specific rural issue, social isolation. None of them contained plans or targets that specifically addressed the need to improve delivery or access to health and social care of residents living in rural areas.

Costs and Budgetary Pressures

In 2015/16, North Yorkshire County Council spent £197million on providing Social Care; with 69% of this on long term care.[15] Data provided by NHS Digital demonstrates the higher cost of providing some forms of long-term support in North Yorkshire for residents aged over 65. A feature that is even more pronounced for the costs of short-term care as shown in Table 2

Total Unit costs of 65s and over for spend on long term support for Primary reason 2015/2016

	Learning disability support	Mental health support	Physical support	Sensory support	Support with memory and cognition
England	£868	£536	£540	£519	£543
Yorks & Humber	£804	£502	£484	£496	£498
North Yorkshire (218)	**£837**	**£441**	**£636**	**£1,118**	**£402**

Source: NHS Digital: Adult Social Care - Finance Return 2015/2016: Comparator report

Total Unit costs of 65s and over for spend on short term support for Primary reason 2015/16

	Learning disability support	Mental health support	Physical support	Sensory support	Support with memory and cognition
England	£381	£544	£529	£365	£455
Yorkshire & the Humber	£187	£342	£487	£423	£352
North Yorkshire (218)	**£547**	**£1,393**	**£545**	**£859**	**£1,012**

Source: NHS Digital: Adult Social Care - Finance Return 2015/2016: Comparator report

Of the total BCF income of £40m, £13m was spent on Social Care.[16] This year NYCC makes the greatest single contribution to the Better Care Fund, totalling over £9m in 2017/18 and an indicative contribution of £12m in 2018/19.[16] As of September 2017 there was no formal agreement on how much of this would fund Social Care, but the conditions of grant funding require that it is used to:

- Contribute to addressing adult social care pressures
- Help stabilise the care market
- Assist with the reduction in delayed transfers of care

Despite these high costs and the pressures of demand on its services, there is a requirement that North Yorkshire County Council makes a saving of £21million on its Health and Social Care budget. Across the three STP areas it has been calculated that there will be a funding gap of £2bn by 2020 if more of the same is done in terms of health and social care provision. It is not surprising therefore that 'the planning process highlighted that radical change is required in the flow of money around the system to develop preventative and out of hospital services that can effectively manage demand and deliver sustainability.'[16]

Response to challenges

In response to the complexity of delivering social care, the diverse nature of the county, requirements of the Social Care Act and the need to make £21m savings in the Health and Adult Social Care budget by 2020, North Yorkshire County Council produced, '2020 North Yorkshire: A vision for Health and Adult Services - People living longer, healthier, independent lives.' It focuses on four areas that will

maintain provision of public health and social care and support across the North Yorkshire health and care system: -

- Distinctive Public Health
- Independence with Support when I need it
- Care and Support where I live
- Better Value for money

The delivery of much of this relies on effective integration between health and social care through the Locality Transformation Boards that cover North Yorkshire. For adult social care the priority has been the launch of a new Care and Support Pathway. The key elements of this Pathway are:

- A Strong Front Door – Customer Resolution Centre (CRC) and Living Well Services Stronger Communities and Public Health
- Independence and Reablement - supporting people to maximise their independence
- Planned Care - supporting people with long term social care and support needs and their carers
- Provider Services – developing a niche role for directly provided services

The second significant shift has been for NYCC to acknowledge and work in much closer partnership with the voluntary and community sectors as part of its strategic approach to provide Social Care and meet its 2020 Vision Objectives.

Two specific streams of work are the Stronger Communities and the Delivering Well Being initiatives.

