

Telford & Wrekin Domiciliary Care Change Programme



Domiciliary Care Market Position Statement: Evidence Base

Table of Contents

Introduction	3
Table of Figures	4
Policy Context and Direction of Travel	6
The National Context	6
The Local Context – Aligning our strategic plans	14
About the Place	16
Achieving Transformation	17
Our vision for adult care and support in Telford & Wrekin.....	18
Transparency, quality and outcomes.....	20
Direction of Travel – Summary	21
Current & Future Demand	22
Population Forecasts	22
Ethnicity	26
Health, care and support needs	28
Older People.....	29
Adults aged 18 to 64 years	34
Carers.....	40
Geographical Analysis	41
Service Demand	47
Summary: key points about current and future demand	51
The State of Supply.....	53
National Overview.....	53
The Local Domiciliary Care Market	53
Diversity	54
Quality.....	57
Sustainability.....	59
Affordability and Value for Money.....	60
Summary – key points about supply.....	64
Glossary.....	66
References, Resources & Citations.....	69
Disclaimer.....	68

Introduction

Telford & Wrekin Council aims to develop and maintain a view of the care and support market that is informed by the national and local policy context and in particular by intelligence gathered from a range of sources. This includes:

Predictive Intelligence – what is our view of future demand and supply? What are the likely future changes that will impact on the market? Demographic analysis of the Borough’s current and future population is central to effective and efficient service planning and delivering the outcomes people aspire to. The Council uses demographic data to forecast need and identify priorities across all its communities, producing annual projections which are used as the basis for its service delivery plans.

Community Intelligence – who is playing an active part in the market? Where are they? What do they offer? Who do they serve? We maintain links with a wide range of community organisations and have sound relationships with care and support service providers, both directly through our contractual arrangements and indirectly through engagement networks such as Shropshire Partners in Care (SPiC). We recognise the need to strengthen our knowledge of the ‘self funded’ market (where people transact directly with providers rather than through Local Authority contracts) and to encourage people and organisations to help us enhance and maintain our community intelligence.

System Intelligence – what do our collective systems and review records tell us about the market? What are the critical relationships and dependencies within the market? We hold quantitative information about our ‘transactions’ with providers on behalf of people who use care and services and some qualitative information based on our contract monitoring systems and quality assurance procedures. We have little information in our systems about self-funders and need to explore ways of filling this gap. We have limited access to intelligence that exists within external systems (for example, those of provider organisations) and would like to explore how to facilitate the sharing of systems intelligence for common benefit.

Personal Intelligence – what do our interactions with people who use services and with providers tell us? What formal and informal engagement mechanisms exist? Our interactions with individuals tend to be scheduled around specific events (e.g. for assessment, support planning, review etc.) and, to a limited extent, through consultative groups over a range of current issues (e.g. service prioritisation in the context of budget setting). We use local and national surveys to gather the views of a representative group of service users and carers. We maintain oversight of comments, complaints and compliments made by people about the services they use and may reflect this in our contract performance discussions with providers. We consult with providers, primarily through SPiC but so far not specifically about our understanding of the care & support market and the changes we need to encourage.

This document accompanies the Telford & Wrekin Domiciliary Care Market Position Statement (DCMPS), providing further detailed information and evidence from these sources to support our analysis.

