



Telford & Wrekin
C O U N C I L

Addenbrooke House Ironmasters Way Telford TF3 4NT

HEALTH & ADULT CARE SCRUTINY COMMITTEE

Date **Tuesday, 16 October 2018**

Time **2.00pm**

Venue **Quaker Room, Meeting Point House, Southwater Square, Telford, TF3 4HS**

Enquiries Regarding this Agenda:

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Committee Membership: Councillors M Boylan, **A J Burford (Chair)**, S P Burrell, E A Clare, N A Dugmore, L A Murray, T J Nelson, 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 9 July 2018.
4. **Building Community Resilience and Neighbourhood Working** Appendix **B**
To receive the report of the Service Delivery Manager Prevent & Health Improvement and the Deputy Chief Executive for Commissioning & Planning (Primary Care) Telford & Wrekin CCG
5. **Adult Care Performance, Budget & Savings & Cost Improvement Plan 2018-19 – Older People** Appendix **C To Follow**
To receive the report of the Assistant Director: Governance, Procurement & Commissioning; and the Assistant Director: Early Help and Support
6. **Update on Unmet Needs Survey**
7. **Chair's Update**

HEALTH AND ADULT CARE SCRUTINY COMMITTEE
Minutes of the meeting of the Health & Adult Care Scrutiny Committee
held on 9 July 2018 at 2.00pm in Meeting Rooms G3-G4, Addenbrooke House,
Ironmasters Way, Telford, TF3 4NT

Present: Cllrs A Burford (Chair), M Boylan, S P Burrell, E A Clare, T J Nelson, R J Sloan;
Co-optees C Henniker, J Gulliver

In Attendance: S Dillon– Assistant Director: Adult Social Care, R Purvis - Team Leader
Projects, Policies & Quality, Service Improvement & Efficiency, Adult Social Care, S
Worthington, Senior Democratic and Scrutiny Services Officer TWC

HACSC-01 Apologies for Absence

Cllrs A D McClements. Co-optees H Knight and D Saunders

HACSC-02 Declarations of Interest

Cllr S P Burrell declared a standing interest in Agenda item 5, as noted on the Register of
Interests.

HACSC-03 Minutes

Resolved – that the minutes of the meeting of the Health & Adult Care Scrutiny
Committee held on 24 April 2018 be confirmed and signed by the Chairman.

HACSC- 04 Work Programme 2018/19 and Terms of Reference Report

The Committee reviewed the Terms of Reference and considered the work programme
suggestions for 2018/19. 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 CAMHS, Social Care criteria and Transition
to Adulthood. Substantive items included:

- STP Neighbourhood Working
- Adult Care Performance, Budget and Savings (inc CHC) - related to Cost
Improvement Plan (CIP)
- Quality of Adult Social Care Provision

The monitoring activity was noted: _

- TW Safeguarding Adults Board Annual Report
- NHS Quality Accounts
- Implementation of Suicide Prevention Plan

The Committee had agreed at previous meetings that the issue of the current provision and

future sustainability of GP services was an important topic for Scrutiny to look into. Members noted that discussions were ongoing in regards to Voluntary and Community Sector funding and that this was being resolved.

Health and Wellbeing Board had looked at CAMHS as an ongoing item. It was noted that the new provider had encountered more difficulties than had been expected, so there was significant further work required to reach an acceptable level of service. This item would be looked at by the JHOSC in September.

Members noted that any work undertaken by the committee would need to be completed by early 2019, due to the elections in May 2019.

HACSC- 05 Commissioning and Adult Social Care Improvement Plan; including Strategy for Adults with Learning Disabilities

The Chair welcomed the Assistant Director: Adult Social Care. The Committee had requested information on performance and savings relating to the Adult Social Care budget. The Assistant Director: Adult Social Care stated that the service had continued to work as per the 5 Year Strategy, which implemented a strength and asset based approach.

Appendix 3 of the report highlighted the Telford & Wrekin's vision for Adult Social Care in a summary document. The approach continued the service to manage the resources wisely and the service was expecting to break even during period 2. During the last financial year, there was a 5% reduction in the amount of people requiring a personal budget to meet their needs. The team were working to maximise the use of assistive aids and technology when appropriate.

Members congratulated the team on the low number of complaints received, noting the numbers received in comparison to the number of service users. In response to a question, the Assistant Director: Adult Social Care advised that Social Workers attend GP Multi-disciplinary meetings and where there was a focus on identifying users with a lower level frailty score, to encourage them to access support earlier to as a preventive measure.

Members discussed the excellent levels of support offered to service users following discharge from hospital, but queried what was being done to support other users, who may not be aware of what support was available. The Assistant Director: Adult Social Care advised that a 'Smart House' was being developed, which would showcase the different aids and technologies available, it was hoped this would open early in 2019. It was noted that there was good communication between the Council and the Carers Partnership Board.

The Committee raised questions and the following discussion ensued.

Where does responsibility lie in regards to public information on normal health, for example, early signs of dementia?

The Assistant Director: Adult Social Care advised that this was the responsibility of the

NHS, NHS Direct provided information on signs and symptoms, but it was important that information from all agencies linked together. The Council was in the process of developing a new website, which would link to NHS Direct and contain information from all partners.

HACSC- 06 Unmet Needs Survey

The Chair welcomed Shobha Asar-Paul, Managing Director of Healthwatch Telford & Wrekin to the committee. The Committee had previously agreed to provide an in-depth review of service user experiences. The Survey would look at My Choices, run by Citizen's Advice, as the 'front door' service'.

Ms Asar-Paul stated that the project would look at how the services were delivered and the impact of this for service users. The objectives of the review were to:

- Understand how well the Adult Social Care pathway was people's needs
- Understand how well the local voluntary and community sector was supporting people's needs
- Understand what needs people were experiencing that were not currently being met and why this was the case.

A range of methods would be used to support the review, from focus groups and mystery shopping, to reviewing best practice and meeting with users on an individual level. The review was scheduled to be completed by December 2018. Members requested interim reports be provided at the October and December meetings of the Committee.

Members acknowledged that other users than the elderly used the service, and it was important that their views were also heard. In response to a question, the Assistant Director: Adult Social Care advised that My Choice was commissioned by the Council and that monthly monitoring reports were received. A discussion was held regarding the brand awareness of My Choice.

2.49pm – S Dillon, R Purvis and S Asar-Paul left the meeting.

HACSC – 07 GP Forward View

The Chair noted that the Committee had previously agreed to undertake a review into capacity of local primary care. A sample of potential questions had been produced and had been circulated to members. Following discussions with the Community Participation Team, it had been suggested that targeted discussions with a number of GPs may receive more results than a survey. Members noted it was important that a mixture of GPs be spoken to, such as male and female, large and small practices, to ensure a balanced result is received. It was noted that Healthwatch had recently completed a GP Roadshow which collected feedback, which could support with the identification of GPs.

Members considered that a combination of a questionnaire and targeted discussions could be used. It was recommended that a questionnaire be sent containing factual questions,

which would provide a background for discussions. A Member suggested that the questionnaire could be distributed at the GP CCG forum.

A discussion was held on the impact of neighbourhood working. Members noted that neighbourhood working was developing well in some areas, but was patchy across the Borough. Members requested that an update report be provided to the next committee in regards to the implementation of neighbourhood working, with regard to what lessons had been learnt and how best practice could be shared across the Borough.

