



Telford & Wrekin
C O U N C I L

Addenbrooke House Ironmasters Way Telford TF3 4NT

HEALTH & ADULT CARE SCRUTINY COMMITTEE

Date **Tuesday 3 October 2017** Time **2.00pm**
Venue **Meeting Room G3-G4, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT**

Enquiries Regarding this Agenda:

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Committee Membership: Councillors M Boylan, **A J Burford (Chair)**, S P Burrell, N A Dugmore, R Mehta, L A Murray, T J Nelson, H Rhodes, and R J Sloan
Co-optees: Mrs J Gulliver, Mrs C Henniker, Ms H Knight and Mr D Saunders

AGENDA

1. **Apologies for Absence**
2. **Declarations of Interest**
3. **Minutes** Appendix A
To confirm the minutes of the meeting of the Health & Adult Care Scrutiny Committee held on 18 July 2017.
4. **Adult Care Performance, Budget & Savings for Older People – Early Help & Support Cost Improvement Plan 2017-18** Appendix B
To receive the report of the Assistant Director: Governance, Procurement & Commissioning; and the Assistant Director: Early Help and Support
5. **STP Neighbourhood Work Update**
To receive a presentation on the development of the Community and Neighbourhood Care Models with an attempt to quantify the effect of projects implemented through STP Neighbourhood Work streams to support the acute services reconfiguration from the Service Delivery Manager - Health Improvement, Telford & Wrekin Council.
6. **Chair's Update**

HEALTH AND ADULT CARE SCRUTINY COMMITTEE
Minutes of the meeting of the Health & Adult Care Scrutiny Committee
held on 18 July 2017 at 2.00pm in Meeting Room G3 –G4 Addenbrooke House,
Ironmasters Way, Telford, TF3 4NT

Present: Cllrs A Burford (Chair), N A Dugmore, T J Nelson, R J Sloan; Co-optees J Gulliver, C Henniker, H Knight.

In Attendance: S Dillon – Assistant Director: Early Help & Support, R Purvis - Team Leader Projects, Policies & Quality, Early Help & Support, T Smart - Finance Manager, Finance & Human Resources TWC, J Tangye, Senior Democratic and Scrutiny Services Officer TWC

HACSC-01 Apologies for Absence

Mr D Saunders (Co-optee)

HACSC-02 Declarations of Interest

None

HACSC-03 Minutes

Resolved – that the minutes of the meeting of the Health & Adult Care Scrutiny Committee held on 11 April 2017 be confirmed and signed by the Chairman.

HACSC- 04 Adult Care Performance, Budget & Savings including CHC

The Assistant Director: Early Help & Support presented a report on the progress against savings plans in Early Help & Support for 2017 -18. It was noted that there was significant challenge in providing support to meet assessed needs and at the same time operating within budget. New activity across the teams was highlighted such as training around an asset and strengths based approach, focussing on what an individual could do for themselves or with the support of their family and local community rather than what they were unable to do. This was important when staff undertook reviews to enable a focus on funded support and integration with additional support from the community which promoted independence and met the needs that the person was eligible for under the Care Act. It was reported that this approach was starting to result in better outcomes. The Committee noted that the community would be informed of the change of emphasis from the Early Help & Support Services via planned public communication.

The Committee noted that 2017/18 savings were being made in accordance with the detailed Improvement Plan which was considered regularly by Officers, the Managing Director and senior Members. The Action Plan appended to the report highlighted the strategies for mental health, older people, adults with learning difficulties and physical and sensory disability being implemented to meet the savings required in the 4 year plan for

delivery of Adult Social Services. A table of risks and mitigating actions was outlined in the report in areas that covered staff capacity, market sufficiency, high cost placements, and preventative services.

It was noted that a key part of the Cost Improvement Plan was ensuring the appropriate level of care was provided whilst meeting statutory need and promoting independence where possible so that clients were less reliant on services. Outcomes were reviewed with a view to increasing independence and reducing need. It was reported that there was evidence of positive progress in reducing the numbers of over 65's moving into residential care and an increase in supported living. The Committee noted:

- From 2015-16 to 2016-17 there had been an increase in Direct Payments which allowed people to have more flexibility, choice and control of their budgets.
- Re-ablement following hospital discharge was important as this improved a return to independent living. The assessments on discharge from hospital were triangulated. Additional money as part of the Spring Budget would allow for appointment of temporary staff to support discharge.
- There was a concern about the reliance on community care, particularly in terms of individual care needs. Assessments under the Care Act meant that the Council had to consider the level of care provided by a Carer and that Carers' needs must be considered individually, particularly what the Carer felt able or not to continue to provide for the cared for person.
- There was a question re the targets for the winter period which were lower than for the summer but there would inevitably be greater pressures in winter. It was explained that the Council's legal duties in respect of the Care Act had to be met whilst ensuring the best use of resources.
- For people with learning difficulties in the transition from children to young people, care services were needed from age 14 including increased provision of supported accommodation.
- The question was posed as to how receptive clients were to the change of culture. It was acknowledged that it had to be a regular conversation with the public about what was available in the community, a communications plan was in development to reflect this regular communication. The Council believed that the more opportunities that were available, accessible and known about, the more likely it would be to generate family decision-making and earlier planning/ choices of care. Innovations such as assistive technology would also play a part. The Improvement Plan would manage demand and future need.
- It was noted that for Continuing Health Care, the Spring Budget had allowed for a specialist in CHC to look at improving performance through challenge. The Council was much closer to the national average now but had a legacy of cases.

For future meetings it was agreed that the quality and financial sustainability of the residential care market should be considered in more detail. This had arisen initially from a scrutiny suggestion received from SPIC.

For Adult care budget, performance and savings, it was agreed that the Committee would explore in more detail the specific strategies being implemented for older people and adults with learning difficulties. Additionally, the Committee recognised that it was worth looking into what happened when older people did not meet the criteria for services and support, and whether help available in the community long term. It was noted that the Council had to take account of the full picture for an older person, the risk areas, how they had managed to the point of a being admitted/ discharged from hospital.

Cllr A England, T Smart, S Dillon, R Purvis left the meeting at 3.20pm

HACSC- 05 Work Programme 2017/18 and Terms of Reference Report

The Committee reviewed the Terms of Reference and considered the work programme suggestions for 2017/18. The Chair advised that Scrutiny Management Board had agreed an initial allocation of 4 formal meetings per year per Committee. It was noted that resources were markedly different this year than in previous years and in recognition of this, Scrutiny Management Board had recommended that each Committee prioritised the top two or three topics and that resource would be required for the reconfiguration of hospital services Future Fit consultation. The Members considered the new and ongoing substantive items and the new suggestions of maternity services across the county (which was a possible Joint HOSC issue) and the resilience and sustainability of GP Practices. Substantive items included:

- Social Care Fee Rates
- Implementation of Suicide Prevention Plan (the draft Suicide Prevention Strategy was presented to Health and Wellbeing Board on 14 June, an action plan was being developed that would return to HWB)
- Growing Isolation of Older People
- STP Neighbourhood Working
- Adult Care Performance, Budget and Savings (inc CHC) - related to Cost Improvement Plan (CIP)
- Mental Health Commissioning Strategy
- Adult Mental Health Services
- Results of Carer's Survey

The monitoring activity was noted: _

- TW Safeguarding Adults Board Annual Report
- NHS Quality Accounts
- West Midlands Ambulance Service Performance Issues
- NHS Independent Complaints and Advocacy Service

The Committee had agreed at the meeting in April that the issue of the independent residential care sector was an important topic that should be explored further. The Members discussed the fragility of the care market and considered Scrutiny's role and contribution to this issue. Fee rates had been raised by SPIC as an area that their members were concerned about. Members considered whether leaving the EU would have an impact

on the market sustainability. It was noted that the care sector was a shrinking market, some care homes were turning down the Council's contracts. Fee rates, capacity and quality of care were issues that would be usefully explored and would be important for the work programme.

GP and Primary Care services was an item considered by the Committee in terms of the NHS plans for the 'left shift' and how this was being proposed. There was still concern about the impact of the closure of Malling Health Clinic and continued feedback and media reports about inadequacy at Wellington Medical Centre. It was noted that there was considerable upheaval around the GP Forward Plan, the direction of travel was multi-disciplinary teams and it was agreed that it would be valuable to get the GPs view on how this was going and capacity; a letter could be sent to practices, the local medical council and GP Confederation; the health roundtable and patient participation groups. It was agreed that this would be considered in terms of the STP Neighbourhood localities and questions raised on whether change was being well-managed, whether the GP Forward Plan and STP plans were achievable, what resource would be required and was available. It was noted that Healthwatch had been targeting surgeries to identify what the issues were.

Mental Health was an ongoing topic, the Chair was continuing to attend the Mental Health Forum and felt that this was a good means of tracking the progress of services commissioned by the CCG and the Council.

The STP Neighbourhoods plan and the implementation of its projects remained on the work programme and it was agreed that Community Resilience tied in well with the Committee's interest in the future of primary care in the community and the isolation of older people.