Table of Figures

Figure 1: Six essential actions for decentralisation.....	6
Figure 2: Health & social care regulatory system	7
Figure 3: A new system for care and support	10
Figure 4: Expenditure & Demand - older people's social care (2009/10 prices)	13
Figure 5: The DH Outcomes Frameworks	14
Figure 6: Service Delivery Model	19
Figure 7: Telford & Wrekin Population Model 2011 - Key Projections.....	23
Figure 8: Telford & Wrekin Population age cohorts - 2001 and 2011 (source: ONS Census).....	24
Figure 9: Population cohort change 2001 to 2011	24
Figure 10: Population age band comparison: 2001	25
Figure 11: Population age band comparison 2011	25
Figure 12: Population projection by age range to 2030 (ONS data).....	25
Figure 13: Ethnic Groups 2011.....	26
Figure 14: Telford & Wrekin population by ethnic group - 2001, 2010 and 2026.....	27
Figure 15: Analysis of Households	28
Figure 16: Long term health problems or disability that limits daily activities.....	29
Figure 17: Factors affecting demand for care and support - people aged 65 and over	29
Figure 18: The growth in dementia.....	30
Figure 19: Dementia prevalence and diagnosis (source: Alzheimer's Society)	31
Figure 20: Projecting limiting long term illness	32
Figure 21: Managing self-care tasks.....	33
Figure 22: Managing domestic tasks.....	33
Figure 23: Factors affecting demand for care & support - people aged 18 to 64 years.....	34
Figure 24: Estimated number of people aged 18 - 64 with a learning disability	35
Figure 25: Estimates of people aged 18 to 64 with a moderate or severe physical disability	37
Figure 26: Projections of people with mental health problems (ONS).....	38
Figure 27: Community Mental Health Profile 2013	40
Figure 28: Provision of unpaid care	41
Figure 29: Older Carers	41
Figure 30: Co-operative Learning Communities	42
Figure 31: CLC Population Profile, (TWPM, 2010 estimates).....	43
Figure 32: Population over age 65 by CLC (TWPM, 2010 estimates)	43
Figure 33: Population by Ward and Age	44
Figure 34: Ward Populations - Age Profile.....	45
Figure 35: Indices of Multiple Deprivations, by Ward – 2011	46
Figure 36: Care and support service users receiving services (source: RAP Return 2011/12)	50
Figure 37: Home and Day Care - service user numbers 2009 - 2012.....	50
Figure 38: Home care numbers by service user group	51
Figure 39: A shift in buying power (illustration only)	52
Figure 40: Domiciliary Care Providers by size of service user base	54
Figure 41: Domiciliary Care Providers - market share	55
Figure 42: Market Share by Provider, Service user Number and LA Expenditure	55
Figure 43: Provider Diversity by service specialism	56
Figure 44: CQC Assessment Summary	58

Figure 45: Adult Social Care Survey - Satisfaction Levels.....	59
Figure 46: Spending by service user group	61
Figure 47: Average spend per service user	61
Figure 48: Average hourly rates - all service user groups	62
Figure 49: Average hourly rates for older people's Domiciliary Care	62
Figure 50: Average hourly rates for Learning Disability services	63
Figure 51: Average hourly rates for physical and sensory disability provision.....	63
Figure 52: Average hourly rates for Mental Health service users	64
Figure 53: Average hourly rates for enablement.....	64

Policy Context and Direction of Travel

Care and Support policy in Telford & Wrekin reflects and is determined by:

- National policy, legislation and direction from central government;
- The priorities and needs of local communities and people.

The National Context

There is a broad policy and legislative framework within which the health and social care system must operate.

Government policy is committed to the redistribution of power from government to communities and people and this is enshrined in the [Localism Act 2011](#), which describes decentralisation across six essential actions:

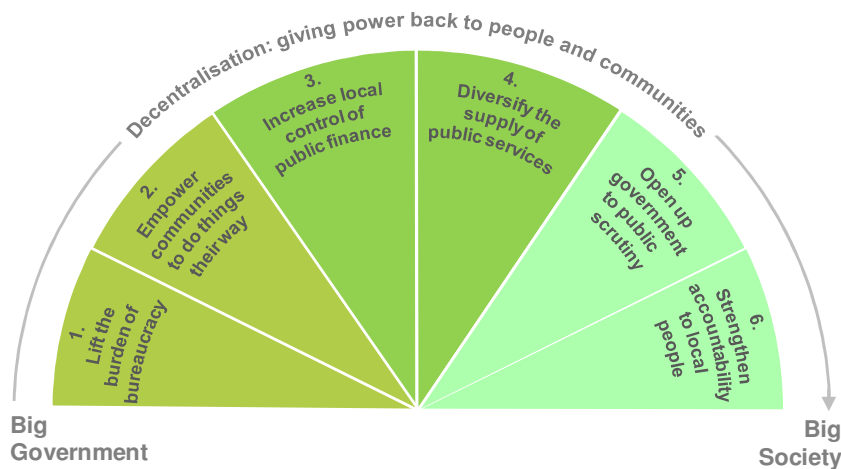


Figure 1: Six essential actions for decentralisation

This policy envisages a [stronger role for Civil Society](#), in particular across three themes of the reform agenda:

1. Empowering communities: giving local Councils and neighbourhoods more power to take decisions and shape their area.
2. Opening up public services: the Government's public service reforms will enable charities, social enterprises, private companies and employee-owned co-operatives to compete to offer people high quality services;
3. Promoting social action: encouraging and enabling people from all walks of life to play a more active part in society, and promoting more volunteering and philanthropy.

These reforms cut across all areas of social policy and are reflected in the policy guidance and supporting legislation of all government departments.

The Department of Health provides strategic leadership for public health, the NHS and social care in England on behalf of the government. The Department's purpose is to improve England's health and well-being and in doing so achieve better health, better care, and better value for all. It does this by developing and implementing government policy and by supporting and mobilising the health and social care system to deliver improvements for patients and the public.

The vision for health and social care is focused around five key priorities:

1. A patient-led NHS
2. Delivering better health outcomes
3. A more autonomous and accountable system
4. Improved public health
5. Reforming long-term and social care

There are a number of key Acts of Parliament, Government Bills and policy guidance documents that describe and enable the reform of health, social care and public health in England.

Health Reform

The [Health & Social Care Act 2012](#) establishes the new sector regulation system within a 'mixed economy' of public, independent and voluntary sector providers, working within the values and principles enshrined in the NHS Constitution.

Figure 2 below provides an overview of the health and social care structures described in the Act, to be active from April 2013.