HACSC- 08 Chair's Update

The Chair advised that the CCGs engagement report on gluten free prescriptions had been circulated for Members comment. No comments had been received from Members regarding this item.

The Chair provided an update to the Committee in regards to Future Fit. The Joint HOSC had arranged a meeting for 30 July, where groups and individuals would be invited to share their experience of the consultation. It was noted that the JHOSC was not undertaking a consultation themselves, but needed to ensure the consultation was effective. Members noted that a schedule of the CCGs engagement with seldom heard groups was not available.

A feedback form had previously been circulated to all Members regarding their experiences of Future Fit events. Members were encouraged to return their forms or to approach the Chair to provide verbal feedback. Some Members raised their concern regarding the public perception of the consultation, that it was a 'foregone conclusion' and that the CCG would not change their plans.

The meeting ended at 15.27pm.

Signed:

Date:

**TELFORD & WREKIN COUNCIL HEALTH & ADULT CARE SCRUTINY
COMMITTEE****12th September 2018****Strengthening our communities and Community Based Support Priority
Update including neighbourhood working****REPORT OF Anna Hammond (CCG) & Louise Mills (TWC)****PART A) – SUMMARY REPORT****1. SUMMARY OF MAIN PROPOSALS**

The Neighbourhood Working programme led jointly by the local authority and CCG is now considered the major piece of work to develop community centred approaches to improve health and wellbeing across Telford and Wrekin. The approach taken has been to work collaboratively between health, social care and the voluntary sector. Wherever possible the work is driven by communities and or those working in communities. Many of the projects have developed organically, driven by local leaders rather than a 'one size fits all' approach.

Our approach has been to:

- Strengthen communities - through community development, asset based methods and developing social networks
- Develop volunteer and peer roles - enhancing individuals capabilities to provide advice, information and support or organise activities around health and wellbeing in their communities
- Develop collaborations and partnerships – working with health partners, communities and the voluntary sector to design and or deliver services and programmes
- Improving access to community resources – connecting people to community resources, information and social activities

A large number of projects are now in the implementation phase and can be broadly categorised under the following themes:

- Encouraging Healthy Lifestyles and prevention
- Promoting Community Resilience
- Direct Care in the Community – including integrated teams, care home support and intermediate care
- Speciality Reviews – Diabetes

This reports summarises progress to date.

2. RECOMMENDATIONS (AND TO WHOM ACTIONS APPLY eg CCG, Council)

That the content of this report is noted

3. IMPACT OF ACTION - (How it is intended that action will make a difference)

- People know how and feel able to live well
- People feel connected with others - with friends and support networks
- People have confidence to know, when their health concern is beyond their knowledge & skills, how to get support that is easy and proportionate to what their needs are
- Our Care services enable and empower patients rather than create dependency
- Our Care system delivers care right first time – better for patients and better for the system
- Our Care services are able to deliver care in the most efficient way across the system – support the shift in care
- Reduced demand on adult social care services

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Strengthen our communities and community based support Priority Encouraging Healthier Lifestyles priority Improving mental health and wellbeing
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	To improve the health and wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes/No	Yes
TARGET COMPLETION/DELIVERY DATE	Ongoing programme of work	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p>The Council holds specific resources which will support the delivery of this programme. In 2018/19 these resources were £1.33m, including £0.27m of one-off resources.</p> <p>Further reductions and changes to Public Health Grant allocations, and other Council funding is expected in future years. Public Health England have already advised a further reduction to Public Health Grant of £0.3m in 2019/20.</p> <p>The Council will need to find further savings of between £20m and £25m over the next two years, 2019/20 and 2020/21, and this may impact on the funding for this work stream.</p> <p>It is anticipated any work associated with the recommendations in this report will</p>

		be met from within existing resources and this will be kept under review as part of the programmed monitoring process. (ER 05.09.2018)
LEGAL ISSUES	Yes	The HWBB has a statutory obligation to encourage integrated working and to encourage commissioners of health-related services to work closely with the HWBB (section 195, Health and Social Care Act 2012). Accordingly, the proposals in this report will assist the HWBB in meeting its legal obligations. This continuing commitment to integrated working is also a requirement of the HWBB's terms of reference.
EQUALITY & DIVERSITY	No	
IMPACT ON SPECIFIC WARDS	Yes	The programme of work impacts across the population of the Borough and includes targeted activity within those wards reporting higher levels of health and wellbeing need and inequalities.
PATIENTS & PUBLIC ENGAGEMENT	Yes	Yes Involvement of advocacy groups Strong community engagement for some projects
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes/No	None

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 Encouraging healthy lifestyles and prevention

The Healthy Lifestyle Service is provided by Telford and Wrekin Councils Health Improvement Team. The team consists of a small number of Advisors who support local people to make improvements to their lifestyle with a particular focus on healthy eating, weight management, emotional health and wellbeing, physical activity, reducing alcohol consumption and support to quit smoking.

This year the council took the decision to allow the contract with an external provider for the provision of our quit smoking service to expire and we insourced the service from the 1st April. We have also incorporated lifestyle support for children and young people so we are now able to offer a holistic behaviour change support service for children, young people and their families.

A performance overview for 2017/18 for the Healthy Lifestyle Service is summarised below:

- Brief lifestyle advice to 17,378 people
- Brief interventions (30 minute health chat) to 27,087 people
- Health Checks were completed for 2,689 people; of these 70% had one or more long term conditions
- The service received 1,842 referrals; of these 1,503 committed to a Personal Health Plan; 79% had one or more long term conditions
- 61% achieved their primary lifestyle goal
- 11,620 referrals were made (including signposting) to support services and community projects provided by partners organisations to support people to achieve their lifestyle goals
- 1501 people set a quit date – of these 50% successfully quit smoking at their 4 week follow up

Priority has been given to developing referral pathways to improve access to healthy lifestyle support. Engagement with General Practice and wider NHS partners has improved significantly over the past 12 months now making up 73% of all referrals to the service. This programme of work contributes to improving outcomes for diabetes and CVD prevention and treatment which are priorities of the CCG.

Healthy Lifestyle clinics take place in all Medical Practices across Telford with the exception of one practice, where due to current room availability this is not possible and an alternative community venue is used. Some GP clinics have increased from 1 half-day session to 2 full days due to the clinics being 100% booked and the GP's being encouraged by the positive outcomes achieved by patients along with a reduction in GP visits. The number of patients with a Personal Health Plan varies considerably across practices ranging from 18 – 242.

The team has also worked collaboratively with the Midlands Partnership NHS Foundation Trust to address the physical health needs of patients on the psychosis pathway particularly those patients with low self-esteem and where medication has led to weight gain. The number of people with long term conditions committing to a Personal Health Plan has increased by 54%. This can be attributed to our increasing work with the musculoskeletal team and clinic within Euston house and the hospital, raised presence in the practices and more structured health care professional referral pathways for clients with long term conditions into the service.

Working with partners to develop our approach to social prescribing is a current priority. Whilst our social prescribing approach for healthy lifestyles is well developed work is required to develop our local programme. This will include further development of our referral pathways, identification of more link workers, community

arts programmes, community learning (including Reading Well programmes) and strengthening links with services that provide local support for social issues (unemployment, welfare and debt).

1.2 Promoting Community Resilience

1.2.1 Community Directory – Live Well Telford

Telford's OCC Market Place (product name for the Community Directory Portal/website) has been named Live Well Telford. Live Well Telford will enable people to access information and advice easily and be signposted, if appropriate, to care and support they may need in order to help themselves or those they care for.

