

APPENDIX 12

Adult Social Care (ASC) **Continuous Improvement Plan 2021/22**

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. We are also seeing increased numbers of people with complex needs discharged from hospital or supported at home to prevent hospital admission. The longer-term Covid legacy impact upon the cost of care, the increased needs of some people and their independence are key challenges as we move forward.

However, we continue to work in a strengths based way in ASC with a focus upon supporting local people to live as independently as they can in their own home, as far as is possible. Our approach importantly focuses upon ensuring early access to information and advice about health and social care. This enables people to make informed choices to enable them to keep independent whilst getting the information they need when they need it.

2 Early Help and Advice

We continue to develop and improve the level of information, advice, support and guidance at our first point of contact Family Connect, enabling people to help themselves to maintain their independence as far as possible. This helps us ensure that we use our statutory resources for those that have care and support needs. Part of the initial support, where it is appropriate to do so, is to signpost to available and suitable community assets.

There are a range of early help, advice and interventions dependent upon the level of need that help us ensure that we use our resources proportionately:

Live Well Telford (LWT)

Our on all age Directory of services providing self-help options and promoting choice, control and independence for people to help themselves. This is proving very beneficial and the usage increases each month for example in Oct 2019 we recorded 3602 users compared to October 2020, with 4658 users.

Wellbeing and Independence Partnership (WIP)

Working in partnership with Voluntary organisations who provide individuals with information, advice, support, guidance and advocacy services without the need to contact ASC services

Family Connect

Providing information, advice, and signposting to other relevant services and organisations but also providing occupational therapy and social work interventions under the Care Act when required.

Virtual Hubs

We continue to provide information, advice and guidance through our virtual hubs and booked appointments. This means that individuals and their families can have an early conversation with ASC staff about their care and support needs with the intention of promoting their independence for longer.

An example of this type of support is our:

Virtual Calm Café

Providing support to those with mental health care and support needs.

Hospital discharge enablement support

and timely input from our Health and Social Care Rapid Response Team to avoid any unnecessary hospital admissions.

Independent Living Centre

Virtual and in person, will open by the end of the year focussed upon providing access to equipment, technology enabled care and a range of information for people with care and support needs. This resource is particularly important as we see the numbers of older adults in Telford and Wrekin increasing over the next few years.

3 Population

- There are estimated 179,900 people living in Telford & Wrekin; 31,100 are over 65 years old. 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 (Updated information for 2019-2020 and all population is rounded to the nearest 100 as they are estimated numbers only)
- There are estimated 16,500 people over the age of 25 years old providing unpaid care to a partner, family member or other person; 3,700 people are over 65 years old.
- There are estimated 2,600 adults between 18 and 64, and 600 people aged over 65 years old with a learning disability
- There are estimated 2,000 people aged over 65 years old that have dementia, by 2035 this will increase to 3,220 (60%)
- There are estimated 10,900 people aged 18-164 years old that have a moderate or serious physical disability
- There are estimated 1,400 people aged over 18 years old that have autistic spectrum disorders
- There are estimated 20,000 people aged between 18 and 64 years old that have a common mental health disorder
- There are estimated 8,600 people aged over 65 years old that have a long term health problem or disability that limits their day to day activities
- There are around 3,831 working age veterans in the Borough

Please note: these are nationally produced figures for each Local Authority Area. For more information about the population of Telford and Wrekin, visit www.telford.gov.uk/factsandfigures

3.1 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

4 Current ASC Activity for 2020/2021

We have developed a multi-year financial plan, which is up-dated at least annually. The plan assists in forecasting the financial requirements of the service model for ASC reflecting the impact on expenditure and income of population numbers, population ageing, strategic changes to service delivery and care support delivered.

Due to the Coronavirus pandemic this year, we have experienced increased numbers of people particularly on our hospital discharge and enablement pathways. We have also seen an increase in the numbers of people referred to our Health and Social Care Rapid Response Team that supports people to avoid any unnecessary hospital admissions by providing timely interventions from both health and social care.

4.1 Hospital Discharge

We continue to work partners in an integrated discharge team supporting people with complex need, to leave hospital on the same day that they are medically fit to do so; many discharges are within the 2 to 4 hour window. We have also introduced Pathway Zero to the process adopting a strengths based approach post hospital discharge which ensures that only individuals with complex needs go on to have reablement and many more are supported with community assets to return home.

Health and Social Care Rapid Response Team

This service is provided in partnership with our Health partners and is working well as follows:

- Timely, appropriate and seamless delivery of community services
- Increasing referrals over time (average of 28 a week increased to 39 a week)
- 93% admission avoidance rate
- Wide range of presenting needs supported in the community
- 252 bed days saved over 5 months

This service has improved:

- The patient experience
- Reduced avoidable unplanned admissions
- Reduce duplication of referral
- Improved access to a range of services
- Happy and productive staff

4.2 Care Act Assessments and Long Term Services (as at 31-10-2020)

- Of a total of 1801 clients here are around:
- 74% in receipt of domiciliary care services
- 16% in residential care
- 10% 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 who cannot be supported this way moving into residential care. We continue to perform well nationally being in the top quartile for the numbers of people supported to live in their own home as opposed to residential care.

An important part of maintaining this performance is ensuring that we complete timely reviews of people with care and support needs.

4.3 Learning Disability & Autism Team

We reorganised ourselves this year so that we could introduce a specialist team supporting those with learning disabilities and autism. This ensures that staff have expertise in supporting people in this group and this has enabled the team to support even more individuals towards greater independence whilst supporting family carers too. We have been engaging with people and their families about the development of a new learning disability strategy and launched the new Learning Disability Partnership to enable us to continue to develop our offer to meet current and future needs. This involves listening to the engagement feedback, understanding the current and future population needs and working with partners to continue to develop alternatives to residential care.

4.4 Direct Payments and Personal Assistants

We are continually improving our offer for Direct Payments. Recently we have updated all our information relating to direct payments and are now developing a personal assistants register on Live Well Telford to help people to recruit their own PAs. This approach enables people to have more personalised care and enables us to ensure that resources are more effectively used.

4.5 Independent Living Centre and Digital Enablement

We are near completion and will be launching this service based in the Telford Town Centre offering low-level Occupational Therapy assessments, information and advice, tours of a digitally set up home showing various digital solutions throughout each room to support individuals to live within their community and their own home, showcasing various digital equipment. 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. The purpose of this work is to enable people to remain as independent as possible in their own home.

5 Our ASC Plans for 2021/2022

Going forward this includes looking at all integrated opportunities with NHS partners in our front line offer and strengthening our early information and support alongside partners in the Voluntary Sector, for example the virtual/actual Independent Living Centre in partnership with the CVS

We are continuing to explore local options and provision for more supported living accommodation for people with learning disabilities and to reduce placements any unnecessary residential placements while supporting people's independence and access to their own front door.

We are continually measuring our performance and activity to ensure that we apply the strengths based approach and maximise community assets wherever it is possible and appropriate to do so; giving people choice and control on how they live well within their communities.

We continue to work with partners and providers to improve and develop ongoing partnership working to ensure that we provide the right level of care and support.

We will continue to build on our prevention agenda to ensure that we provide the right information and advice in a timely manner to reduce and/or delay the needs of funded care and support

We are planning our ongoing work to support individuals with mental health needs by improving the access to mental health services through a single approach with the NHS and voluntary sector partners. We plan to extend the Calm Café's by developing stronger links with the voluntary sector and third sector partners