Members noted that questions should be raised about:

- What Community Resilience meant on the ground to patients, residents and families
- What were the limitations
- What was the current picture in the voluntary sector, which organisations were being commissioned
- How much was rhetoric and how much would develop into sustainable services
- Where was the data on community assets when the STP was predicated on the availability and use of community assets? The Council was already an active manager of premises, providing for the voluntary sector.
- How would a quantity and value be placed on resources provided by friends, families and communities?

The meeting ended at 3.56pm

Chairman:

Date:

1.0 PURPOSE

- 1.1 To enable the Health and Adult Care Scrutiny Committee to consider progress in terms of support and future needs specifically regarding older people.

2.0 RECOMMENDATIONS

- 2.1 **That the Committee consider the report and agree any recommendations or further actions.**

3.0 INTRODUCTION

We are continuing to further progress the Early Help and Support Services (EHS) approach by providing early advice and guidance to individuals in relation to adult social care and focus on the individual and community assets available. This means in practice those contacting both the Council and the Council's commissioned advice and information service 'My Choice' are receiving advice earlier and being signposted and connected to local voluntary and community led support ahead of needing statutory adult social care.

This approach as we know ensures that response to individual need is proportionate and the most intensive resources are reserved for the most vulnerable in our communities. Whilst this is positive for local people and the best use of resources, it has meant that those adults who are referred for and need statutory interventions have a greater acuity or level of need. This increased acuity is being felt in both the community and hospital discharge work.

In practice this often means that those referred for assessment and are likely to receive eventual services may have had any previous services from EHS but still have a very high level of need. The average age range for admission to care homes for example is 88-96 years old.

This and the pressure that the population increase described within this paper, present a consistent challenge to all our interventions. As a result of this the Assistant Director EHS and finance colleagues have been reviewing the original 4 year plan in detail so that it more accurately reflects both the demographic pressures and the acuity of need being currently experienced.

Throughout the service staff are being trained around an asset and strengths based approach focussing on what individual can do for themselves or with the support of their family or local community. This is important when staff undertake reviews to ensure that using alternatives such as community capacity is always considered where this is feasible. Promoting the person's independence is key to meeting any eligible needs under the Care Act. This approach is being embedded across the service.

Priorities

In accordance with corporate priorities:

- “Protect and support our most vulnerable children and adults”
- “Improve the health and well-being of our communities and address health inequalities”

In addition, the Council’s co-operative values:

- Openness & Honesty
- Ownership
- Fairness & Respect
- Involvement

4.0 KEY INFORMATION

This report focuses on services for older people.

5.0 FINANCIAL/VALUE FOR MONEY IMPACT

The available budget in 2017/18 for spot purchasing of Residential, Nursing, Homecare and Direct Payments for Older People is £13.6m. A target level of spend has been set by each quarter and to date this area of spend is projected to be £218k more than the Quarter one target.

6.0 LEGAL ISSUES

This is an information report so there are no legal issues for members’ consideration

7.0 ACTIONS TO ADDRESS

At the last Scrutiny meeting (July 2017), the Committee agreed to focus on the budget, performance and savings for Older People in receipt of services as well as those who are not eligible for services and what options are available to them.

Report prepared by Sarah Dillon, Assistant Director, Early Help & Support Services

1 Understanding Telford & Wrekin; Older Peoples demographic and population

The 65+ population of the Borough and in all localities is increasing as a proportion of the population, rising from 14.3% to 15.9% between 2010 and 2015. Hadley Castle locality has the largest 65+ population, both proportionally and in actual terms with some 12,300 in this locality aged 65 and over, 1,600 of these aged 85 and over. The proportion of the population aged 65 and over varies considerably across small areas of the Borough, from as high as 78.3% in an area of Madeley and Sutton Hill ward to as little as 0.9% in an area of Oakengates & Ketley Bank ward.

This table demonstrates projected population of Telford & Wrekin 2031

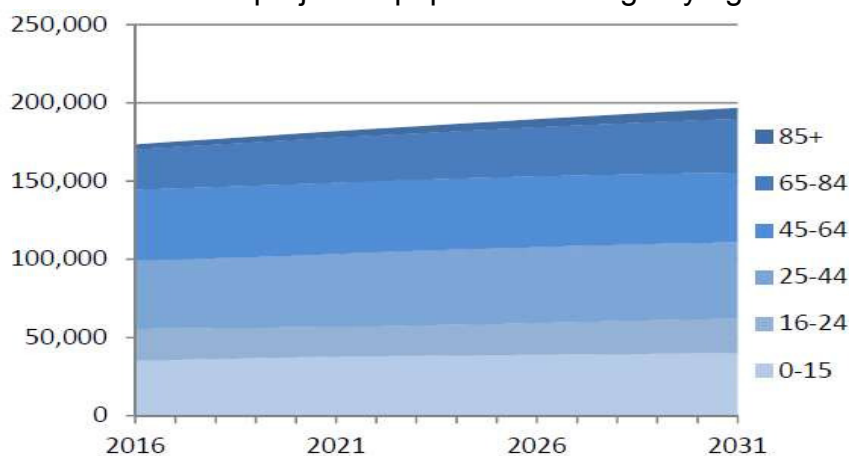
	2016			2031			Population change 2016 to 2031		
	Telford and Wrekin		England	Telford and Wrekin		England	Telford and Wrekin		England
	♂	%	%	♂	%	%	♂	%	%
0-15	35,500	20.4%	19.0%	40,300	20.4%	18.5%	4,800	13.5%	7.5%
16-24	20,300	11.7%	11.1%	21,900	11.1%	10.9%	1,700	8.2%	8.1%
25-44	43,900	25.3%	26.5%	49,000	24.9%	24.9%	5,100	11.6%	3.2%
45-64	45,000	25.9%	25.4%	44,400	22.6%	23.6%	-600	-1.3%	2.3%
65-84	25,800	14.9%	15.5%	34,400	17.5%	18.4%	8,600	33.1%	30.9%
85+	3,200	1.8%	2.4%	6,900	3.5%	3.7%	3,700	117.6%	68.5%
<i>All ages</i>	<i>173,600</i>	<i>100.0%</i>	<i>100.0%</i>	<i>196,900</i>	<i>100.0%</i>	<i>100.0%</i>	<i>23,300</i>	<i>13.4%</i>	<i>10.2%</i>

This table further breaks down the above projected populations of localities 2031

	0-15	16-24	25-44	45-64	64-84	85+	All ages	Population change 2016-2031
Lakeside South	9,900	5,800	11,800	10,600	8,400	1,700	48,100	5,700
Hadley Castle	18,300	9,200	21,100	18,900	14,600	3,100	85,000	10,100
The Wrekin	12,100	7,000	16,100	14,900	11,400	2,200	63,700	7,500
Telford and Wrekin	40,300	21,900	49,000	44,400	34,400	6,900	196,900	23,300

Between 2016 & 2031 the Borough population is expected to increase by 23,300 (13.4%). Over half of these are 65 and over, with the 85+ ages more than doubling (117.6%) and the 65-84 ages increasing by 33.1%. All England is expected to grow 10.2%, a slower growth than the Borough (13.2%). The largest difference is seen in the Borough's 25-44 age group which expects 11.6% growth compared with just 3.2% for England.

The below indicates Telford & Wrekin projected population change by age band 2016-2031



A total of 12,313 households in Telford and Wrekin identified themselves in the 2011 Census as only containing people aged 65 and over, 18.5% of households in the Borough. Hadley Castle has the highest proportion of households where all residents are aged 65 and over (19.8%) whilst Lakeside South has the smallest proportion (16.4%). Proportions of those aged 65 and over vary across the Borough. Newport has the highest proportions of households aged 65 and over (24.5%). Sutton Hill has the highest rate of households in the borough where a person aged 65 and over is living alone (14.3%).