It is being designed to help people find the right help, at the right time to promote their independence. Workshops have been held providing the implementation project team with an overview of the portal's functions, together with an overview of the migration of data functions (to aid the harvesting of data from existing directory's e.g. MyLife and Family Connect).

Since the migration workshops the Live Well Telford Lead has been working with the supplier, internal ICT and Web Services to test the data uploader tool to ensure that it populates into Live Well Telford correctly. There are two rounds of testing for Live Well Telford scheduled during August and September 2018, involving project staff and stakeholders. During this time, the configuration of the website and branding will be implemented. Key stakeholders involved in the implementation of Live Well Telford include: Community Participation and Community Champions; voluntary sector organisations and groups; providers of services (Health and Social Care); Public Health; CCG and links to health, including GPs and Pharmacies; Adult Social Care; and Children's Social Care

1.2.2 Health Champions

The council's Community Participation Team have successfully created a network of 52 community Health Champions. Our Health Champions are all local people who, with training and support are voluntarily bringing their ability to relate to people and their own life experience to transform health and well-being in their communities. They are delivering health conversations to friends, family, neighbours and their local community; embedding the Health Champion's role into existing volunteering; engaging with and supporting existing initiatives and starting up their own small community projects. Health Champions work closely with our team of Healthy Lifestyle Advisors.

1.2.3 Feed the Birds

Feed the Birds is delivered in partnership with Shropshire Wildlife Trust. The project supports people who are lonely and/or socially isolated get closer to nature, by feeding the birds in their garden and contributing to their overall health and wellbeing. Clients are identified and referred by colleagues and partner agencies. Once a client and volunteer match has been identified, the volunteer visits the client in their home,

once/twice a week for up to an hour, to help feed the birds. For the clients the project has a positive impact on the client's quality of life including becoming more socially active, building confidence and developing new skills. For family members they see a positive change in their loved one. For the volunteer they have a positive experience taking part in the pilot, knowing they are making a difference to the quality of people's lives. To date 17 volunteers have been trained and matched with a client and plans are in place to recruit and support an additional 16 volunteers over the next 12 months.

1.2.4 Branches Mental Health Hub

The Branches Mental Health Hub was commissioned to provide practical and emotional support for people who are suffering mental ill health and dual diagnosis issues. The service is averaging 743 attendances a month. 57 volunteers support service delivery and to date have contributed nearly 10,000 volunteering hours. There are five mental health support groups running weekly including topics such as Anxiety & Depression, Family & Carers Group, Understanding Personality Disorders, and Grief & Loss. Branches also have an office in the Park Lane Centre in Madeley two days per week to cover South Telford & runs six days a week from Strickland House. Various training courses and qualifications are also being offered to service users, staff and volunteers as well as to those in the wider community.

1.2.5 Enterprising Communities

Enterprising Communities is a collaborative partnership supporting people who are currently running a community business and have an interest in extending their work into health and social care and supporting the development of 'new' community businesses in areas where we have high demand for care and support. Six community businesses were supported in year 1 and a further six have been identified for support in year 2. Work has started with Birmingham University to gather evidence to demonstrate outcomes and value. An additional 35 community businesses and entrepreneurs have received support to apply for funding, access training and signposting to a range of organisations.

Case Study

Craft group community reunited after support from the Enterprising Communities Project

When their old day centre closed down at short notice, the Cottage Crew craft group were determined to stay together and to find a new venue – one which would help them to become more integrated in the neighbourhood. August saw the group reunited at a new venue. Community Catalysts worked with the council's Community Participation Team to find and facilitate the use of a new venue, a vibrant arts and craft community café called Forge Urban Revival. Together, they were also able to source support workers from another local community business, Hub on the Hill. Finalising the details and organising logistics around finances proved to be a

challenge, and the team spent some time in negotiations, but in the end the Cottage Crew were able to resume their crafting activities after just a four-week break. The group members are really pleased to be back together.

“We’re delighted to have been able to help them with their mission. It’s been a real team effort, with the council, community businesses and former staff and volunteers. It has brought the community closer together.” Chris Clarke,
Community Business Coordinator at Community Catalyst

1.2.6 Wellbeing Hubs Network

The Wellbeing Hubs Network is now recognised as an independent consortium led by T&W CVS. The network has 40 Members connected by the common aims to improve Community Care with people for people including care, support, housing and assistive technology. The network has established community ‘Hubs’ within Wellington and surrounding areas and hold regular ‘Art of Wellbeing Events.’ The Hubs coordinate community activities, provide local information and raise awareness of care and support across all ages.

The network has coordinated a number of community care initiatives. Examples include:

Living well with dementia in the community (SPIC, Wellington Library & CCG) - The ‘Keeping Active Live well with Dementia Collection’ is a service that increases dementia awareness and supports carers to be aware of a range of items available to include jigsaws, books, puzzles, DVD’s, table top games, inflatable games and activities <https://library.telford.gov.uk/web/arena/keepingactivedementia> ;

Wellbeing Groups – focussing on empowering family carers to keep resilient, avoiding crisis and breakdown, dealing with common challenges with others through peer-led support groups, a social scene, promoting health & wellbeing and strengthening personal networks.

1.2.7 Carers

The wellbeing of the carer is paramount to enable them to carry out their caring role as well as build their own personal resilience. As part of the local carers strategy there is a range of offers available to carers to access throughout their caring journey. This includes access to creative activities, education and wellbeing workshops – outcomes include improved wellbeing; personal resilience and improved connectivity with other carers reducing isolation.

Case Study

Telephone Befriending Service – a Peer-Led Service

Iris approached us to become a volunteer after seeing our volunteer section in the Carers Newsletter. Iris has become a valued Phone Friend, calling her carer every

week to offer conversation, advice and support. Her assigned carer is dealing with the same issues as Iris has experienced herself – a husband with dementia – and is able to give the carer valuable dementia insights. At 86 years old she is our oldest volunteer and freely admits that her role with the Carers Centre keeps her mind agile and she contributes a long way to continuing well-being, despite several medical issues of her own.

Well-being Volunteer

Carer JR cares for his wife who has Multiple Sclerosis: On attending the Well-being Sessions as a carer JR has learnt Reiki and has now become a carer volunteer. As a volunteer he now provides Reiki treatments and also provides 'peer' support to carers. JR was recognised in the 2017 Active Lifestyle Awards for his outstanding contributions to volunteering and carer support.

1.2.8 Locality Plans

The Public Health team working with partners has taken a strong leadership role at a strategic and community level in developing neighbourhood working to improve health and wellbeing and resilient communities. Asset based community development has been at the heart of our approach building social capital, connecting people and organisations to work collaboratively to improve wellbeing. General Practice and the voluntary sector are key partners supporting our approach.