Stronger Communities Programme[17]

The aim of this Programme is to create conditions for effective social action in all communities in North Yorkshire. Although not confined to Adult Social Care, this is one of its priorities, alongside Community Transport. It is based on the principle that the voluntary, community and social enterprise sector (VCSE) can with capacity building, small injections of cash and sustainable business plans, provide care that improves health and well being and reduces demands on more intensive and costly Social Care and Health interventions. It is very much a locality based Programme based on the Rural Partnership areas. Drawing on Local Insight data the council is able to identify at Super Output Area the care needs of the locality. VCSE groups are encouraged and supported to then design a service or facility that meets these needs. For example, Ryedale Carers set up Farmers Breakfasts for retired farmers that helps reduce the social isolation that this group often experience. Sometimes these activities then give rise to the provision of further services, such as a mobile eye clinic provided through the Wilberforce Trust in York at these breakfasts.

It was also recognised by stakeholders during the design of the Programme that it would be 'undesirable' for it to support the estimated 8000 VCSEs in the county. To address this a number of these organisations were identified as Community Anchor Organisations and received investment to enable them to affect longer-term community benefit at scale. It was also revealed through a Due Diligence report at a very early stage that many of the voluntary and community sector organisations were weak. To overcome this, and build the strength and credibility of these sectors, a third of the

Programme's budget is used to build the capacity of these organisations. It has also fostered innovation by providing a 'small sparks' budget whereby any organisation with a charitable bank account can test an idea that they can then develop further if successful.

Currently this Programme supports services across almost 100 communities, at a cost over the last two years of £1.5m, with an average grant per organisation of £15,000. The aim is that funding for projects tapers off over 3 years, by which time, with the capacity building provided by the council, they are self sustaining.

Living Well Programme[18]

In line with the prevention ethos of the Care Act, the Living Well Programme was set up in 2015. Through it 24 Living Well Co-ordinators have been employed to work on a one to one basis with individuals, on the cusp of needing regular social and health care. With the support of the Co-ordinator they are helped to access services and facilities in the community that will help them meet their personal health and wellbeing goals. In so doing it aims to reduce loneliness and isolation and help prevent or resolve issues before they become a crisis. Each co-ordinator is tied to a particular geographic patch and works closely with other related professional organisations, not least the CCGs. The service is targeted and free and available for up to 12 weeks.

Inter-relationship of the two Programmes

The two Programmes are complementary and inter-dependent. The former enables the provision of community based services and facilities that can be accessed by those using the Living Well Programme. In turn it supports the Stronger Communities Programme by helping to identify the approaches that work and where there are gaps in community led provision. Key to the success of both is regular sharing and review of information as new resources, services and activities are discovered.

References

1. **North Yorkshire County Council** Rural population analysis by Strategic Support Service

2. **North Yorkshire County Council** ONS population estimates for local authorities, mid-2016 – analysis by Strategic Support Service, Central Services

3. **Nomis** Official Labour Market Statistics https://www.nomisweb.co.uk/reports/lmp/la/1941962793/report.aspx?town=North%20Yorkshire#tabempocc

4. **Department of Energy and Climate Change** - processed by Policy & Partnerships North Yorkshire County Council

5. **Health and Wellbeing Board North Yorkshire (2016)** North Yorkshires Winter Health Strategy 2015 - 2020

http://www.nypartnerships.org.uk/sites/default/files/Partnership%20files/Health%20and%20wellbeing/Public%20health/Aging%20Well%20-%20Winter%20health%20strategy.pdf

6. **ONS (2016)** Subnational Population Projections for Local Authorities in England: Table 2 2014 based https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

7. **ONS (2016)** 2014-based Subnational Population Projections for Local Authorities,

8. **North Yorkshire Health and Wellbeing Board** (2017) Healthy transitions: Growing old in North Yorkshire - Report - September 2017 http://democracy.northyorks.gov.uk/committees.aspx?commid=27&meetid=3703

9. **North Yorkshire Health and Wellbeing Board (2017)** Draft V3ii Integration of Health and Social Care and the Better Care Fund Plan pages 23 and 46 - report to pg 19 - September 2017

10. **NHS Digital (2016)** http://www.content.digital.nhs.uk/catalogue/PUB21934 - Community Care Statistics and Health Activity England 2015/16 - comparator dashboard