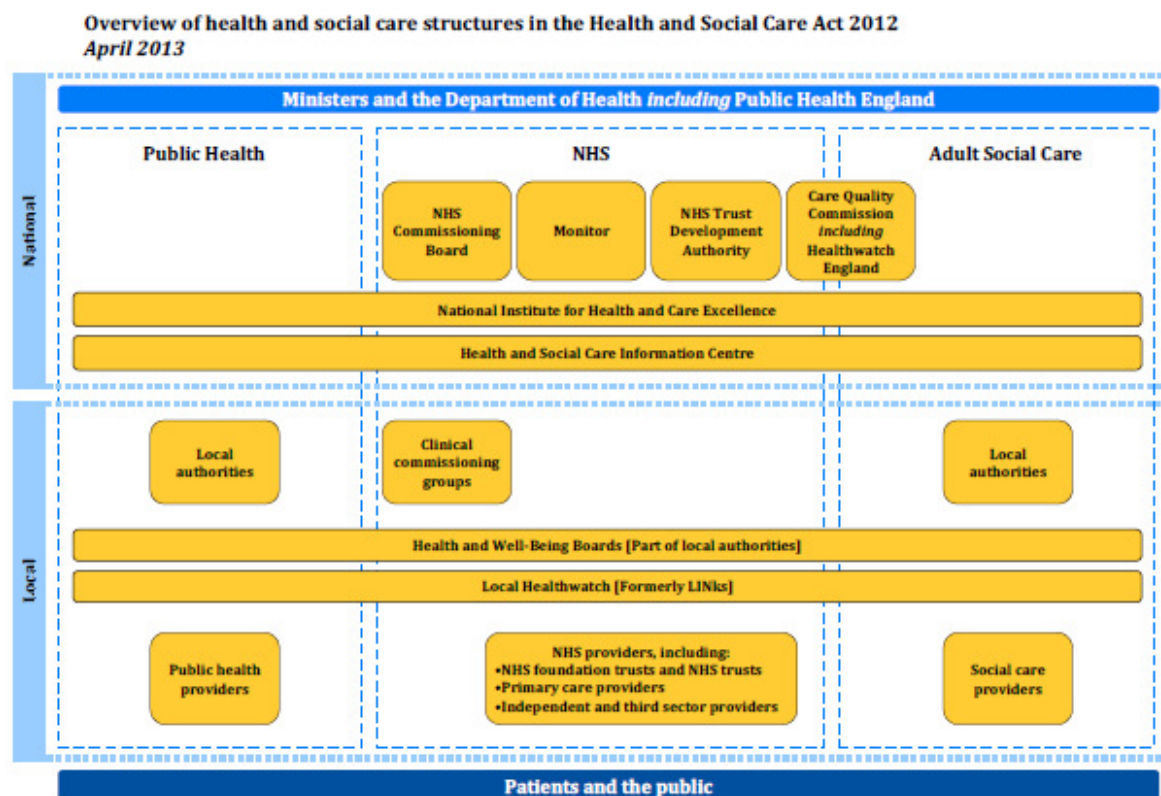


Figure 2: Health & social care regulatory system

The Act focuses on 6 policy areas:

- **Clinically led commissioning** – the Act puts clinicians in charge of shaping services, enabling NHS funding to be spent more effectively. Supported by the NHS Commissioning Board, new clinical commissioning groups will directly commission services for their populations.
- **Provider regulation** to support innovative services - enabling patients to choose services which best meet their needs and establishing *Monitor* as a specialist regulator to protect patients' interests.

- **Greater voice for patients** - the Act establishes new Healthwatch patient organisations locally and nationally to drive patient involvement across the NHS.
- **New focus for public health** - the Act provides the foundations for Public Health England, a new body to drive improvements in the public's health.
- **Greater accountability locally and nationally** – the Act sets out clear roles and responsibilities, whilst keeping Ministers' ultimate responsibility for the NHS. It limits political micro-management and gives local authorities a new role to join up local services, with Health & Wellbeing boards playing a key role.
- **Streamlined arms-length bodies** – the Act removes unnecessary tiers of management, releasing resources to the frontline. It also places NICE and the Information Centre in primary legislation.

Social Care Reform

The policy direction for social care in England as set by successive governments is towards self-directed support, where people not organisations make decisions about the care and support they need. The current Government's reform of the system, set out in its "[Vision for adult social care: Capable communities and active citizens](#)" aims to provide much more control to individuals and their carers, making services more personalised, more preventative and more focused on delivering the best outcomes for those who use them.

The Vision is built on seven principles:

- **Prevention:** empowered people and strong communities will work together to maintain independence. Where the state is needed, it supports communities and helps people to retain and regain independence.
- **Personalisation:** individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.
- **Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and Councils - including wider support services, such as housing.
- **Plurality:** the variety of people's needs is matched by diverse service provision, with a broad market of high quality service providers.
- **Protection:** there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.
- **Productivity:** greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.
- **People:** we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.

The sector's response to this vision, set out in the [Think Local Act Personal](#) partnership agreement, calls on care providers, Councils and their partners to work to further develop and deliver a

personalised, community-based care and support system with a focus upon effective prevention and the shifting of resources from crisis and acute interventions. The agreement describes the need for universal approaches designed for all alongside more targeted support for particular groups.

The partnership agreement goes on to describe a series of challenges to be addressed by care providers, Councils and their partners. Underpinning these is the need for an evidence-led approach to planning and system change:

“Councils and their partners need to understand their local context regarding care and support needs, and the relative supply position, if they are to develop a diverse range of high quality provision that people want. ‘Market Position Statements’ ... and market development strategies can be produced to assist this. Commissioning and supply partners should collaborate across public sector boundaries to achieve better efficiency and support innovation.”