A Health Improvement Practitioner has been assigned to each locality. Population profile information has been reviewed and emerging priorities have been identified for the next 12-18 months. These are:

- Excess weight and obesity (across all localities)
- Emotional mental health & wellbeing (across all localities)
- Loneliness & isolation (across all localities)
- Smoking (Hadley Castle)
- Smoking in pregnancy (Lakeside South)

Over the next few months practitioners will be working with council service delivery teams, key partners and communities to co-produce a locality health improvement plan. Plans will adopt the Community centred approaches framework developed by Public Health England. The assets within communities, all of which are building blocks for good health include:

- skills and knowledge,
- social networks – friendships, neighbours, local groups and community organisations,
- facilities and resources and
- physical, environmental and economic infrastructure

Whilst plans are still in the development phase the small team of Health Improvement Practitioners have started to work directly with communities and voluntary sector

organisations to strengthen their health improvement role. Early achievements include:

- Secured 'Food for Life' Funding for 4 Telford schools with the highest obesity levels
- Working with Silver Threads Hall (Donnington) to support development of two wellbeing groups
- A successful National Lottery Small Grant of £10,000 for Donnington Community Hub (physical activity)
- Big Local (Brookside) has funded an outdoor gym for residents – Health Practitioner supporting the training and development of local residents to lead sessions
- Supporting planning and delivery of a 'Fit and Fed - Holiday Hunger' summer programme for Woodside, Sutton Hill, Donnington & Dawley. Also receiving support from the national Street Games Park Activator programme.
- Secured £15,000 from the Telford Trust – funding will be used to support community based physical activity programmes
- Delivered a successful community event to connect the Arts and Care sector
- Partnership working with the Wakes around arts activity with the aim of reducing social isolation

1.3 Direct Care in the Community – including integrated teams, care home support and intermediate care

1.3.1 Development of Integrated Teams

Integrated teams are made up of people from multiple organisations, harnessing the skills and knowledge of the professionals working within them. This work brings together professionals from within health, social care and voluntary sector and involves GPs, social workers, community nurses, therapists, health care assistants, pharmacists, care navigators and mental health workers.

Encouraging health and social care services to work together in Neighbourhood Teams will allow these services to consider an individual's physical, mental and social needs as a whole, instead of just focusing on a single part and will mean that people will only have to tell their story once. This programme of work uses a strength based approach to improve care and respond more appropriately to rising demand.

Health and social care staff have been realigned to specifically work in one of four neighbourhoods and two of the four neighbourhoods are running multidisciplinary meetings to review patient needs. This work is in its very early stages but will be a priority for the CCG over the next few months.

Case Study

A local GP was concerned about a lady who was attending the GP practice an average of 200 times a year for non-medical reasons. She did not leave the house, other than to attend the practice or go to A&E. Via the MDT approach with both health, social and third sector, the integrated team were able to explore different ways of working with the patient. This individual is now volunteering full time, has not

accessed the GP or A&E, and has said she is “delighted”, describing her experience as “life changing”

1.3.2 Care Homes Team

The CCG has commissioned a dynamic, inspiring and supportive multi-disciplinary team who facilitate care home staff to provide confident, comprehensive care until the end of life for their residents. This is a small team embedded within the Community Rapid Response Team, and their functions include:

- Following an intervention by rapid response (whether patient is taken to hospital or not), the dedicated care homes staff follow this up with the home, supporting them to carry out a root cause analysis to understand what happened, why, and how it can be prevented from happening in future.
- Providing a supporting function which focuses on prevention and proactive working, specific to the needs of the home and residents. This includes more intensive input following training provided by Shropshire Partners in Care (SPIC) to enable care home staff to have the competencies to apply learning to ensure confidence in delivering care to their residents, with a particular focus on end of life. Progress to date includes:
 - Increased profile of the rapid response team – care home staff are contacting the team first rather than dialling 999 when they are worried about a resident.
 - The team have successfully formed working relationships with the dementia team and have been actively raising the profile of dementia within care homes, in addition to participating in neighbourhood MDT meetings.
 - Intensive roll out of “Emergency Passports” for the residents in some settings. This is already recognised and used by the ambulance service in the Walsall area and has achieved a reduction in conveyances to hospital.
 - The team are also working with SATH and the Dementia Team to develop a “Red Bag Scheme”
 - In addition to falls prevention awareness, “I-Stumble” protocol has been implemented in the six homes by the team, which is a tool aimed at care homes for use in assessing falls, and includes guidance for staff on what to take during and after a fall, and when it is appropriate to call 999.
 - The team have been collating case studies and feedback from homes to demonstrate impact and admission avoidance.

Case Study

Feedback from a local care home:

“We have been trialling the new Emergency Passports with the Care Home MDT and I have to say it has so far been entirely successful for us as a Residential Care Home.

We allowed admission of a lady, Jane, with Type 1 diabetes and were advised by family prior to admission that this lady's diabetes was very well managed. However, upon admission it transpired that this was not the case. Jane had settled very well onto the unit and Rapid Response were coming into the home to administer her insulin both morning and night. There were episodes happening during the day where we were unsure whether it was diabetes related and very few care assistants had received training in checking blood glucose levels.

Julie was immediately on hand to attend the Scheme and provide staff members with the training they required to be able to check blood glucose levels and understand what they needed to do if these readings were outside of Joan's usual parameters.

This has saved countless 999 calls and GP/Shropdoc visits as we are able to manage this in house and are now learning the signs of hypos and hypers in Joan. This training was invaluable. The support of care home MDT meant that Joan was able to stay with us.

We have had approximately three emergency 999 calls following falls since the introduction of the emergency passport and these have been graciously accepted by the ambulance service and they have confirmed and agreed that the passports contain all of the information required in one place. Usually we would need to provide them with MAR sheets and this prevents the need for them to carry copious amounts of paperwork and avoids that information becoming lost in transport. The emergency passport is one document which follows the patient and is much simpler for us to provide and keep up to date.

The support from the Care Home MDT has been invaluable and I appreciate all of their help. I know and understand that if I have any concerns regarding any of our residents, I can ring them for advice and they get back to me and avoid unnecessary GP calls and prevents issues from deteriorating to the point we need to consider hospital admission. I feel much able to manage the residents and keep them here.

1.4 Speciality Reviews – Diabetes

Improvement of outcomes for people with diabetes is now one of the CCGs top priorities. Comparisons with other areas demonstrates that people with diabetes in Telford and Wrekin may be more likely to have health issues. Over the next year a lot of work will take place to promote early diagnosis and with GP practices to make sure patients with diabetes are receiving the best possible care and advice. This is in addition to encouraging adoption of healthy lifestyles to try and avoid development of the disease wherever possible'

Next Steps

The early signs of success are promising and both the CCG and Local Authority are keen to increase the scale of the work and pace of change. Partners continue to work together to:

- Have a clear vision and strategic plan across the health and social care system to balance the 'bottom up approach' that the programme has taken to date - this work is being supported by the LGA
- Develop a framework of outcome indicators to measure success and to demonstrate impact
- Work with the Strategy Unit to develop an evaluation strategy so we can measure successes and adapt accordingly
- Agree a communications and engagement plan to better help the public and professionals understand the opportunities and galvanise support

2 IMPACT ASSESSMENT – ADDITIONAL INFORMATION

3 PREVIOUS MINUTES

- None

4 BACKGROUND PAPERS

Report prepared by

Anna Hammond Deputy Executive for Commissioning and Planning (Primary and Integrated Care)

**Louise Mills, Service Delivery Manager Prevention & Health Improvement,
01952 380505**

TELFORD & WREKIN COUNCIL

**HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE – 16th
OCTOBER 2018**

ADULT SOCIAL CARE & COMMISSIONING IMPROVEMENT PLAN 2018/19

REPORT OF THE ASSISTANT DIRECTOR, ADULT SOCIAL CARE

1 Purpose

To enable the Health & Adult Social Care Scrutiny Committee to consider the management of the Adult Social Care Budget and Statutory Services

2 Recommendations

For the Committee to consider and agree any recommendations or further actions

3 Introduction

The Committee have asked that this report focusses on Older People in terms of budget, performance and activity.