11. **Health Watch North Yorkshire (2017)** Rural Access Report - 2017 http://www.healthwatchnorthyorkshire.co.uk/sites/default/files/rural_access_2017_0.pdf

12. **NHS England (online) (2017)** Delayed Transfers of Care by Reason https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/

13. **North Yorkshire County Council (2017)** Draft Dementia Strategy, Bring me Sunshine: living well with dementia in North Yorkshire https://www.northyorks.gov.uk/news/article/bring-me-sunshine-new-dementia-strategy

14. **North Yorkshire Health and Wellbeing Board (2016)**The 2016/17 North Yorkshire Better Care Fund Narrative Plan August 2016 https://www.northyorks.gov.uk/recruitment/adhas/docs/BCF%20Plan%20North%20Yorkshire%20HWB.pdf

15. **NHS Digital**: Adult Social Care - Finance Return 2015/2016: Comparator report: Gross Expenditure

16. **North Yorkshire Health and Wellbeing Board (2016)** Better Care Fund Narrative Report 2016/17 https://www.northyorks.gov.uk/recruitment/adhas/docs/BCF%20Plan%20North%20Yorkshire%20HWB.pdf

17. **North Yorkshire County Council.** Stronger Communities Programme https://www.northyorks.gov.uk/stronger-communities

18. **North Yorkshire County Council.** Living Well Programme. https://www.northyorks.gov.uk/living-well-north-yorkshire