The table below highlights households where all residents are aged 65 and over

	One person households	One family	Other household type	All households aged 65 and over		All households
Lakeside South	10.0%	6.3%	0.2%	2,745	16.4%	16,688
Hadley Castle	11.3%	8.3%	0.3%	5,643	19.8%	28,439
The Wrekin	10.4%	7.6%	0.2%	3,925	18.3%	21,481
Telford and Wrekin	10.7%	7.6%	0.2%	12,313	18.5%	66,608

2 Older Age Groups Rapid increases with Limiting Illnesses

Older Age Groups Rapid Increase with Limiting Illnesses

The age profile in Telford & Wrekin is changing, with the older age groups increasing more rapidly. The table below sets out population forecasts for Telford and Wrekin for particular needs and which create potential demand for care and support

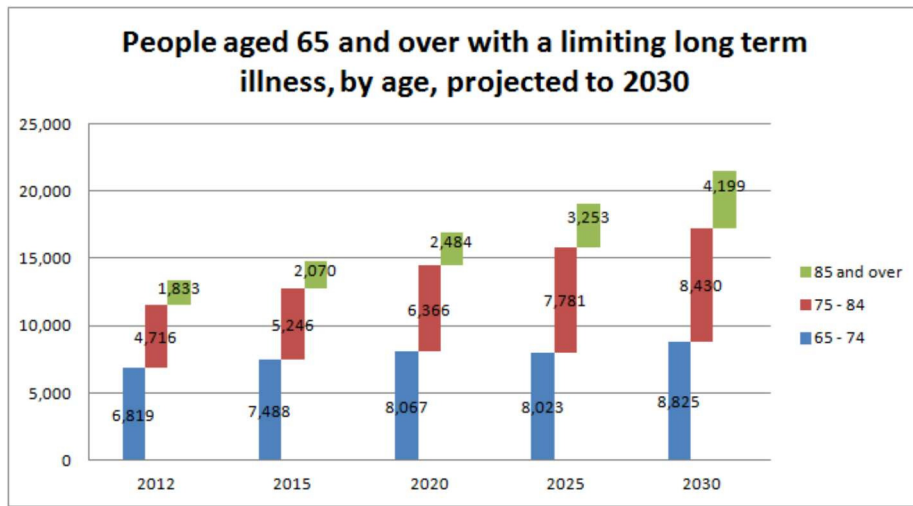
Adults aged 65 years plus	2015	2020	2025	2030
People living with dementia (POPPI)	1,747	2,084	2,551	3,091
People with a limiting long term illness (Office of National Stats.)	14,804	16,917	19,057	21,454
People unable to manage at least one self-care task (POPPI)	8,917	10,443	11,983	13,856
People unable to manage at least one domestic task (POPPI)	10,862	12,781	14,696	16,941

Projecting Older People Population (POPPI)- <http://www.poppi.org.uk/>

ONS - <https://www.gov.uk/government/organisations/office-for-national-statistics>

ONS and Census 2011 data shows that those people aged 65+ years and older who may have a variety of illnesses which may include dementia.

- The 'Health and Wellbeing Strategy' has identified key priorities to tackle with the vision 'to improve the health & wellbeing of our communities and address health inequalities.'



Graph to show forecast of limiting long-term illness (ONS projections)

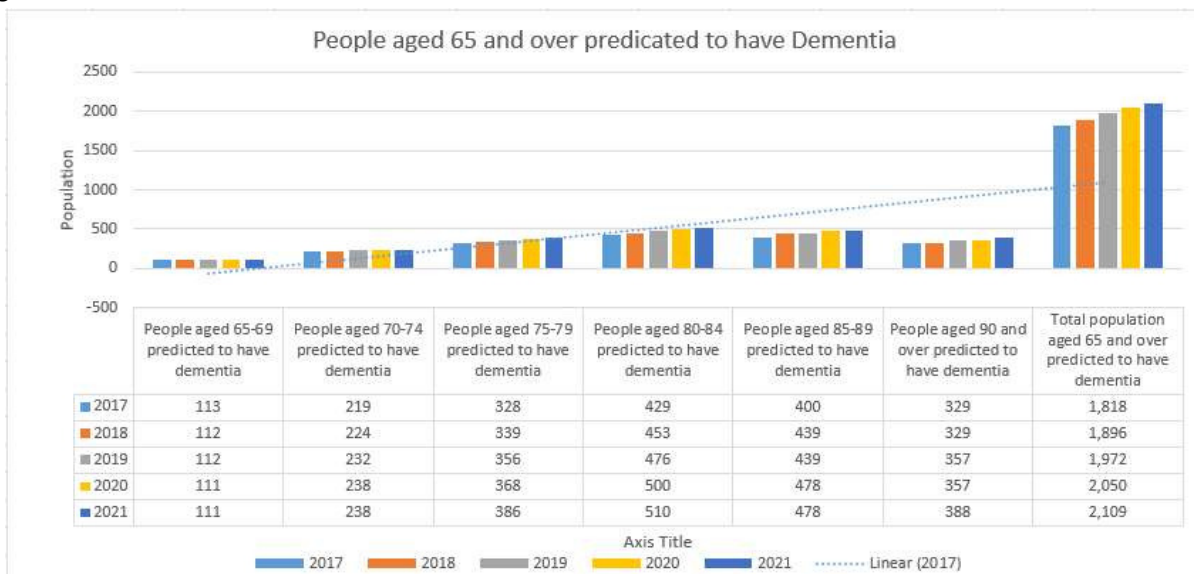
This information published within our Market Position Statement to ensure that we continue to work with Partners and Providers and other stakeholders to ascertain how care and support solutions can be made effective to meet

- The increase in projected demand and to address the priorities and issues that this age group has.

People with Dementia

The term 'dementia' is used to describe a syndrome which may be caused by a number of illnesses which there is progressive decline in multiple areas of function, including decline in memory, reasoning communications skills and the ability to carry out daily activities. Alongside this decline individuals may develop behavioural and psychological symptoms such as depression, psychosis and aggression which cause problems in themselves which complicate care and which can occur at any stage of the illness.

Around 1,800 residents are suffering from dementia over 64. The number of sufferers increases with age band with 800 sufferers aged 85 and over. Dementia is more prevalent in females than males aged 75 and over, resulting in 1,000 female sufferers aged 75 and over compared with 400 male sufferers



Carers

Many people with social care needs are supported by others who care for them and it is important to ensure that we are supporting Carers which is a key part of the Care Act, 2014. We must ensure that appropriate information, advice and support is available to carers at all stages of their caring journey. We should also ensure that carers are informed of their right to have a carer's assessment, which they can have either together with their cared for person or separately. For more information on [Carers](#) please visit the [MyLife](#) website.

There were 3,670 adults aged 65 and over in Telford and Wrekin who identified themselves as unpaid carers. They represent 15.2% of all adults aged 65 and over in the Borough. There are 1,537 (42%) of these adult carers providing up to 19 hours of care each week. A further 1,610 (44%) are providing 50 hours or more of care each week.

The table shows the level of unpaid care provided by residents aged 65 and over

	1-19 hours	20-49 hours	50+ hours	Unpaid care total		All residents aged 65 & over
Lakeside South	309	114	361	784	14.6%	5,377
Hadley Castle	686	248	691	1,625	14.8%	10,960
The Wrekin	542	161	558	1,261	16.3%	7,752
Telford and Wrekin	1,537	523	1,610	3,670	15.2%	24,089

Commissioning also have in place Contractual Agreements for Carers Respite and Carers Counselling Services across age groups.

Support for Carers in Telford & Wrekin

As part of our joint funding arrangements between Telford & Wrekin and Telford and Wrekin Clinical Commissioning Group (CCG), services to carers are offered. For more information please visit the [take time for yourself](#) pages or contact the [Carers Centre](#). Carers Assessments are also available to carers in Telford & Wrekin.

Around six million carers in the UK provide unpaid help and support to a partner, relative, friend or neighbour who is ill, frail or disabled.

There are an estimated 17,000 unpaid carers in Telford & Wrekin. Anyone can become a Carer. Carers can be of any age, from any cultural or social background.

A carer doesn't have to be someone who lives with the person they care for or be related to them. If a person devote substantial amounts of time to supporting someone cannot manage at home without help, they are a Carer. Often because people don't recognise the caring role they have, many people don't get the support they need so the Carers Centre alongside the Council and other partners have an important role to raise awareness of Carers issues. There is an active Carers Partnership Board in Telford which includes partners alongside the Council but also critically Carers who help shape the development of services to ensure they meet the needs of Carers.

3 Current Support for Older People in Telford

The Care Act 2014 sets out the requirement to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support responsibilities.

This support can range from advice and guidance on healthy living to ensuring that those people in receipt of services are able to remain as independent as possible. The aim is to prevent needs for care and support developing where possible.

This approach has the dual benefits of enabling people to retain independence and autonomy over their care as well as ensuring public funds are spent economically and effectively.

The Care Act 2014 also sets out clear council obligations in providing good and effective information and advice. For this, the information is of high quality, up-to-date, reliable, and effective to assist and support people to help themselves, supporting self –care and self-management as well as prevention and early intervention.

Telford & Wrekin Council (T&W) through our co-operative values and priorities is committed to delivering the best quality services for residents who have eligible care or support needs, within the resources available.

The Council is committed to working with its partners (particularly the voluntary & community sector, local providers of care and support, the NHS and of course service users and family carers) to develop services for residents that help people live as independently as possible with minimal intervention.

Our [Commitment Statement](#) also sets out our Co-operative Council Values and Principles to ensure that we work together with our residents, partners and local organisations to collectively deliver the best we can for the Telford & Wrekin. Underpinning this approach is our commitment to deliver the best quality services, for people who have care & support needs within the resource available. This also reflects the national Think Local Act Personal commitment in Making it Real, to transform adult social care through personalisation and community based support. Making it Real is built around 'I' Statements, which express what people have said they want to experience.