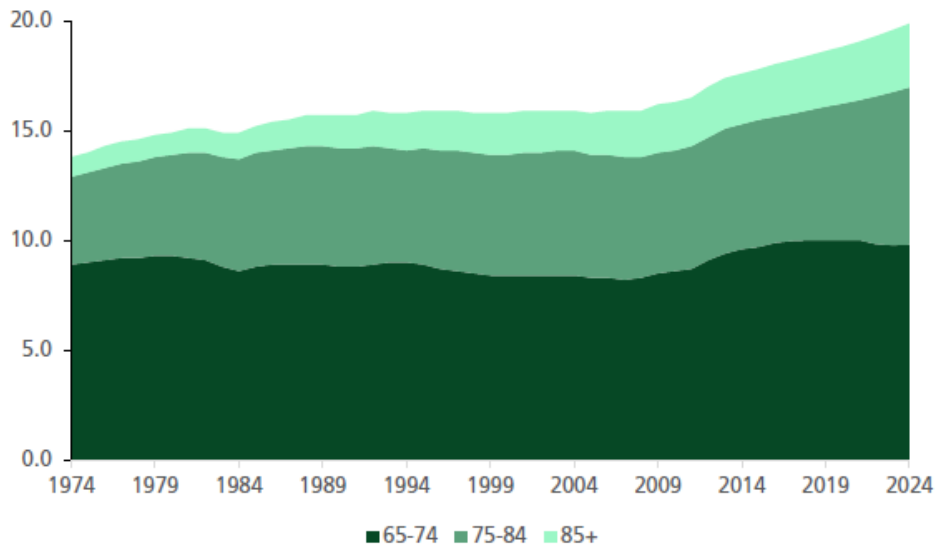
Adult Social Care is responding to the growing and changing needs and it is changing its approach to organising care and support by working more closely with health partners to better integrate and co-ordinate health and adult social care services. Our approach is so that people can be provided with the right combination of care in the right place at the right time. Our work is unpinned by changes to national legislation governing social care, in particular the Care Act 2014 that has brought new responsibilities including new eligibility for services, support for carers, new areas of work around information, advice, prevention, support for the care market and safeguarding. There are further impacts due to the significant funding pressures, the combination of a growing and ageing population, increasingly complex care needs, and reduction in central government funding and increases in care costs.

4 KEY INFORMATION

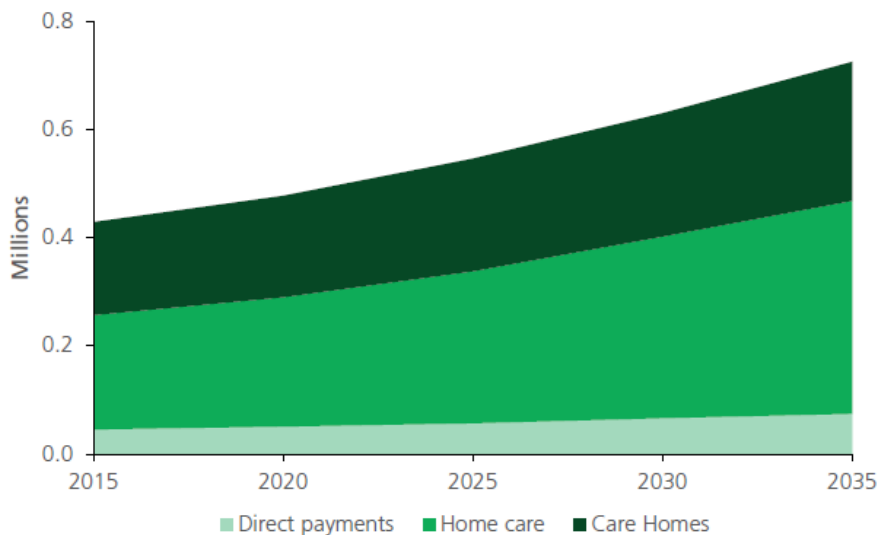
Demographic Pressures

The UK population is growing in size and more people are living longer. The demand for ASC is therefore rising as more adults with long term and multiple health conditions and disabilities are living longer. In particular, the number of adults aged 85 or over, the age group most likely to need care, is rising faster than the population as a whole. The overall adult population grew by 8% between 2005 and 2015 while the number aged 85 or over rose by 31% in the same period.

The below illustrates actual and projected (from 2015) percentage of the UK population at 65-74, 75-84 and 85+ since 1974. (Taken from ONS; ageing of the UK population and 2014 based population projections)



In terms of projections of future demand for social care, it is widely acknowledged that with an ageing population the pressure on social care funding will increase further in the longer term. The Personal Social Services Research (PSSR) has modelled projections of demand for long term care for older people and younger adults in England to 2035 and associated future expenditure. The PSSR estimates that the number of older people needing publicly funded social care could increase by 300,000 up to 2035, a 69% increase.



Telford & Wrekin's Changing Population – A profile of Older People in our Community – [Understanding Telford & Wrekin 2017](#). This document provides an overview of the population characteristics of Telford & Wrekin.

There are around 27,200 people aged over 65 living in Telford and Wrekin. The overall population of the borough is due to increase by around 23,300 people by 2031, and over half of this increase will be in the 65+ age group. The 65-84 age group is projected to increase from 25,800 to 34,400 (an extra 8,600 people, +33.1%) and the 85+ age group is projected to increase from 3,200 to 6,900 (an extra 3,700 people, +117.6%).

The proportion of people aged over 65 from a BME background is lower than the borough average and the England rate, around 4.2% (England 8.4%). There are around 12,313 households in the borough where all residents are aged 65+. Around 3,670 people aged 65+ provide unpaid care (15.2%), with around 1,600 of these reporting to provide over 50 hours per week of care.

In line with the rates in all age groups, people aged 65+ report higher levels of long term limiting illness or disability than the national average, around 56% of people (13,495 people). These rates increase with age, from 39% of people aged 65-69, to 86% of those aged 85+. It is estimated that around 700 people over 65 have severe depression and around 1,800 have dementia.

The life-expectancy at birth is significantly worse than England rates at 78.1 years for males (79.3 England) and 81.8 years for females (83.0 England). Levels of excess weight in adults are 71.1% and obesity 26.5%, both worse than England rates. 18.7% of residents aged 16 & over are binge drinkers and 28.5% of adults are inactive, both similar to England rates (all rates are for all-age adults).

Although hospital admission rates below are all-age (not specifically 65+), it is worth noting that hospital admissions rates for a number of causes are higher than England: For all ages, the Standardised Admissions Ratio of emergency admissions for all causes is worse than national. This ratio is also worse than national for Coronary Heart Disease, stroke, Myocardial Infarction (heart attack), Chronic Obstructive Pulmonary Disease (COPD), and intentional self-harm. The ratio is similar to national for hip fractures and alcohol attributable conditions.

As with all age groups, population, with around 18.1% (6,805 people) of older adults aged 60 & over living in income deprived households.

As our population grows older and young people with disabilities live longer there will be challenges and the changing age profile will have the single biggest impact on the development of local services as detailed below.