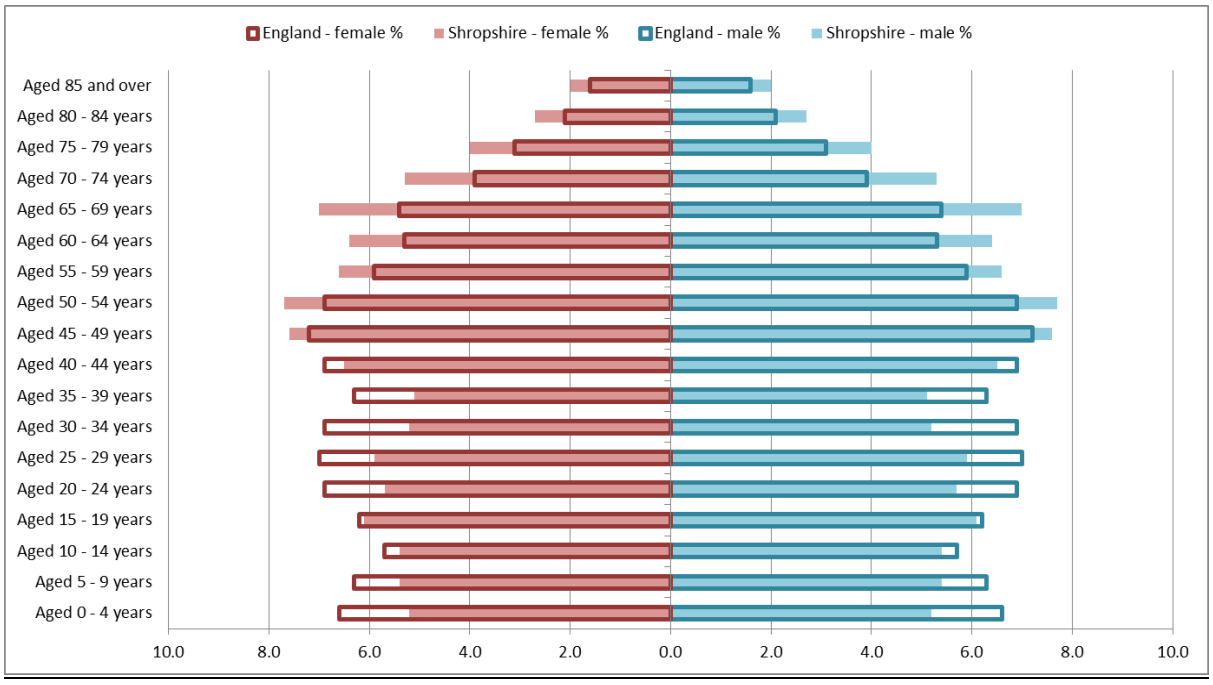
Shropshire

1. Characteristics of Shropshire

Shropshire is a very sparsely populated rural area, with a population of about 311,400 (mid 2015 estimate) and a population density of only approximately 0.96 people per hectare (Shropshire Council)[1]. It is located adjacent to the Welsh border and has eight neighbouring authorities: Cheshire West and Chester; Cheshire East; Wrexham; Powys; Herefordshire; Worcestershire; Staffordshire ; and Telford and Wrekin. Some 23% of Shropshire's population live in Shrewsbury which has a population of 71,500. No other towns exceed 20,000 population and only four, Oswestry; Bridgenorth, Ludlow and Market Drayton, have populations in excess of 10,000. A further three have populations of over 5,000.

The population of Shropshire contains a higher proportion of older people than the national average. About 76,000, 24% of the population, is aged over 65 and around 10,000 (or slightly over 3%) is over 85. Comparative figures for England are 17.6% and 2.3% respectively (ONS). The Council's statistics state that Ludlow North and Church Stretton Wards have particular concentrations of older residents with 33% and 30% of their residents being over 65.

2014 population estimate. Population pyramid (ONS[2])



It is estimated that by 2025 some 4.3% of the population will be aged over 85. Looking ahead to 2039 it is expected that some 7.4% of Shropshire's population will then be aged over 85.

Population Projections (000s)

	England			Shropshire		
	All Ages	65+	85+	All Ages	65+	85+
2017	55,640	10,063	1,370	314	76	10
	100%	18.1%	2.5%	100%	24.2%	3.2%
2025	58,770	11,727	1,785	325	89	14
	100%	19.9%	3.0%	100%	27.4%	4.3%
2039	63,282	15,184	3,029	339	114	25
	100%	24.0%	4.8%	100%	33.6%	7.4%

Source: ONS 2016

The Council[1] identifies the following characteristics of the local economy:

- "Generally, Shropshire is an affluent location, with low levels of deprivation and minimal unemployment. However, like other places, there are pockets of deprivation, where unemployment is higher and where incomes are low. " " Just under 5% of the Shropshire population live in the 20% most deprived areas of England"
- "Shropshire has a high economic activity rate amongst the 16-64 population"
- "Despite high and rising qualification levels, skills are not always aligned to the needs of businesses as reflected in skills shortage data, which suggests 15% of our businesses have either skills gaps within their existing workforce, skills shortage vacancies or both."
- "Shropshire supports a primarily small business economy, with more than nine out of 10 enterprises employing less than 10. Self-employment is high and significant numbers work from home/run businesses from home. There are comparatively few large employers, and employment is largely concentrated in the county town of Shrewsbury and the main market towns."
- "Key employment sectors include health, education, retail and manufacturing. Shropshire is underrepresented in private sector services such as professional, scientific and technical and finance and insurance. The mix of sectors in Shropshire contributes to comparatively low workplace wages and to low levels of productivity (GVA generation). "
- "A tendency to out-commute is more prevalent amongst higher earners, and this factor contributes to the considerable differential between workplace and resident's earnings."

16% of households in Shropshire live in fuel poverty compared to a National average of 11% (DBEIS[3])). Shropshire Council[4] observe that "Shropshire, as a large rural County, faces exceptional challenges in relation to the age and type of housing, the availability of mains gas and the population

profile." "Shropshire had 1,740 excess winter deaths between 2002 and 2012"and data from Public Health England[5] places the authority in the worst quartile nationally for this variable.

Shropshire has 1 acute hospital; an orthopaedic centre of excellence (serving an extensive area beyond Shropshire); 4 community hospitals (with 97 beds); and 44 GP practices. (SATH[6])

2. The challenges facing providers of domiciliary Social Care in Shropshire.

Overview

Public Health England's Health Profile for Shropshire[5] notes that the area is worse than average for road deaths and serious injuries and for homelessness, but better than average across other areas of adult health covered in the Profile.