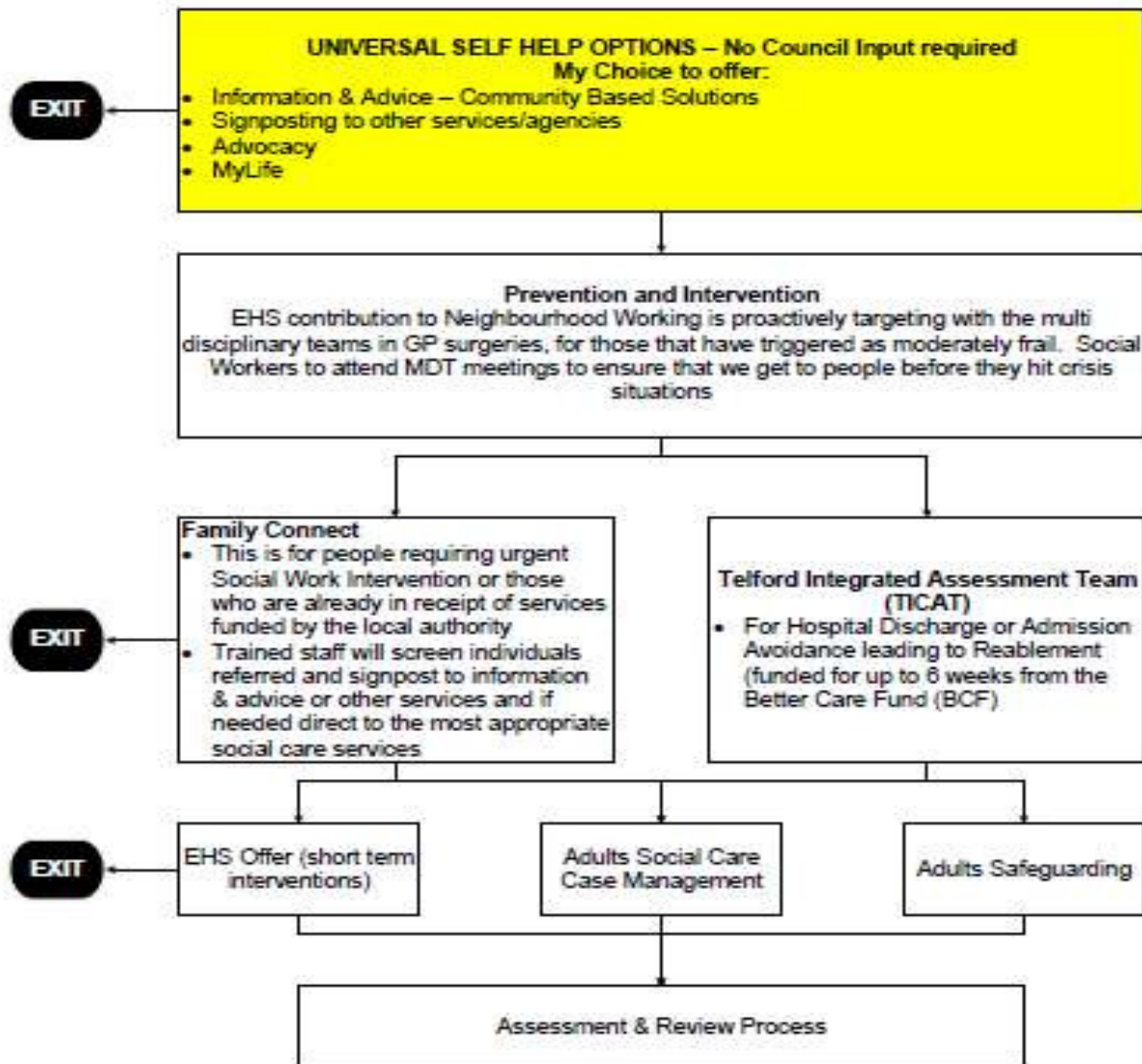
Safeguarding and promoting the welfare of all adults and older people from significant harm requires effective joint working between all officers based in the Family Connect Service, which is the Council's front door for all enquiries relating to adults and older people. All officers working within this service take responsibility for ensuring all actions are undertaken to prevent unnecessary escalation of issues or problems by delivering or seeking early intervention support to ensure the right response is given by the right services, at the right time.

The diagram below describes the Early Help & Support Services model for Adults and Older People.

EARLY HELP & SUPPORT SERVICES – Our Pathways		
Right Help, Right Time to Promote Independence		
Service Improvement & Efficiency Team	27-09-2017	Version 1

Principles of Early Help & Support

- Always start with the assets and strengths of people, their families and their communities and think about services last
- You cannot have conversations effectively without knowing the communities and neighbourhoods of those people you are listening to
- Putting the individual at the centre of what we do
- All that we do, every single word is based on building independence for all and preventing dependencies at every level



4 – Prevention and Reablement Offer for Older Adults

Information, advice and advocacy services for adults & older people in Telford & Wrekin.
Contract with Age UK Shropshire Telford & Wrekin to 31-03-2019

This service is offered outside of the Council front door by My Choice, who provide information on:

- Access to carers services
- Welfare benefits advice for carers and cared for
- Community based care
- Services to promote and support independence
- Personal budgets
- Support and coping strategies for dealing with long term health conditions

The service is open Monday to Friday from 9am to 5pm and is provided by Telford Advice and Advocacy Alliance from Taking Part (Adults with Learning Disabilities Advocacy Service), Citizens Advice Bureau, Age UK, Alzheimer’s Society and Shropshire Independent Advocacy Scheme (Mental Health Advocacy Service)

We have also developed the [Information & Advice Strategy](#) to ensure that Telford & Wrekin Early Help & Support Services meets its statutory obligations in providing good and effective information and advice as set out in the Care Act 2014 for all residents in the Borough of Telford & Wrekin.

The below data shows numbers of people who have contacted us compared to the national data which indicated that for older people aged 64 + years old is reducing.

Request for Support Per 100,000 Population

	Per 100,000 Population				
	2014-15	2015-16	2014-15	2015-16	2016-17
	National	National	T&W	T&W	T&W
18-64	1552	1495	1182	1769	742
65+	13765	13403	9210	9089	7825
Total	4279	4178	2857	3322	2245

My Choice were in place from October 2015, at which point the Access Team were also disbanded as part of re-structuring.

Neighbourhood Working

We are working collaboratively with our health partners as part of the Neighbourhood Strand of the Sustainability and Transformation Plan (STP). From an EHS perspective we are collaborating with the local GP areas and arranging with partners to run local sessions where people can come for help and advice around social care. The aim of this work is to ensure that local people have early advice when they need it without having to tell their stories numerous times.

Family Connect

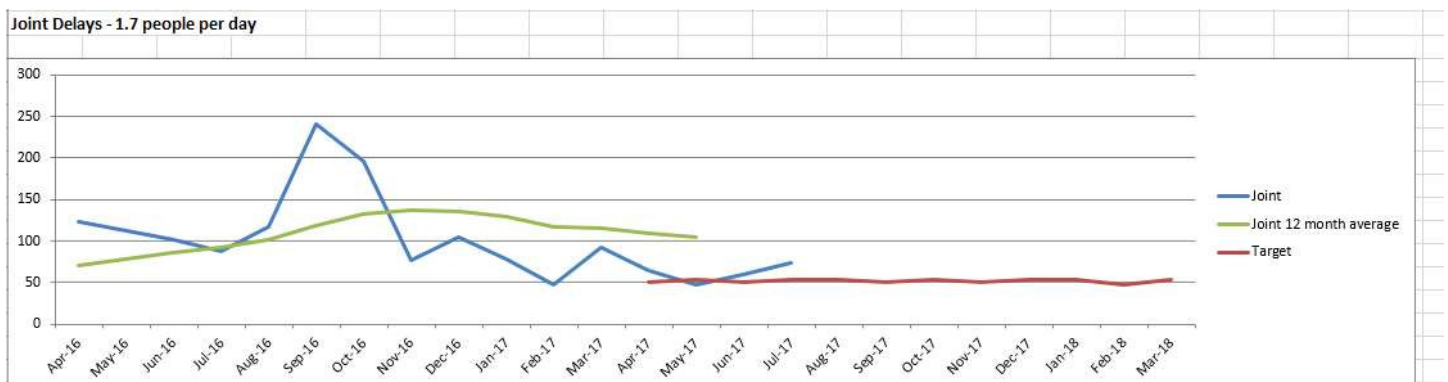
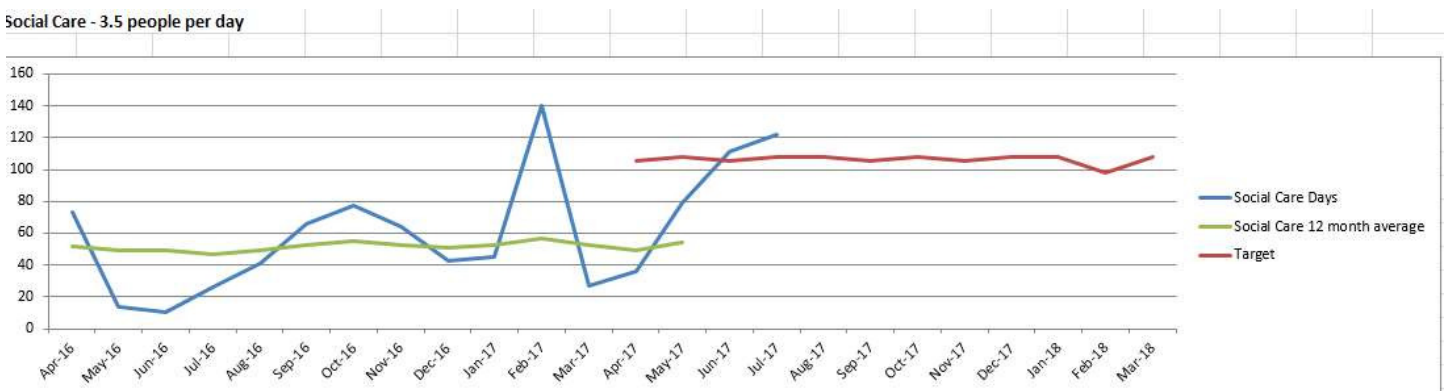
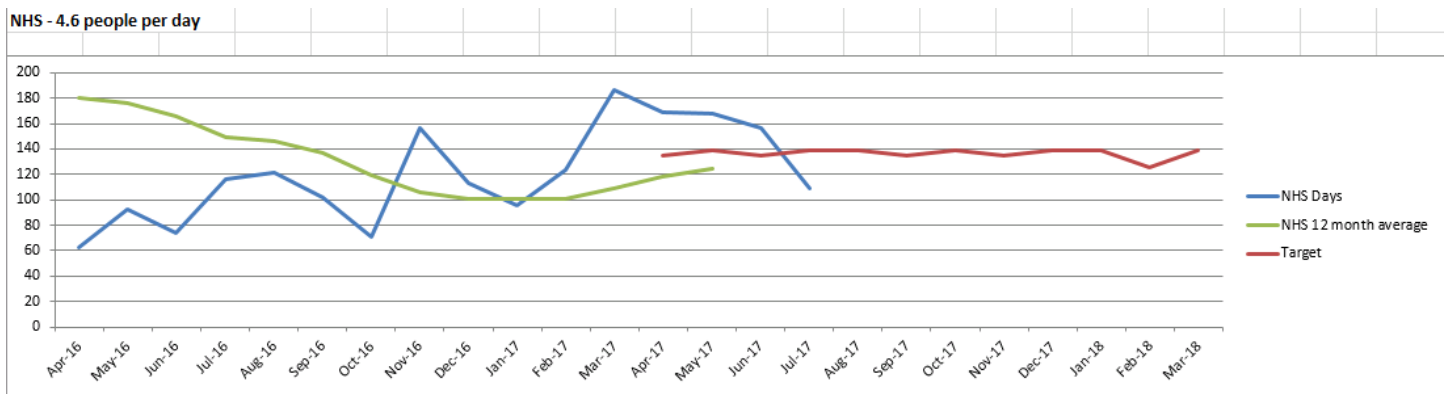
As the diagram suggest for those people needing urgent social care interventions, the first point of contact will be Family Connect. Trained staff will be answering the telephone and able to offer individuals advice and information and where necessary, direct to the most appropriate team within our Early Help & Support service.