- Approx. 18,000 people provide unpaid care to a partner, family member or other person
- By 2031 there will be 41,300 people aged 65 and over living in Telford, this is an increase of 12,300 people (42.4%)
- Estimated that 10,400 people aged 65 and over live alone
- Approx. 2,400 of those have a severe disability
- Approx. 8,100 of people (aged 18-64) have a moderate physical disability
- Around 31,000 people report having a long term limiting illness
- Approx. 16,600 people are estimated to have a common mental health disorder
- 2,500 people aged 15-64 are estimated to have a learning disability
- The 85 plus population is expected to grow by 130% by 2031

Therefore, based on the information above, we need to move forward with services that would meet the needs of individuals, families and our communities by:

- Enable individuals and families within our communities to achieve their full potential and be safe from harm
- Target services at the most vulnerable and those in greatest need
- Integrate services more closely with the Health, Voluntary and Community Sectors in a way that supports independent living
- Be clear about what individuals, families and our community care expect
- Focus on finding different ways to do things rather than reduce or remove services
- Adopt an early help and prevention approach.

Cost Pressures

The 2015 Spending Review Submission by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) provided a detailed analysis of current and predicted future pressures on social care core costs, arising from inflation, the National Minimum Wage (NMW), the introduction of the National Living Wage (NLW) for workers aged 25 and above, Deprivation of Liberty Safeguards and the close of the Independent Living Fund.

For further information the LGA Green Paper for adult social care and wellbeing can be accessed here <https://futureofadultsocialcare.co.uk/the-green-paper/>

Our Performance, Operational Development & Continual Improvement

Given the above information, this is how we are managing the challenges in Telford & Wrekin Adult Social Care

1. We are focusing on providing early help and information in a range of different ways to enable people to plan their future and avoid early entry into the ASC system
2. We are supporting people to stay in their homes longer. We are moving away from residential care into supported accommodation and developing extra care schemes for older people and particularly those with dementia
3. We are focusing on building independence by using reablement
4. We are implementing a Strengths and Community Asset approach and striving to excellence in social work practice.
5. We have developed our 5 year plan strategic model.

1 Early Help and Prevention

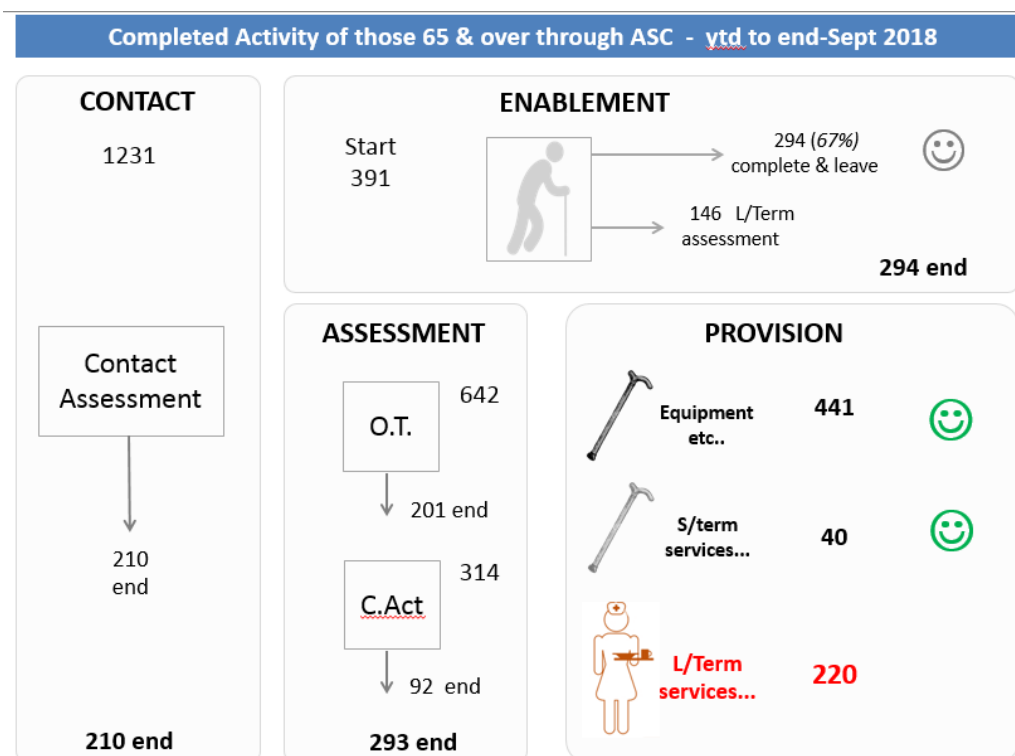
Given the population increases particularly around older people moving forward offering early help and advice to older people and their carers will be important.

We have recently with our work with NDTi, reviewed our customer pathway involving carers and experts by experience, staff and partners to make sure that the pathway is clear and seamless for the public. Linked to this we are currently reviewing the Information, Advice and Guidance contract currently provided by My Choice to ensure that it fits with this vision.

It is critical to ensure that those who contact Adult Social Care receive a quick response to their enquiry and the right information and intervention at the right time for them. The survey currently been undertaken by Scrutiny & Health watch will further inform this work. In addition to this we have reviewed our internal telephone response within all our teams, to ensure our response is quick to all enquires received and have shared the new guidance with all staff. This particular issue was highlighted by the Making it Real Board, who have advised us on best practice.

To help us to make further improvements we have also developed a simple feedback form which will be given to all clients in receipt of services to complete and return to us following any visits/assessments we undertake. For more information the form can be accessed here [Feedback Form](#)

For this financial year to the end of September we have received 1231 for 65 years old and over Contacts, of which 210 ended at first point with information and advice offered. We had 391 that went through to enablement services of which 300 left enablement services after a short term intervention and 150 went on to receive long term services. During this time we completed 642 OT assessments of which 201 ended at this point and 314 Care Act Assessments, of which 92 ended with no further input resulting in 293 did not go onto service provision. We have had 441 that were offered equipment and 40 had short term services. This shows that only 220 from the initial contacts of 1231 went on to receive long terms services.



2 Supporting People to staying in their Home

Given the population challenges and the known likely increase in the numbers of people with dementia, it is important that we have a range of care and support to meet these needs.

Our Dementia developments include:

- [Telford & Wrekin Dementia Strategy 2016-2020](#) – this sets our vision for people living with Dementia and their carers to be achieved by 2020 and how we will make it happen
- [A Guide to Dementia Care in Telford & Wrekin](#) – this sets out what to do when a person is concerned about their memory and where and how to seek help
- There is a move to ensure Telford & Wrekin is Dementia Friendly: Currently Newport has made contact with over 130 businesses who have received support to be Dementia Aware. Other locations across Telford are being sought. The T&W Dementia Alliance who has a range of local partners (which the LA, Carers Centre and Alzheimer’s Society) are pursuing this ambition. In addition the Council has become a Carer Friendly Employer and is working over the coming months to promote their commitment of being a Carer Friendly Employer through the signing of a local pledge. With the population 3 in 5 people are carers, we are keen to support carers to have a ‘career’ as well as care for a family member or friend.
- Bi –monthly meeting of the Health Economy Steering Group (Dementia) which is co-chaired with SPiC and people with lived experience. This brings together good practice and development and monitors the Dementia Strategy Action Plan
- We have invested in 3 specialist Admiral Nurses, who support carers and families of those living with Dementia.
- Dementia companions are available in some local GP practices and support the person with Dementia along with the carer during the duration of their dementia journey

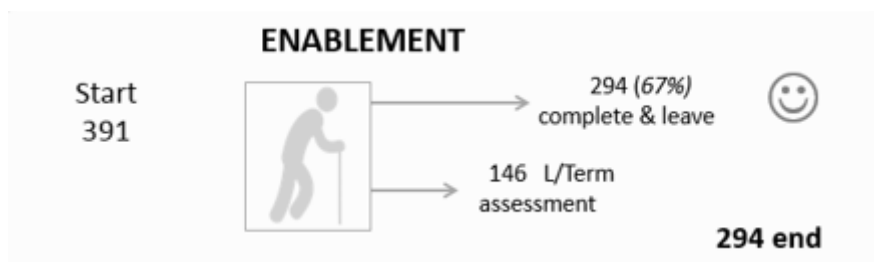
We have around 40 domiciliary care providers registered with us to provide services and just under half are regular providers of care right across the borough. Providers will register an interest but may not always have capacity or even a local footprint to be able to mobilise carers. There are challenges with the marketplace especially around providers being able to recruit and retain quality carers this is in part due low unemployment in the borough and competition for staff with hospitality and retail businesses.

