APPENDIX 12

ADULT SOCIAL CARE COST IMPROVEMENT STRATEGY

1 Introduction

Demand for Adult Social Care (ASC) continues to rise each year, people are living longer and there are more people living with long term conditions, particularly dementia. There are increasing numbers of young adults in transition to ASC with complex needs.

2 Population

- There are around 110,200 people aged 16-64 living in Telford and Wrekin based on the 2017 mid-year population estimates and although the population of the Borough is set to increase in coming year, very little of this increase will be in the working age population
- An estimated 29,600 people aged 65 and over live in Telford and Wrekin
- The age 25-44 age group is projected to increase by around 4,500 people by 2031
- The age 45-64 age group is predicted to decrease by 1,200 people over the same period. Despite this, the 25-44 age group will increase at a notably higher rate than the England rate
- Around 10.7% of the population aged 25-64 were from a BAME background at the time of the 2011 census
- There are around 3,831 working age veterans in the Borough
- Around 12,744 of the population aged 25-64 reported providing some form of unpaid care (14.4%) over the same period, with around 3,169 of these reporting to provide care for more than 50 hours per week

2.1 Health and Wellbeing

- As with all age groups in the Borough, a high proportion, nearly 16,000 of the working age between 16-64 adults reported having a long term illness or disability than the national average at the time of the 2011 census
- An estimated 10,600 people aged 16-64 have a moderate or serious physical disability based on the 2017 mid-year estimates
- An estimated 3,400 people have a baseline learning disability, aged 15-64+, with 800 moderate or severe learning disability

3 Current ASC Activity for 2019/20

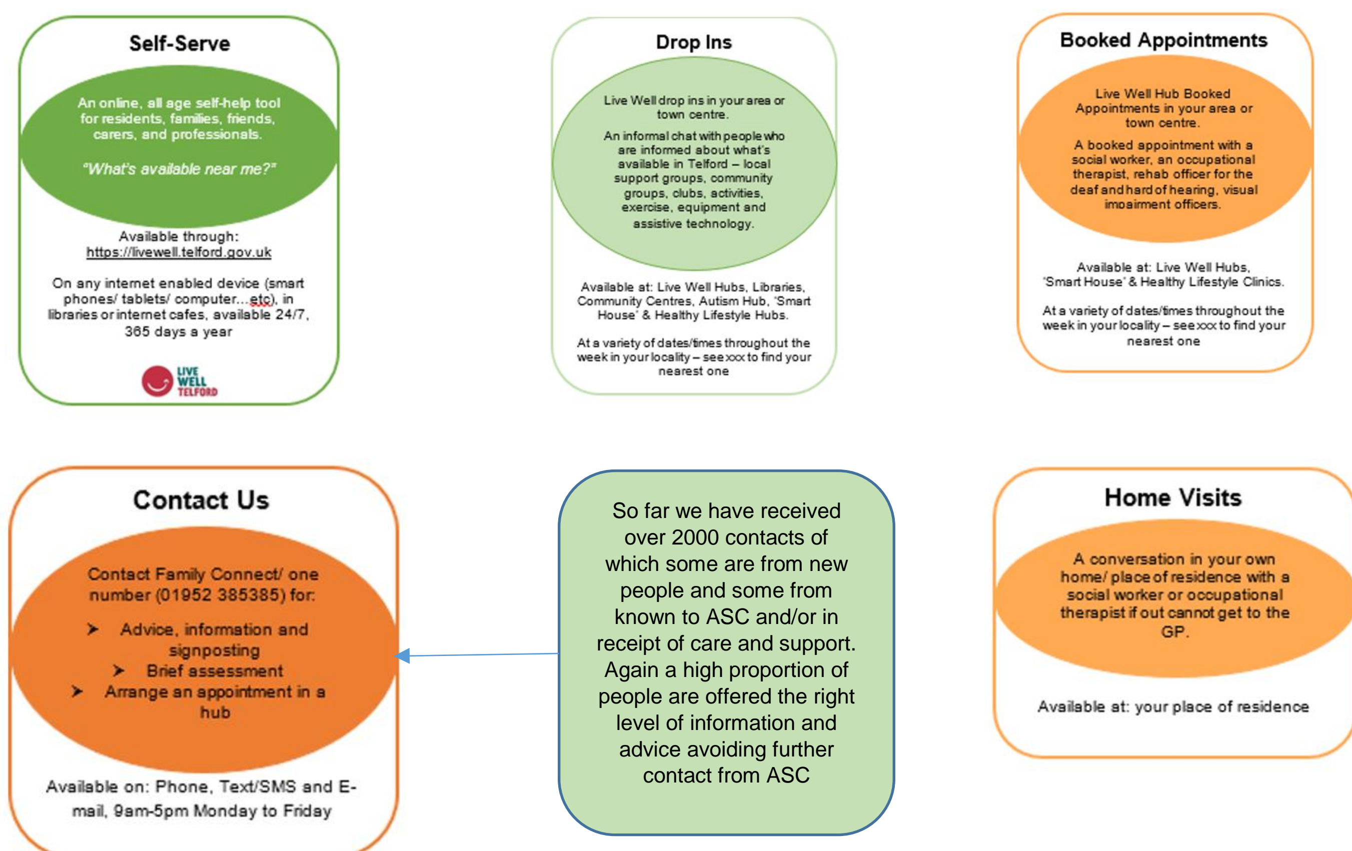
We monitor our performance and budget on a continuous basis throughout the financial year as detailed below. We have developed a 5 year plan, which is up-dated at least annually. The plan was established in order to forecast the financial pressures and gains accruing to the service model for ASC given the complexity and variable which impact the expenditure and income of the service i.e. population numbers, population ageing, strategic changes to service delivery and care support being delivered.