Telford Integrated Community Assessment Team (TICAT)

For those who are in hospital and require support with discharge the first point of contact is TICAT. There is a team of social work staff based at Princess Royal Hospital (PRH) who work within the hospital to arrange early discharge and ongoing enablement for those that need this level of service. With the increasing demand for NHS services there is a real pressure on ensuring that speedy discharges from hospital. This is also a Better Care Fund requirement and each local authority has now been set a target to reduce the delay in hospital discharges.

In Telford we are roughly in line with the targets set and with the locally agreed target for discharges for those returning home with domiciliary care within 48 hours. This is an area of continued and monitoring work with NHS colleagues given the demands in this area.

The graphs show the targets for delays per day for the NHS, Social Care and those that are joint delays



Enablement Services

The numbers in 2016/17 the number of people per 100,000 population completing enablement was similar to the 2015/16 national figures, we have far more people going through enablement from hospital and less from the community. This highlights positive work and success of the enablement service as shown below.

Route of Access for Those Completing Enablement

	Per 100,000 Population				
	2014-15	2015-16	2014-15	2015-16	2016-17
	National	National	T&W	T&W	T&W
Transition	2	0	0	0	1
Hospital Discharge	239	263	276	265	342
Diversion from Hospital	26	27	0	15	36
Community/ Other route	216	196	134	152	103

Assistive Technology

Using community alarms and/or telecare technology can help people of any age and ability to live independently, safely and securely in their own home. It can also give family and friends peace of mind that they can be contacted in an emergency. Additionally, carers pagers can be purchased which alert live-in carers only when help is needed allowing them some respite from their caring role. This can be particularly helpful during the night when on site carers can sleep soundly with the assurance that the telecare pager will alert them when support is required, i.e. bed /door exit, epileptic seizure or fall, etc.

We have a nominated Assistive Technology Officer who is focussing on reducing night care arrangements and develop night time hubs with the use of the Just Checking units and other digital technology from Grand Care. This will ensure that assistive technology is used and promoted when commissioning care. This will enable individuals to be less reliance upon care support at night so they have greater independence but will also reduce night care costs considerably.

Further use of assistive technology, investing to save, to enable the reduction of night time care costs, is being considered because of the clear evidence that this can reduce night time support.

Night time care service

The night time service started on the 4th September to support toileting/turning during the night. This helps prevents hospital and residential care admissions by providing care during the night and helps people to stay in their own home. We continue to evaluate the use and impact of this service so that we can make longer term plans.

5 Community Social Work & Safeguarding Services

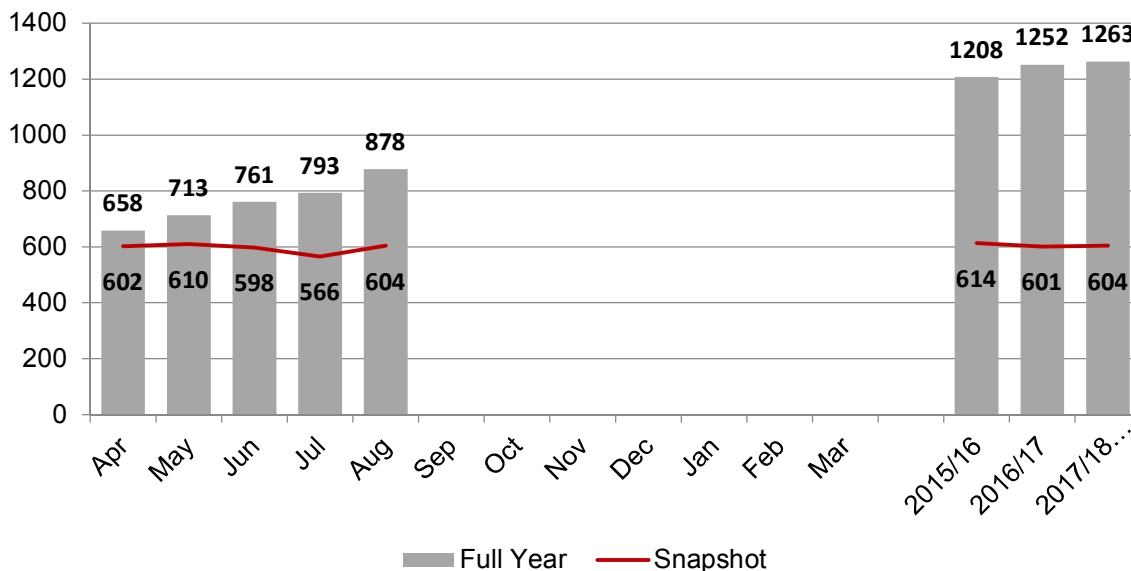
Social Work staff consider the proportionate assessment conversations under the Care Act and listen to what people have to say ensuring that full consideration is given to whether the individuals needs impact upon their wellbeing and establish the impact of this on the person's outcomes. There will be instances where immediate action is required and examples of this include:

- People that are terminally ill
- Rapid deterioration in an adult's condition
- The occurrence of an incident
- A specific issue such as a stroke
- Evidence of a safeguarding issue
- Unsafe living quarters
- Admission avoidance

For those that are eligible under the Care Act and there is no alternative other than funded support we commission a range of care and support. The following information is broken down by service type to show the activity across domiciliary care, direct payments, residential and nursing home placements.