Sufficiency has been particularly challenging since the end of last winter when one of the larger Providers in Borough took a decision to leave the area citing our low fee rate as a contributory factor, while another suffered quality issues due to taking on too much Care. This reduction in supply showed the true level of fragility of the Domiciliary Care market as remaining providers have not been able to offer carers to deal with the increasing level of demand since then.

To help us get back to having good sufficiency, we have been working very closely with Shropshire Partners In Care, Skills for Care and Providers around different ways of upskilling and training staff to make care, as a profession, be more attractive. We have looked at procuring and brokering care base around zones which will reduce the amount of travel and gaps in delivery of Care, while also giving successful Bidders guaranteed volumes of business for periods fixed within smaller areas. Our next Provider Forum takes place on Friday 19th October and this piece of work will be further explored with those Providers attending. We expect to see zoned contracts awarded in the Spring of 2019 and new arrangements fully operational ahead of the Summer break.

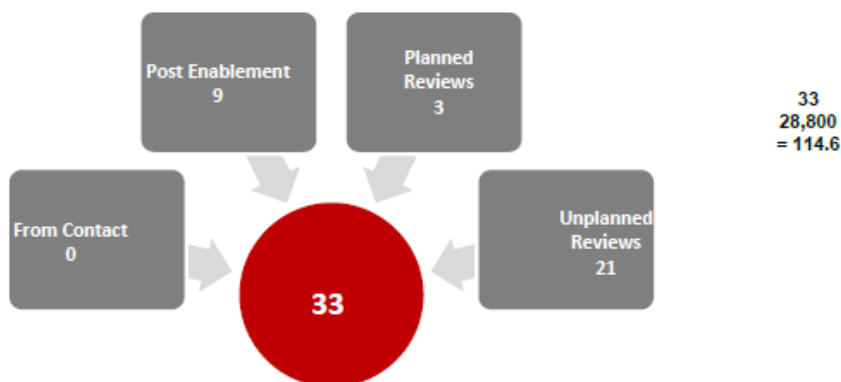
3 Building Independence by using Reablement

Reablement is an important part of enabling older people to maximise their independence. Performance information shows we continue to offer more enablement (32% more than last year) in Telford and that this has increasingly positive impact on people's ability to maintain their independence and not require longer term support. The below highlights that out of 391 reablement support provided, 67% left the service at this stage and 146 went to have further enablement and/or Care Act Assessment.



Our performance continues to show we are supporting more people to remain in their own homes. This is highlighted in the national targets as shown below.

2A(2) - Long Term Support Needs Met by Admission to Residential and Nursing Care Per 100,000 Population (65+)



Previous Performance	2014-15	2015-16	2016-17	2017-18
Telford & Wrekin	701.3	474.3	382.4	334.6
National	668.8	628.2	610.7	

Our progress on accommodation for older people

An increasing number of people who need residential care need specialist support for people with dementia as can be seen in the finance data below. We are working with partners including Midlands Partnership Foundation Trust (MPFT), to ensure we have integrated pathways of care for people with dementia to help people stay at home as long as possible with partners such as MPFT.

We can generally meet demand for care home provision at the moment but will need more complex care provision in coming years as the trajectory shows an increase in people living longer with increase psychological and physical need. These people may be self-funders or come through the council's assessment process.

The new developments coming soon are:

- 66 bed residential and nursing home in Lawley. Managed by Walden Care, this is due to open early 2019. We are working closely with the Provider so that we can ensure their business model supports our need when they open.
- Rotherwood Care, who run St Georges Park and Roden Hall, are opening a new 60 bed residential and nursing home adjacent to Roden Hall. This will be a 45 beds home and is due to open in April 2019

These 2 developments will increase the number of beds in the borough by 81. It important to note that both providers will aim to fill a percentage of their beds with self-funding residents.

We now have a Specialist Accommodation Programme running that is looking to ensure we have suitable housing availability not only for our adults with disabilities but our older people too so resident of the borough can have a home of life. We are looking at an increase in the Extra Care provision which again will support people living independently in their own home but with the peace of mind that core support is not far away. Part of this will include specialist dementia extra care provision to help people remain in their own home for longer and avoid a move to residential care as we know (figures above) dementia will affect a growing number people.

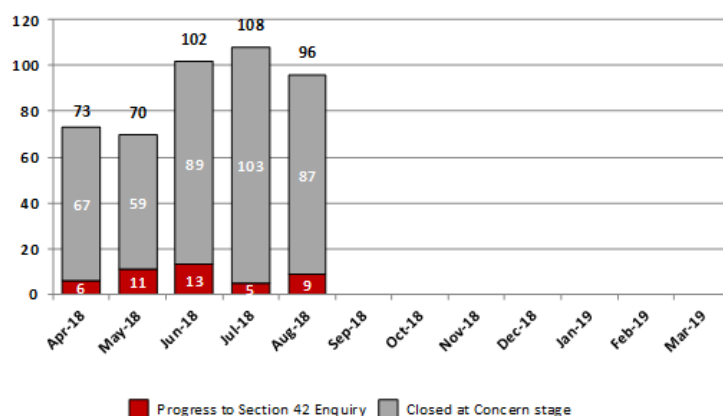
Prospective providers and investors are looking at our Market Position Statement (MPS) online and contacting us for further discussions before they start their business plans, which is helpful. Colleagues in the planning team are also signposting to the MPS so we can ensure that we are getting the right supply to meet the need

Safeguarding

We have re-organised our service to have a specialist team with specific skills and competences to respond to Section 42 enquiries under the Care Act 2014. Having a Specialist team enables a consistent approach to adult safeguarding. The safeguarding team also supports quality of practice across adult social care to ensure that our qualified workforce have the skills to respond to assessments of capacity and best interest decision making.

Our Safeguarding Concerns completed have increased to 405 received from last year's figure of 361. However, we have less people going through to the next stage of a Section 42 Enquiry. This time last year we had 85 people moving to a S42 enquiry and this year the number has dropped to 44.

We report our safeguarding performance regularly to the Safeguarding Adult Board and this month we will report in detail our progress on Making Safeguarding Personal



	Month-on-month		Year to date		
	Jul-18	Aug-18	2017-18	2018-19	
Closed at Concern stage	103	87	361	405	↑
Progress to Section 42 Enquiry	5	9	85	44	↓

4 Strengths and Community Asset Approach Making it Real Board

We have made excellent progress with the Making it Real Board and co-produced the ASC Charter alongside our Vision and Priorities. We have now up-dated the Think Local, Act Personal (TLAP) website with the top 3 priorities identified by the Board to work on and the draft Action Plan to monitor progress. By doing this we have received the TLAP Kite Mark pledging our commitment towards Personalisation.