The Sustainability and Transformation Plan (Shropshire and the Wrekin 2016) identifies a number of challenges facing health and social care in Shropshire. In addition to demographics, and sparsity considered earlier in this chapter the Plan notes:

- The pattern of demand for services has shifted with greater need for services to support frailer people, often with multiple long-term conditions
- Long-term conditions are on the rise due to changing lifestyles which necessitates a move away from short-term support towards services that support earlier interventions to improve health and deliver sustained continuing support in the community.
- Preventable lifestyle-related diseases associated with smoking, alcohol consumption, excess weight and physical inactivity make a significant contribution to the burden of ill-health. Some 65% of adults in Shropshire carry excess weight.

The report also acknowledges the need to consider rural urgent care and travel time map shows that about half of South Shropshire is over 45 minutes away from a hospital.

NHS 'Future Fit'[7], a programme for redesigning health services in Shropshire, has adopted 4 key principles:

- Home is normal
- Empowerment for patients and clinicians
- Sustainability
- New ways of working

The programme[7,8] identifies a number of specific challenges:

Changes in population profile. Demand for services has shifted with a greater need for the type of services that can support frailer people, often with long-term conditions, to continue to live with dignity and independence at home and in the community.

Clinical standards and developments in medical technology- relating to the employment of specialists and using them to best effect.

Economic challenges. "The NHS will at best have a static budget going forward. Without changing the basic pattern of services costs will rapidly outstrip available resource and services will face the chaos that always arises from deficit crises"

Higher expectations. "A push towards 7-day provision or extended hours of some services require a redesign of how we work, given the inevitability of resource constraints"

Opportunity costs in quality of service. "hospital services, across multiple sites means that services are struggling to avoid fragmentation and incurring additional costs of duplication and additional

pressures in funding". "The acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/ 7 days a week" there are also recruitment issues around A&E services.
Impact on accessing services. "Particular factors include… responsibility for meeting the health needs of sparsely populated rural parts of the County". "Provision across a network of community hospitals can be part of the redesign of services to increase local care."

Demand for home care
Shropshire's vision for the future of adult social care[9] is "to put people in the driving seat deciding how they want to 'live life their way'. Put simply, we want people who are able to, to commission their own care within the resources available to them. Our vision for the future is that the council's role will become one of a facilitator and enabler rather than a provider of services. We will provide support to help people plan their care and take control over decisions. We will ensure that we safeguard the most vulnerable adults and maintain a high quality service."

Although the population demographic might be expected to place a high level of demand of home care services , this is not reflected in the number of requests made to the Council for funding, any significant delays in providing care needs assessments, or acute difficulties in arranging and maintaining care contracts. Indeed, the number of requests for support per 100,000 of the population aged over 65 during 2015-16 was 6,665, significantly lower than the England average of 13,490 (NHS [10])

However, NHS statistics[11] for delayed transfers of care, sometimes referred to as hospital bed blocking, indicates a significantly higher number of such delays in Shropshire than might be expected on the basis of overall population numbers. 2016-17 figures (NHS digital 2017) for average daily delayed transfers of care per 100,000 of the adult population attributable wholly to Social Care or to Social Care jointly with health care were 10.0 in Shropshire, compared to the 6.4 average for England.

A snapshot of a single night in February 2017 showed that, of the delayed patients, the percentage awaiting a social care package in their own home was almost 1.7 times the national average.

Delayed transfers of care (DTOC) February 2017 single night snapshot.

	Total patients DTOC	Social Care Caused	Awaiting Social Care package in own home
England	6834	2523 (36.9%)	1452 (21.2%)
Shropshire	56	21 (37.5%)	20 (35.7%)

Source: NHS England online.