The work programme detailed below is to ensure that we remain on track ensuring we remain within budget as much as possible and achieve the targets over the 5 year plan.

4 Managing Demand

We continue to develop our front door options as described below and these services proves that we are providing an excellent level of information, advice, support and guidance at first point of contact, enabling people to help themselves, preventing and/or delaying funded care

and support needs. We also ensure that we maximise and signposting appropriately to community assets.



We continue to closely work with our commissioning colleagues to ensure the right level of services can be developed and/or available locally for the people of Telford and Wrekin. This work includes initiatives for carers which include training, Extra care provision and re-modelling the offer consulting with residents and providers to understand the challenges and develop a service fit for the future demands of the aging population. We are working with the domiciliary care market and assisting them with the recruitment and retention of care staff. We have started early conversations with Thrive Partners regarding the supporting people offer. We continue to explore options for the older population who require specialist dementia care and support locally

5 5 Approach to the management of ASC services

5.1 Enablement and Occupational Therapy

These services helps to manage the demand for on-going and long term ASC services. Our performance shows that with the level of support provided, people leave the service at this stage and require no further input from ASC; this also includes the provision of equipment.

5.2 Hospital Discharge

We continue to sustain our Delayed Transfer of Care and we are ranked overall 2nd in the West Midlands for total delays and 4th for social care delays. We have also introduced Pathway Zero to the process adopting a strengths based approach post hospital discharge.

5.3 Care Act Assessments and Long Term Services

- There are around 900 people in receipt of domiciliary care services
- There are around 301 people in residential care
- There are around 200 people in nursing care

Our trend in providing long term care demonstrates that we are supporting more people to live within their own communities with the right level of funded care and support needs, with only those people with high level complex needs being placed in care homes.

5.4 Reviews

It is important to remember that some people will have more than one review dependent on personal circumstances that result in unscheduled reviews. We continue to increase the number of reviews we complete.

6 Our ASC Plans for 2020/21

We continue to explore options to improve our performance management in ASC. Going forward this includes re-modelling front line services and further strengthening our front door services to help us manage our demand.

6.1 Learning Disabilities Service

We will be introducing a new learning disability and autism team in the New Year. Our work programme includes consultation and engagement working with organisations, voluntary sector, families, carers and people in receipt of services, financial modelling, working with commissioning to explore alternatives such as supported living accommodating and re-shaping the My Options service to increase our targets around employment and settled accommodation and moving away from traditional services such as day centre attendance.

6.2 Direct Payments

We will be scoping our options to establish the benefits of having an in house direct payments team to help increase our performance to ensure people who have capacity to manage their own care arrangements can do so with the right level of support including finding suitable personal assistants to deliver the care.

6.3 Independent Living Centre (ILC) & Digital Enablement

We are working with colleagues in the CVS to jointly develop an ILC in a central location, which will become the main hub for information and advice, signposting, showcasing various types of assistive technology & digital solutions, equipment to aid people to make informed choices to help themselves. Our digital enablement agenda will include working together to develop a ‘Smarter Borough’ with our approach being multi-disciplinary including universities, business, council social care, health key stakeholders, partners, education and employment

6.4 Integrated Place Programme

Excellent progress has already been made with continual publicity, Newport pilot with community nursing and mental health, increasing the micro provider provision, exploring the personal assistants model, implementation of the new Rapid Response Team, community engagement groups, implementation of pathway zero. We also continue to work with colleagues in Public Health and the CCG

6.5 Continuing Health Care (CHC)

We will continue to work with our colleagues at the CCG to ensure that appropriate funding is provided to support clients work is continuing to streamline the process for agreeing and invoicing the various CCGs for all agreed funding