Think Local, Act Personal, January 2011

Specific priorities, identified through analysis of the evidence base at a national level, have been passed down to the sector to implement, in the form of a series of national strategies. These include:

- The [National Dementia Strategy](#), which aims to deliver quality improvements to dementia services and address health inequalities relating to dementia: The Prime Minister’s [Dementia Challenge](#), set in 2012, is a challenge to the whole of society to “go further, faster” making commitments; to drive improvements in health and care; to create dementia friendly communities that understand how to help; and to improve dementia research.
- The national Mental Health strategy [No Health without Mental Health](#), which sets out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services. It supports the Government’s aim of achieving parity of esteem between physical and mental health and stresses the interconnections between mental health, housing, employment and the criminal justice system.
- The [National Carers Strategy](#), which seeks to ensure that carers are supported and valued and have access to educational and employment opportunities and to remain mentally and physically well.

In addition, the government has released limited funding to stimulate activity in priority areas, as for example with the creation of a £300 million fund to provide new and modernised homes designed to meet the needs of older people and people with disabilities.

The focus in all of this is on improving outcomes for people who use care and support services. Whilst outcomes are expected to differ for every individual, there are some common priorities that will increasingly guide commissioning and service provision:

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

These outcomes are described in more detail in the [Adult Social Care Outcomes Framework](#) (ASCOF) along with a range of suggested performance indicators.

The Law Commission’s three year review of social care legislation, set up under the last government, made recommendations aimed at streamlining and aligning the legislative framework more closely with social care policy. Many of these recommendations are reflected in the White Paper, ‘[Caring for our future: reforming care and support](#)’ and the draft [Care and Support Bill](#), both published in July 2012, which set out how the social care system will be transformed from a service that reacts to crises to one that focuses on prevention and is built around the needs and goals of people.

Two core principles lie at the heart of the White Paper. The first is that ***we should do everything we can – as individuals, as communities and as a Government – to prevent, postpone and minimise people’s need for formal care and support.*** The system should be built around the simple notion of promoting people’s independence and wellbeing.

The second principle is that ***people should be in control of their own care and support.*** Initiatives like personal budgets and direct payments, backed by clear, comparable information and advice, will empower individuals and their carers to make the choices that are right for them. This should encourage providers to respond; to provide high-quality, integrated services built around the needs of individuals. Local authorities will also have a more significant leadership role to play, shaping the local market and working with the NHS and others to integrate local services.

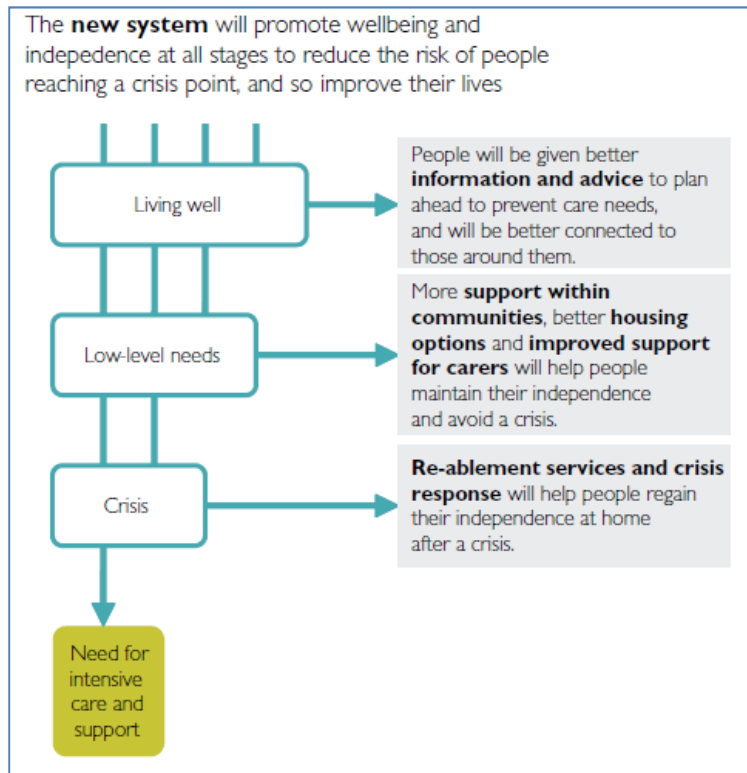


Figure 3: A new system for care and support

Described as the most comprehensive overhaul of social care since 1948, the government’s plans seek to ensure that:

- People will be confident about the quality of care.
- People will be treated with dignity and respect.
- Everyone will know what they are entitled to.
- Everyone will have control over their care.
- Carers will have new rights to public support.