All five people we interviewed considered that DToC is a serious issue in Shropshire. Some observed that assessments seldom seem to take place before a person is considered clinically fit to be discharged, even when the discharge date is quite predictable, for example after elective surgery. We were also told, anecdotally, that NHS staffing issues have sometimes resulted in hospitals

attempting to discharge large numbers of elderly patients on the same day creating capacity problems for the council. The problems of accessing GP services, due to poor public transport and long delays in getting appointments, and the lack of 24/7 GP coverage were widely seen as factors contributing to pressures on local hospitals. Furthermore, the acute pressure on local NHS budgets were seen as discouraging initiatives to lessen pressures on A7E admissions.

2015-16 statistics (NHS[12]) of older people over 65 who are still at home 91 days after discharge from hospital are slightly lower in Shropshire 80.6% than the national average of 82.7%.

Often older people requiring care first present with quite complex needs. The council is trying to "get upstream of the problem" by encouraging older people to have a conversation with them well before the point at which they would qualify for statutory support. Those conversations can help cover related topic such as future housing and identify locally available low level support such as 'friendly neighbours' and Third Sector run day centres.

The council does not have a backlog of older people awaiting care assessments and it actively tries to find solutions, for example by providing information on local opportunities and resources, to meet an individual's needs without automatically undertaking a Community Care Assessment. The council calls back two weeks after the first contact to check whether the older person's concerns have been resolved. This call-back system indicates that about 70% of enquiries are resolved at the first point of contact.

In the past the council experienced difficulties with disjointed home care arrangements but they now operate a brokerage system whereby requests for domiciliary care are put onto a digital system linked to GIS . That system, which is also used for health care, shows the duration and times of care needed and shows the location on a map. This not only makes it easier for any of the 90 approved providers to decide whether to bid but also assists them to predict demand. A care provider commented that this was a very helpful initiative as it helped them to identify clusters of clients.

Costs

NHS statistics [13] show that Shropshire Council paid an average of £16.03 per hour in 2015/16 for externally provided home care, well above the England average of £14.28 although slightly less than the minimum £16.16 suggested by the UKHCA (2015).

We were told that costs are now (Summer 2017) typically between £16.50 and £17 an hour. This is significantly more than a more urban neighbouring council due largely to additional travel costs. The council is usually able to secure timely contracts for care provision but sometimes uses other interventions such as spot purchasing and buying blocks of care. Shropshire council does not experience hand-backs of contracts.

The council supports a variety of preventative measures aiming to keep people well and reduce hospital admissions. Although outcomes are often difficult to measure statistically the council has "a lot of metrics around well-being. A detailed evaluation of the effectiveness of social prescribing is being undertaken by Westminster University.

The general budget situation facing the council was described as “terrifying” with revenue needs growing at about £8m per annum. With 2% on Council Tax yielding only £2m the council has no option but to use reserves.

Recruitment and retention.

All our interviewees commented on the difficulty of recruiting and/or retaining carers and the council also identified a shortage of social workers which often necessitates the use of agency staff. The two care providers both identifies a particular difficulty in recruiting carers for clients in rural areas because those are not the areas where most carers live and also because carers are paid only for contact time plus modest travel costs.

Other issues identified as contributing to recruitment problems included:

- Low local unemployment rates
- Poor rates of pay
- Low status
- Competition from retail and catering sectors which often offer fixed hours contracts
- Unpopularity of zero hours contracts which are the norm for carers
- Lack of any career structure or opportunities for upskilling
- Younger people with child care responsibilities not wishing to work in school holiday
- Carers in rural areas need to have a car available

The care providers also noted a number of business challenges including:

- Problems meeting higher winter demand
- Client resistance to having male carers
- Supervision, training, appraisal and monitoring costs
- Council payments not covering the costs of caring for rural clients
- Client expectations for continuity of care by the same carers not always possible (e.g. carer cannot await a client’s return from hospital.)
- The drive to care for people at home, rather than in a hospital or residential care setting, has resulted in a dramatic increase in clients levels of frailty and the complexity of their needs.

Both care providers noted the difference between council funding at a maximum of around £17 an hour and payments by self-funders which are £3-£4 more. One suggested that self-payers are subsidising those who are council funded and the other provider raised qualitative issues around council funded care suggesting that it often has to fit the providers schedule rather than the client’s.