Domiciliary Care

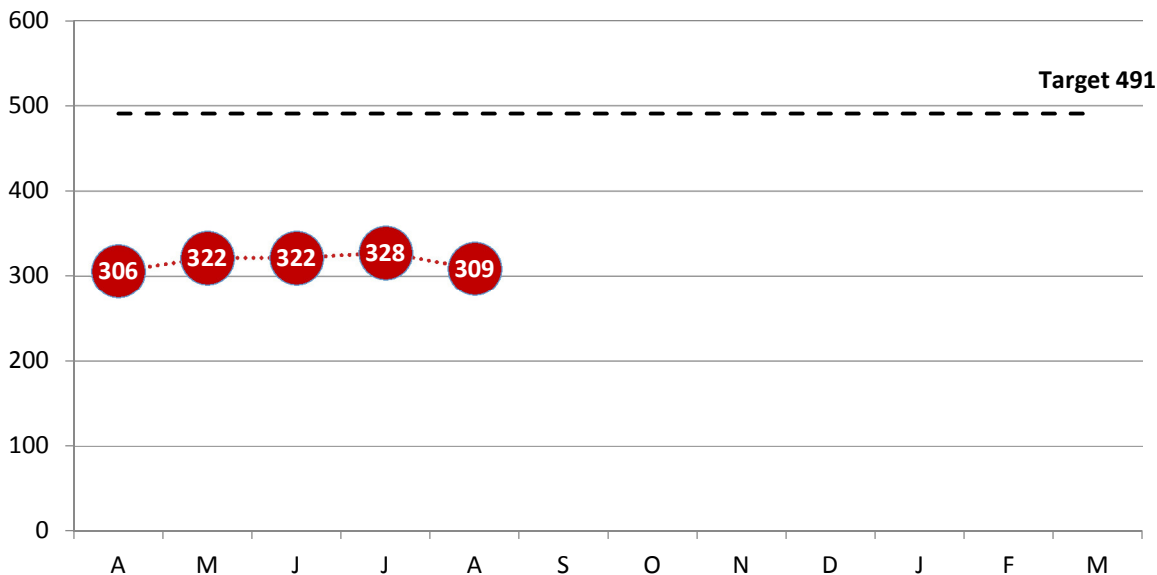
This graph illustrates the activity of people in receipt of services that are 65+ years old and over. This remains a key part of the service to enable older people to remain in their own homes. The focus of reviews being undertaken is to ensure that support is being provided in the most effective way and promotes independence whilst using local community wherever possible. This enables us to direct more intensive resources to the most vulnerable in our communities and whilst supporting those that can be to be supported by their communities and/or family networks.



Direct Payments (DPs)

We are working with POhWER via a Contractual Agreement to offer the Direct Payments Service for all adults who receive a DP from the Council to use to meet their eligible needs under the Care Act. Increasing the number of older people eligible under the Care Act, to receive direct payment is a key focus of our improvement plan. We are working with the Community Catalyst co-ordinator (a national community interest company working with the DoH) to promote the businesses and encourage use of these to help deliver health and social care services. POhWER and social workers jointly undertaking and completing reviews to promote Direct Payments.

This graph illustrates the number of clients in receipt of Direct Payments for all Adults



Previous Performance	2014-15	2015-16	2016-17	
Telford & Wrekin	21.1%	21.8%	25.5%	309
National	26.3%	28.1%		1,222
				=
				25.3%

Residential Placements for Older People

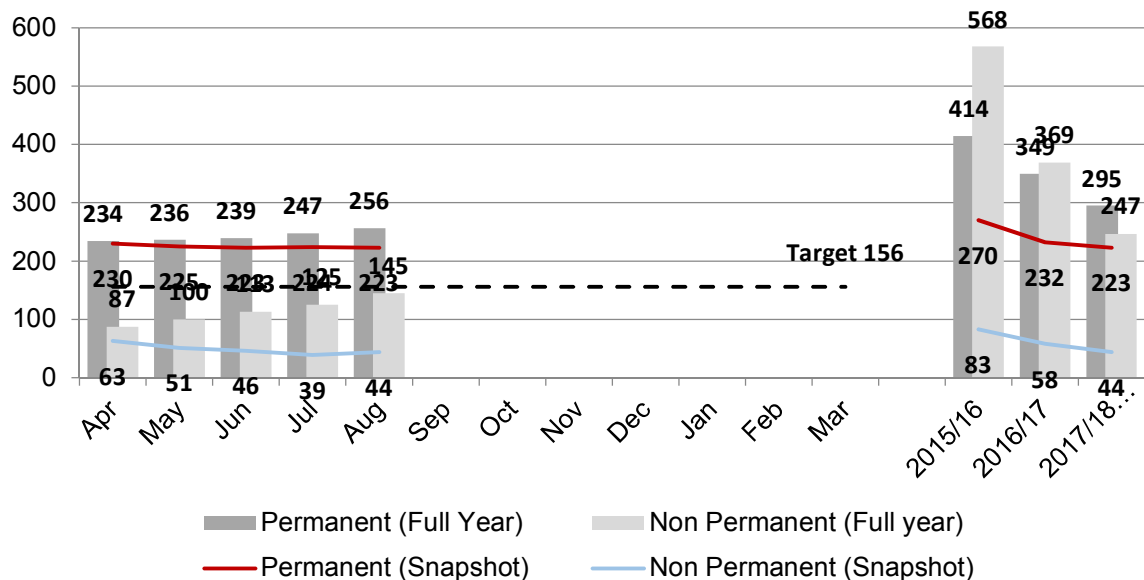
For those people where there is no alternative option given the level of their needs other than bed based care, we commission both block and spot arrangements of residential and nursing care. We have noticed that the level of need and the age and level of needs of those entering residential and nursing care has increased over the last 3 years due to the range of community options available to people to enable them to continue to live in their own home longer.

Placements for Older People for both Residential/EMI and Nursing/EMI have followed expected demand however the cost of this care has increased.

Given the population increases described above, we are working with partners to develop a range of alternatives to bed based care including Extra Care housing options. Due to the likely increase in the numbers of older people with dementia in future years described above, the Extra Care housing options need to be suitable for people with dementia.

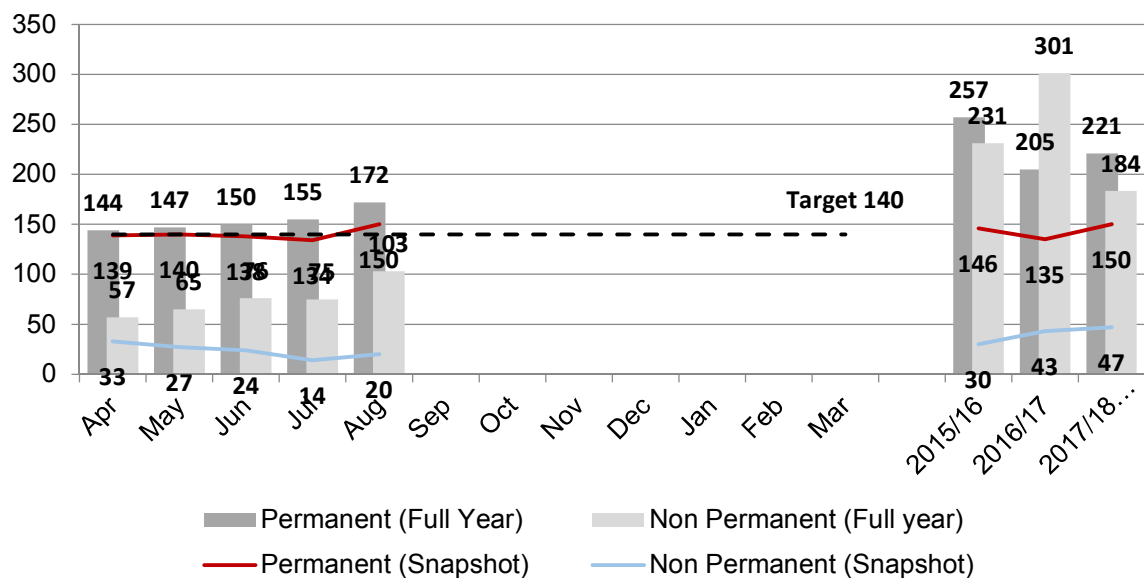
For those who are admitted to residential care as part of their reablement post hospital discharge we are working hard to improve the speed of reviews so that people can return to their own home as soon as this is possible. However, longer stays in residential care can for some people mean that they can lose their independent skills.

The graph below illustrates the number of residential placements for people aged 65+ years old and over



Nursing Placements for Older People

This graph illustrates the number of nursing placements for older people aged 65+ years old and over



The following information is related to all Adults and Older People supported in a year and at year end

All Clients Supported In Year

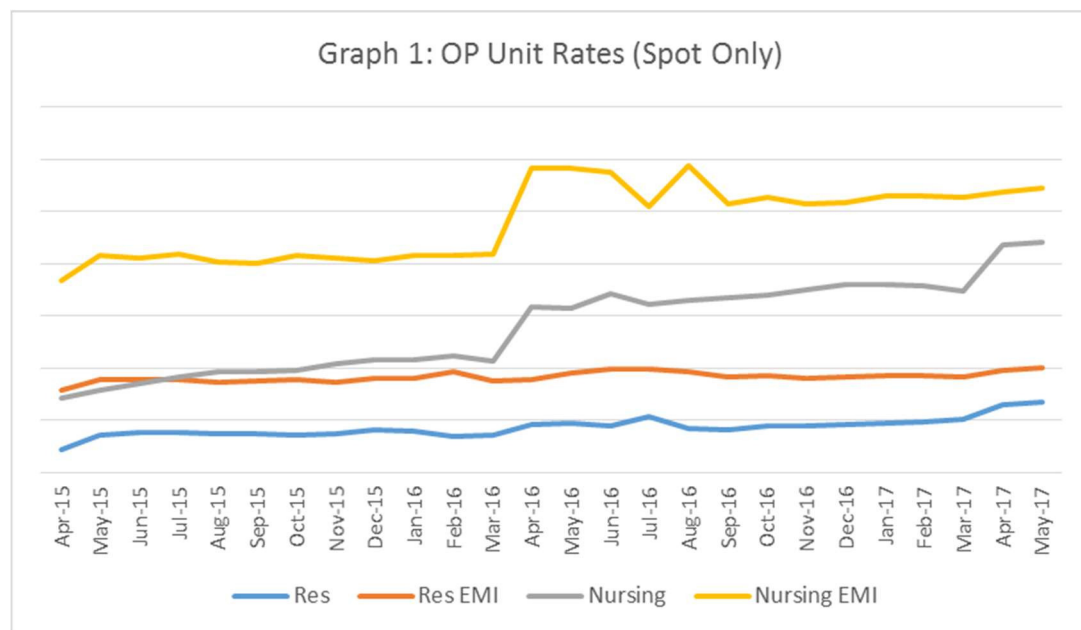
	Per 100,000 Population				
	2014-15	2015-16	2014-15	2015-16	2016-17
	National	National	T&W	T&W	T&W
18-64	857	853	809	813	822
65+	6288	6049	5919	5054	4846
Total	2070	2024	1875	1712	1676