To deliver these aims, the White Paper sets out a number of commitments:

- Strengthening support within communities
- Housing and support to help people live independently
- Better information and advice
- Assessment, eligibility and portability for people who use care services
- Carers' support
- Defining high-quality care
- Improving quality
- Keeping people safe
- A better local care market
- Workforce
- Personalised care and support
- Integration and joined-up care

These commitments represent an improvement challenge that has significant implications for all parts of the care and support system.

The draft Care & Support Bill redefines the responsibilities of local authorities, legislating for new duties on Local Authorities in three key areas:

Prevention

- General duty to promote an individual's well-being;
- Duty to prevent or reduce the need for care and support

Integration

- Duties to co-operate, generally with partners and more widely in specific cases;
- Duty to integrate care and support with health services in order to
 - (a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,
 - (b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or
 - (c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

The care & support market

- Duty to provide information and advice on
 - (a) the care and support system and how it operates in the authority's area,
 - (b) the choice of types of care and support, and the choice of providers, available in the authority's area,
 - (c) how to access the care and support that is available, and
 - (d) how to raise concerns about the safety of an adult who has needs for care and support.
- Duty to promote diversity and quality in the provision of services, with a view to ensuring that any person wishing to access services in the market
 - (a) has a variety of providers to choose from;
 - (b) has a variety of high quality services to choose from;

- (c) has sufficient information to make an informed decision about how to meet the needs in question.

In exercising that duty, a Local Authority must have regard to the following matters in particular

- (a) the need to ensure that the authority has, and makes available, information about the providers of services for meeting care and support needs and the types of services they provide;
- (b) the need to ensure that it is aware of current and likely future demand for such services and to consider how providers might meet that demand;
- (c) the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not);
- (d) the importance of fostering continuous improvement in the quality of such services and the efficiency and effectiveness with which such services are provided and of encouraging innovation in their provision.

The importance of the Local Authority's role in ensuring market sustainability is reinforced in the DH consultation on Market Oversight, which envisages responsibility for oversight of all but the 'highest risk' local providers resting with the Council.

Collectively these duties will have an impact for commissioners in respect of the services they commission and, more broadly, in terms of the way they manage and oversee the whole of the care and support market – requiring them to influence all providers within the market and not just those under contract to the Council.

The challenge must also be seen in the context of the country's current and future economic situation. The Government's economic strategy is focused on reducing the country's structural deficit¹, restoring stability, rebalancing the economy and equipping the UK to compete globally. This means action across a number of economic drivers and it is clear that we are at the start of a sustained period of austerity, with public sector funding settlements likely to be further constrained for some time to come. The 2010 Spending Review cut the allocations to local government in real terms, whilst overall local government spending on services, including social care is projected to fall by 14 per cent in real terms by 2014/15 (House of Commons Health Committee, 2012).

The [Commission on Funding of Care and Support](#) (or Dilnot Commission) identified a number of demographic pressures which serve to exacerbate the financial constraints within the system. Increased longevity of life has created a challenge of how best to meet the care needs of older and vulnerable adults. By 2030, more than one in ten people will be aged 75 or over; there will be 2.8 million more people in this age group than in 2008, representing a growth of 70 per cent (based on ONS projections). This increase will bring a rise in the conditions associated with old age: for example, the number of people living with dementia in the UK is expected to reach 1.4 million by 2040 (Knapp and others, 2007).

The gap between demand and expenditure would have grown regardless of the current financial climate, but the spending cuts designed to reduce the public sector deficit are likely to have made the gap worse.

¹ "A budget deficit that results from a fundamental (and sustained) imbalance in government receipts and expenditures, as opposed to one based on one-off or short-term factors." Financial Times Lexicon 2013.