A Third Sector provider of day centres reported experiencing an unexpectedly rapid increase in the numbers of older people using their facilities and also a dramatic increase in levels of frailty and complexity of needs. These changes were attributed to family carers struggling to cope and increasingly using the day centres as “default respite” because “there is nowhere else for them to go”. This is presenting real difficulties as the centres are intended to provide opportunities for social contact but are not designed to provide personal care. Volunteers are struggling to cope with demand and they have had to put a cap on the percentage of dementia sufferers using their centres.

Interestingly, the two home care providers both saw opportunities for carers to upskill by providing some more straightforward health care services. Examples suggested included diabetes monitoring and control, managing medication, administering ear/eye drops, and monitoring temperature and blood pressure. It was suggested that this could be a win-win-win situation with carers having potential to up-skill and have a career, reducing pressure on the NHS, and assisting clients who may currently find it difficult to access health care. However, given the separation of health and care budgets such a change was thought unlikely to happen.

Vulnerable groups

It was commented that some older rural residents can be very resilient and reluctant to seek help until they are forced to in moments of crisis.

Informal help from family or the local community is not always available. Shropshire attracts a number of retirees from elsewhere who may be particularly isolated if their family live some distance away and they have fewer close friendships in the local community.

A further dimension of rural vulnerability is the lack of suitable housing, particularly small bungalows. A comparatively high proportion of housing stock comprises older houses which are often harder and more expensive to heat and may present other difficulties such as steep narrow staircases. The council would like to see a wider provision of supported living units, a solution which could suit both urban and smaller rural communities.

References

1. **Shropshire Council (2017)** Shropshire Economic profile
http://new.shropshire.gov.uk/media/4195/shropshire-economic-profile-january-2017.pdf

2. **ONS (2016)** Subnational Population Projections for Local Authorities in England: Table 2. 2014 based
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

3. **Department for Business, Energy and Industrial Strategy (2017)** Sub-regional fuel poverty, 2015 data. Fuel poverty by Local Authority Table 2
https://www.gov.uk/government/statistics/sub-regional-fuel-poverty-data-2017

4. **Shropshire Council (2015)** report to Health and Wellbeing Board 27 March 2015
https://shropshire.gov.uk/committee-services/documents/s6876/8%20HeatSavers%20report.pdf

5. **Public Health England (2017)** Health Profile Shropshire
http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000051.pdf

6. **NHS (2016)** Shropshire and Telford & Wrekin Sustainability and Transformation Plan (2016)

https://www.sath.nhs.uk/wp-content/uploads/2016/09/160630-11-System-Sustainability-Transformation-Plan-V0-9.pdf

7. **Future Fit** why services need to change. http://nhsfuturefit.org/why-change

8. **Future Fit** Long term conditions and frailty https://nhsfuturefit.org/why-change/long-term-conditions-and-frailty

9. **Shropshire Council** The strategy for the future of adult Social Care in Shropshire-A summary https://new.shropshire.gov.uk/media/2198/asc-strategy.pdf

10. **NHS online (2016)** Requests for support for new clients per 100,000 within age band. http://digital.nhs.uk/pubs/commcaressa1516

11. **NHS England (online) (2017)** Delayed Transfers of Care by Reason . Patient snapshot February 2017, Local Authority https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/

12. **NHS Digital (2016)** Measures from the adult Social Care Framework, England 2015-1016. Disaggregated 0utcomes Framework England 2015-16. Measures 2B(1). http://www.content.digital.nhs.uk/catalogue/PUB21900

13. **NHS Digital (2016)** Personal Social Services: Expenditure and Unit Costs, England - 2015-16 [NS] Reference data Tables. Table 16 Hourly rates for home care by External and Internal provision http://content.digital.nhs.uk/searchcatalogue?productid=23352&topics=1%2fSocial+care%2fSocial+care+expenditure&sort=Relevance&size=10&page=1#top

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