The Making it Real Board members also contributed to a customer journey workshop with NDTi to ensure that all processes focus upon the individual being at the centre of their care and support needs (see above illustration)

Our Adult Social Care Charter

- We will always promote independence
- We will listen with empathy and understanding
- You will know who to contact and we will always get back to you
- Our conversations will be honest and personal to you we won't just tick boxes
- We will respect your decisions and be honest and open

Examples of Operational Practice

Example of having different conversations at Assessment:

X was referred to us from the Memory Service, who felt that X required a support package daily, to support with medication, making meals and taking out in the community. There was also concerns around X and her husband's memory and capacity to prepare meals for X due to her dysphagia. On assessment, it was clear that X's husband did have capacity to prepare his wife's meals appropriately. To ensure transparency I asked the husband to keep a 3 week dairy of food he had prepared for this wife, this also enabled me to ensure that he was preparing the right types of food for X. I made a referral to Wellbeing to request Pivotal to support X to be independent with medication. This helped and preventing a carer's visit to administer medication. I also highlighted that medication was a medical need so that the Memory Service could fund this, this was agreed with a care package twice daily for 15 minutes to administer X's medication funded by the Memory Service. I also made a referral to Age UK for the befriending service to support X to access community support enabling X to go out to socialise and avoid loneliness. The Age UK Help at Home Service also provide support with cleaning and domestic tasks.

Assistive Technology

"The Gator watch is proving a godsend! A couple of times Helen has wandered off up the drive whilst we were gardening, and on both occasions I could track where she was and had been, so I could meet her and bring her back. She wears it when we go out, and gives peace of mind there won't be a repeat as when we had to involve the police to find her!"

It is estimated that cost avoidance for the above example is approximately £5k per year as the individual would have needed care and support during the week from a commissioned care and support service.

- Client A – night time ‘on call’ has been removed and replaced by community alarm, saving a £100 per week
- Client B – replaced half an hour call with portable pill reminder, saving £2,537 per year
- Client C – replaced half an hour call with reminder clock, saving £2,537 per year

Occupational Therapy

- Client A - Property has now had adaptations- doors widened to allow this person to be able to remain in her own home safely. Following hospital admission she is now practicing with a gutter frame with support from Physiotherapy. Equipment provided- hospital profiling bed, shower chair, doors widened, and rise and recline chair.
- Client B - Received 1 carer for the morning however is now independent
- Client C - Gentleman previously at cottage care, returned home with no support, independent, (Equipment, A.T, community participation).
- Client D - Care agency reported that this gentleman required 2 carers however following observation of transfers and tasks carers carry out he requires 1 carer.

Continuing Health Care (CHC)

- Client A – Older person in EMI Nursing Care whose dementia presented some considerable challenges and required constant 1:1 support. With this level of need the Continuing Health Care process was applied and the threshold was met given the complexity of need. This person now receives the NHS fully funded support and doesn't contribute towards their care costs. This was also reduced cost to the Council of £145k a year.

5 FINANCIAL/VALUE FOR MONEY IMPACT – Our 5 year Strategic Model

The overall **net budgeted** spend on Adult Social Care is £42.414m (for 2018/19) which is 39% of the overall net council budget (source RA form).

Period 4 (July)

Projected 2018/19 net expenditure based on information to the end of P4 (July 2018) is £42.9m against the budget of £42.4m the overall projected variance being £0.5m. However, the pressure on budgets set for purchasing care at period 4 to be c.£900k for 2018/19.

Table 1 Older people 65+				
	18/19 Budget at P4	18/19 Actual at P4	18/19 Projections at P4	18/19 Variance at P4
Purchasing Spot Care:				
Over 65's - Residential Care	4,743,892	1,599,191	4,527,967	(215,925)
Over 65's - Nursing Care	5,479,552	2,012,422	5,439,464	(40,088)
Over 65's - Direct Payments	1,079,009	314,024	759,745	(319,264)
Over 65's - Respite	936,400	37,586	590,000	(346,400)
Over 65's - Homecare	5,266,011	1,222,334	5,794,818	528,807
Over 65's - Daycare	179,480	12,277	163,958	(15,522)
Shared Lives			(43,001)	(43,001)
Over 65s	17,684,344	5,197,834	17,232,951	(451,393)

In addition to the spot purchasing of care in the table above, there is care purchased through block provision for the 65+ age group. The total budget in 2018/19 for block contracts for OP is £3.41m, therefore the total budgeted spend for this financial year is £21.1m being around 42% of the gross budgeted expenditure on all care provision (excludes Social Work teams etc)

Older People Numbers of People

This table confirms the number of clients in receipt of care and support services in the Older People's category. This details the original estimated numbers for 2018/19 (pink column) and the new targets set for 2018/19 (blue column).

		17/18 Client No	18/19 Original Model Client No	18/19 Revised Model Client No(based Period 4)	19/20 Forecast Client No
OP	Residential	83	89	87	86
OP	Residential EMI	97	86	82	82
OP	Nursing	78	102	89	90
OP	Nursing EMI	84	56	54	55
OP	Homecare				
OP	Direct payments	47	57	43	43
OP	Total	389	390	355	356

The 2 tables below report the average unit costs and activity (units of care purchased i.e. beds days or hours related to the numbers above) for Older People for 2018/19 and the estimates currently being used to model 2019/20 budget requirement.

Older People Activity

Row Labels	Sum of 17/18 Days/Hours	Sum of 18/19 Original Model NET Days/Hours	Sum of 18/19 Revised Model NET Days/Hours	Sum of 19/20 Forecast NET Days/Hours
OP	495,574	492,400	526,952	488,255
Direct payments	20,198	20,714	15,677	15,677
Homecare	347,884	350,400	396,187	358,220
Nursing	36,044	37,102	32,933	32,933
Nursing EMI	23,409	20,436	20,077	20,077
Residential	34,397	32,404	31,767	31,402
Residential EMI	33,642	31,345	30,311	29,946
PSD	136,710	153,314	140,774	168,409

Older People Rates

Row Labels	Average of 17/18 Rate	Average of 18/19 Original Model Rate	Average of 18/19 Forecast Period 4 rate	Average of 19/20 Forecast Rate(2% added-PSD £16)
OP	464.99	462.41	473.20	482.67
Direct payments	366.85	364.64	344.44	351.33
Homecare	14.21	14.81	14.63	14.91
Nursing	647.37	640.00	683.24	696.90
Nursing EMI	761.95	715.00	775.68	791.20
Residential	487.65	575.00	509.17	519.36
Residential EMI	511.90	465.00	512.05	522.29

6 LEGAL ISSUES/DEBT RECOVERY

We are working closely with colleagues in Revenues and Legal to recover client contribution debt where appropriate. This involves working with family representatives and/or their legal representations.

Examples of cases we are dealing with

- Client passed away and there is a dispute over exactly what care was delivered. Our legal team are working with the decease's family solicitor to recover debt of £82k
- The debt is secured against the property which is now up for sale and debt will be recovered through the Deferred Payment Arrangement in place of £67k
- Client passed away. This is a sensitive case as Executor was previously suspected of mishandling funds. Approx. £85k in estate therefore, Revenues have requested advice from our legal solicitor if Executors were not forthcoming.

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