All Clients Supported At Year End

Support Setting - 18-64	Per 100,000 Population				
	2014-15	2015-16	2014-15	2015-16	2016-17
	National	National	T&W	T&W	T&W
Nursing	16	17	19	24	15
Residential	111	110	111	96	82
Community - DP Only	176	188	102	101	153
Community - Part DP	57	64	63	87	66
Community - Manage PB	258	268	392	356	353
Community - Commissioned	121	93	10	72	57
Support Setting - 65+					
Nursing	514	511	643	536	475
Residential	1133	1104	1066	964	814
Community - DP Only	342	339	184	179	232
Community - Part DP	101	105	110	89	46
Community - Manage PB	1836	1822	1930	1875	1629
Community - Commissioned	356	292	0	54	39

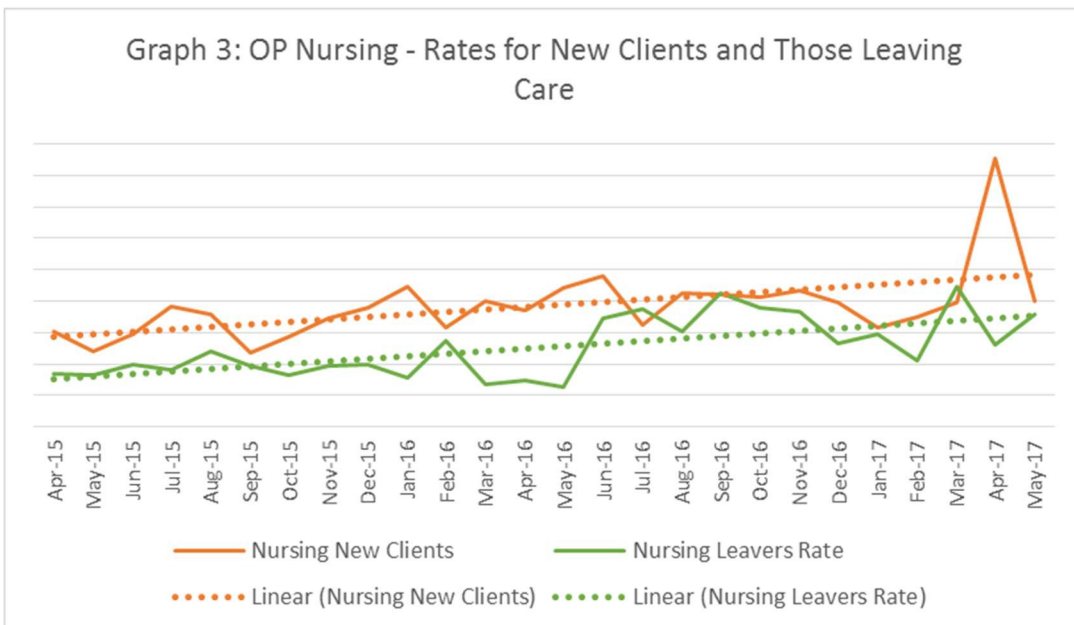
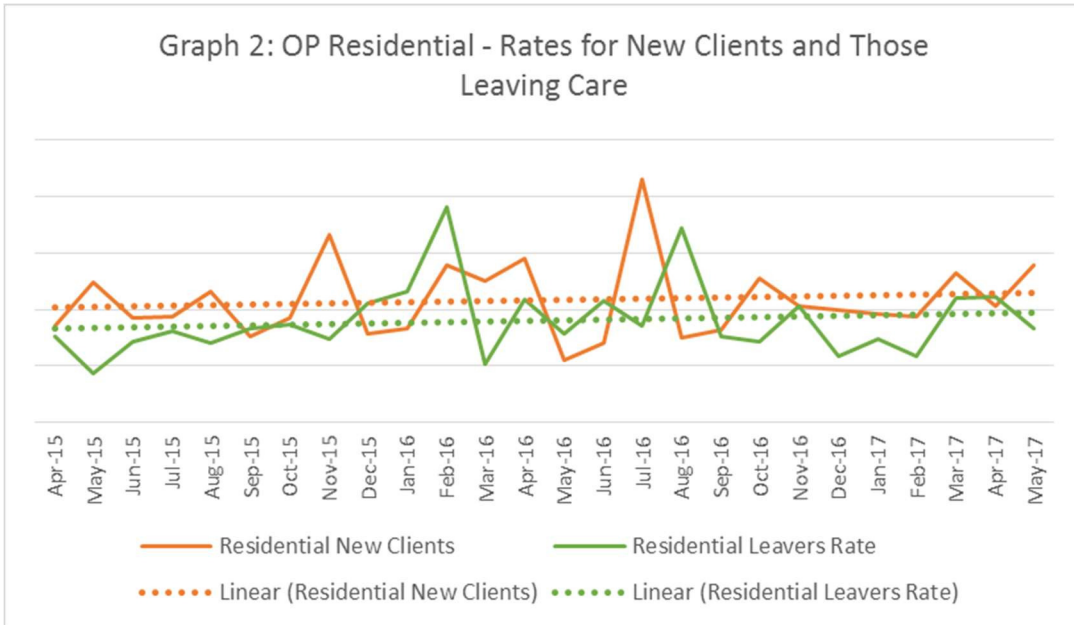
Older People Price of Care

The following graph indicates average prices paid for Residential and Nursing care beds. Of particular note are the increases in prices paid for both Nursing and Nursing EMI beds.



There are a number of factors that can adversely impact on price levels and therefore on total cost, for example:

- An increase in the cost base incurred by Providers in delivering beds, for example increases in the national minimum wage and other associated employee costs.
- A lack of supply in particular care placements generally or as a result of a peak in demand.
- The price differential of clients leaving the care system compared to new entrants. Graphs 2 and 3 below demonstrate the trend relating to this in the last two years.



6 Continuing Health Care

Collaborative work has been undertaken with the Complex Care Team at the CCG to jointly agree processes for care requirements that need full CHC and/or joint funded care. The new process for all CHC considerations will start from 14th October. There will also be a monthly joint meeting between LA and CCG to quality check cases considered for joint funded care

An adult social care focussed solicitor has been appointed to advise with our work around CHC.

Continuing Health Care training is booked on the 24th January 2018 for all practitioners to attend. We have commissioned Jane Reynolds, who works for the Association of Directors of Adult Social Services (ADASS) and NHS England as well as an Independent Chair for reviews for Social Services.

Table below shows newly eligible CHC funding. It demonstrates a fairly positive picture with trend from Q4 2015 being for increased eligibility of new clients.

Q3 to Q2 represents the largest increase in eligibility of all the compared areas.

		Patients NEWLY Eligible for CHC per 50,000 GP Population, aged 18+						
		2015/16 - Q4	2016/17 - Q1	2016/17 - Q2	2016/17 - Q3	Growth/- Reduction (13/14 Q4 to 16/17 Q3)	Growth/- Reduction (15/16 Q4 to 16/17 Q3)	Growth/- Reduction (16/17 Q1 to 16/17 Q3)
North Midlands		36.3	38.8	39.8	41.9	43.3%	15.4%	8.0%
Geographical Neighbours		34.2	37.7	36.9	38.7	24.4%	13.3%	2.6%
Telford		32.0	33.0	28.9	38.0	11.5%	18.8%	15.3%
Statistical Neighbours		29.5	31.7	31.2	32.2	0.7%	9.1%	1.5%
Midlands & East of England		30.0	30.6	30.5	30.2	4.3%	0.7%	-1.4%
Central Midlands		26.5	26.2	26.7	28.2	-4.9%	6.3%	7.5%
All England		28.1	27.6	27.9	27.8	5.9%	-1.1%	0.5%
West Midlands		30.8	30.8	31.0	26.5	5.2%	-13.8%	-13.8%
East		27.6	28.3	26.5	26.1	-17.5%	-5.3%	-7.6%

7 Case examples

81 years old in residential care following hospital discharge.

- Following re-ablement did not require 24 hour care
- Work undertaken with housing colleagues and individual has taken a tenancy at extra care scheme.
- Quality of life improved whilst reducing costs.

In some examples there will be no reduction in costs achieved in care arrangements but reviews undertaken highlight much better outcomes for the individual as a result.

The following case studies demonstrate this:

81 years old, living in sheltered accommodation with a diagnosis of Dementia. Displaying increased confusion and leaving her house at inappropriate times often with the police bringing her back home with some very unsettled periods and behaviours. A review was undertaken and the care needs have increased from 1 carer to 2 carers (double up calls). This is to prompt the individual with her daily living tasks and to ensure that risks towards carers are managed. Continuing Health Checklist completed with an outcome that she does not meet this criteria. The cost of this care has increase by two thirds.

8 Key Risks and Challenges with Mitigating Actions

Area	Risk	Mitigating Actions
Workforce	<ul style="list-style-type: none"> • There is on-going work to improve the quantity and effectiveness of reviews and assessments – no significant changes to adult social care can be made without a review or assessment being undertaken and there is pressure on this resource that means that this can delay other savings initiatives. • Also reviews and assessments can lead to increase in care costs and well as decreases. 	<ul style="list-style-type: none"> • New appointments made and more planned • New SDM for Community Social Work started September 2017 • Staff returning from Maternity leave • CHC Lead appointed • Dedicated roles from new appointments to undertake target reviews
Market Sufficiency	<ul style="list-style-type: none"> • We have to balance the duty to secure competitive prices against the Council's statutory duty to maintain sufficiency in the market. The threat to the on-going viability of many providers is a national issue – and we face the same issues in our local market. For example there are well documented cost increases for the sector, wage inflation caused by National Living Wage and lack of supply is driving prices up, there are increasing costs of regulation that the providers are having to bear. • As we reduce referrals to the residential sector we could see providers failing or withdrawing from the market. • A key element of the Council's strategy is for the provision of alternative services, for example by way of direct payments and through Personal Assistants but take up is slow. 	<ul style="list-style-type: none"> • We are working with the sector wide body, Shropshire Partners in Care (SPIC), to understand the challenges that the market faces and with individual providers where appropriate - we want to identify a fair cost of care to inform price negotiations The cost of care locally is very competitive against regional and national comparators. • In respect of direct payments and Personal Assistants work is being undertaken to increase the take up of this option working jointly with POhWER • New Extra Care schemes are planned in the short and longer term to increase local sufficiency and prevent the increase needs in residential care

<p>Preventative Services</p>	<ul style="list-style-type: none"> • Preventative services help to keep people out of more expensive services and avoid homelessness 	<ul style="list-style-type: none"> • The implementation of changes needs to be carefully planned, in consultation with service users and providers and we plan to provide a lot of similar services using a different model that is less reliant on Council funding. Again we are working with vulnerable people and it takes time to effect changes. • Maximising the use of MyLife Portal and My Choice for appropriate signposting to other agencies and Information & Advice • Project group in place to work through reducing the delivery of domiciliary care hours delivered and where appropriate convert and or offer direct payments as the first option for council funded care
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Telford & Wrekin

C O U N C I L



Telford and Wrekin

Clinical Commissioning Group

Telford and Wrekin Neighbourhood Working Programme

A collaborative programme of work
between Telford & Wrekin CCG and
Telford & Wrekin Council

Neighbourhood Working

Our Vision

*Resilient Communities
– strong and
connected*



*People
supported to
stay well*



Treatment in the community

*People with LTCs supported to live their life
to their full potential*

Our Approach



How Does It Fit?



futurefit
Shaping healthcare together

The Journey So Far....



COPD
self-management
coaching programme

From June 2017 we will be running
6 COPD self-management programmes across Telford.

1 Run by qualified professionals 2 Includes telephone coaching and group workshops 3 Focus on behaviour change

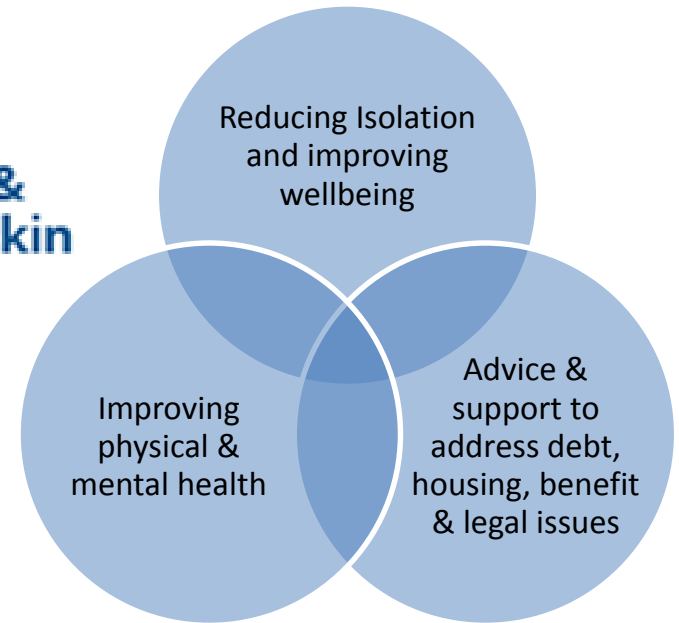
Example 1: Branches



Example 2: Community Prescribing



**Telford &
the Wrekin**



Example 3: Diabetes



- New Three Tiered model
- 546 more people have achieved all three target values and are now at reduced risk of diabetes related complications, for example amputations.

Case Study

Patient Story

John, 39 years old

John, 39, was referred into service after several admissions into SaTH for Diabetic Ketoacidosis. The gentleman had Type 1 Diabetes since his teens and had been poorly managed. During the 6 months leading up to his referral he had been admitted to SaTH 8 times in DKA.*

John lived in a Nursing Home and relied on the nursing staff to give him his insulin, which had been written up in conjunction from consultant/GP. When the team first met John, his insulin regime was “completely inappropriate” resulting in multiple problems, and he was being fed by a peg tube.

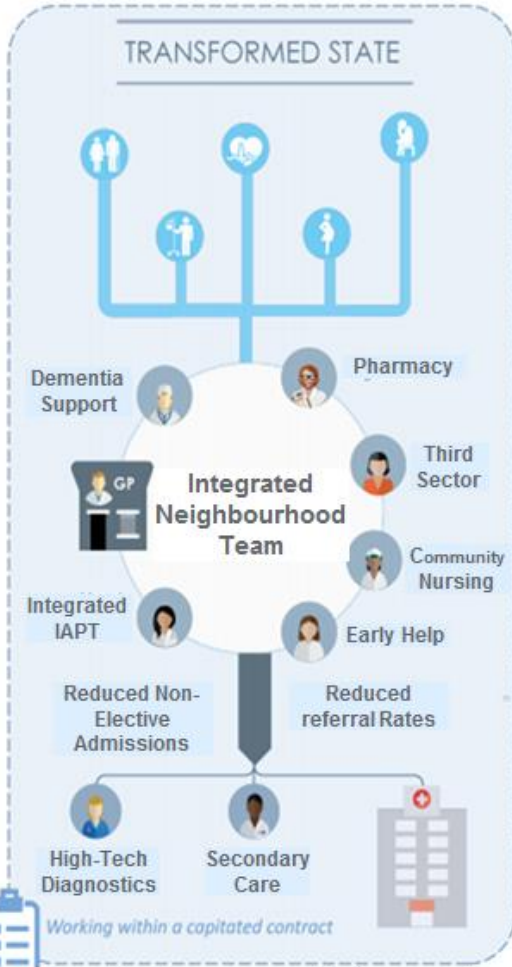
When the team became involved, they changed his background insulin to a more appropriate one, but more importantly, taught John to give his QA insulin in conjunction with a dose advising meter, and empowered Rob to take control of his Diabetes. Within 6 months, Rob had not had 1 admission with DKA, he was able to tolerate a normal diet, his PEG had been removed, and he became fit enough to undergo a pancreas/kidney transplant. John is now living an independent life in his own home.

**Patient name changed for privacy purposes*

Some other outcomes achieved so far....

- Health Champions - 27 new volunteers have been recruited
- MECC Training – Making Every Contact Count Training has been delivered to 50 staff with a further 100 scheduled this month
- Respiratory – 15 patients have been identified in the area who are the most at risk of unplanned admission to hospital; these patients have since commenced a course for self-management.
- Diabetes – improvement in patient outcomes has been achieved
- Hypertension – An increase in the number of individuals being screened and identified is currently being achieved
- Dementia – Named consultant psychiatrist now linked to each Neighbourhood
- Branches
- Citizens Advice - outcomes achieved include an estimated £15,200 in welfare benefit gains
- Cancer Detection – 2 pilots have taken places with practices, both achieved an increase in screening for bowel cancer.
- Reduction in demand on social care

What Next?



Adapted from: <http://www.napc.co.uk/primary-care-home>

- One Team
- Early Help and Support Teams
- Staff alignment around Neighbourhoods
- Risk Stratification
- Wound Care
- Estates Planning
- Communications and Engagement