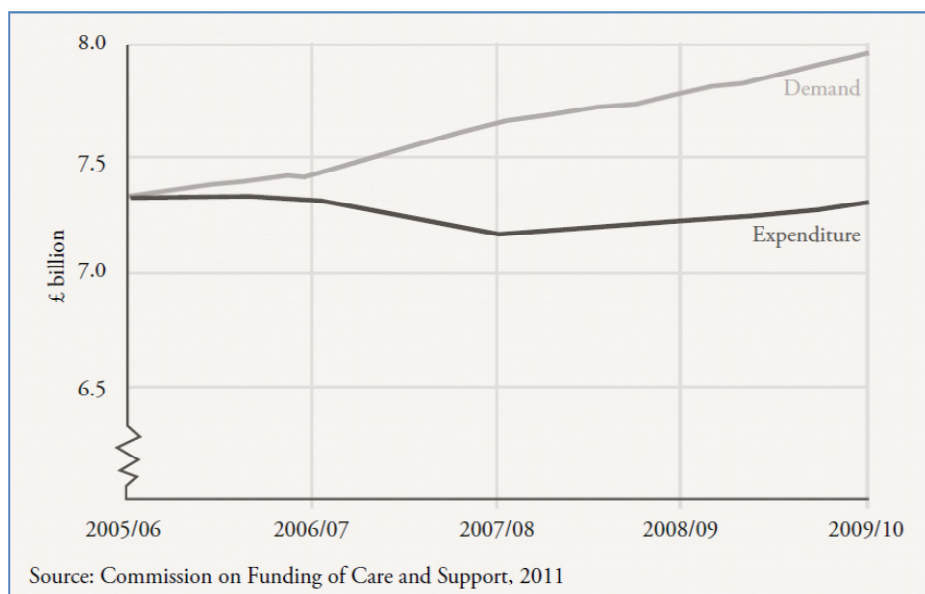


Figure 4: Expenditure & Demand - older people's social care (2009/10 prices)

The government accepts that the current system of funding for social care is outdated and unfair and has confirmed in its [progress report on social care funding](#) that it agrees the principles of the Dilnot Commission's recommendations – financial protection through capped costs and an extended means test of the system for funding – as the basis for reform.

A £72,000 cap on care costs will be introduced in April 2016 alongside an increased means test threshold of £118,000 with both of these measures potentially increasing the number of FACS-eligible people qualifying for state-funded support. A system of universal deferred payments for residential care (meaning that no-one will be forced to sell their house in their lifetime to pay for care) and national eligibility criteria (which will address an unfairness in the current system, where eligibility for care and support can depend on where someone lives, and will provide improved clarity on entitlements) will be introduced in April 2015.

Public Health Reform

The White Paper [Healthy Lives, Healthy People: Our strategy for public health in England](#) sets out a bold vision for a reformed public health system in England in which:

- Local Authorities take new responsibilities for public health. Giving this role to local government opens new opportunities for community engagement and to develop holistic solutions to health and wellbeing embracing the full range of local services (e.g. health, housing, leisure, planning, transport, employment and social care). Local Authorities' new public health responsibilities will be supported by a ring-fenced budget. Directors of Public Health will lead this work, as the principal adviser on health to the Local Authority;
- Local Authorities will be supported by a new integrated public health service, Public Health England, which will drive delivery of improved outcomes in health and wellbeing and protect the population from threats to health. Public Health England will bring together in one body the diverse range of public health expertise currently distributed across the health system. It will ensure access to expert advice, intelligence and evidence and will provide a focus for the development of new approaches including adopting insights from behavioural sciences; and provide an expert and resilient health protection service;

- there will be a stronger focus on the outcomes we want to achieve across the system. A new [public health outcomes framework](#) sets out the broad range of opportunities to improve and protect health across the life course and to reduce inequalities in health that still persist. These outcomes require the collective efforts of all parts of the public health system, from national to local levels, and across public services and wider society;
- public health has a clear priority, is seen as a core part of business across Government and is supported with the resources to ensure the focus on public health interventions is maintained; and
- the commitment to reduce health inequalities is a priority for all parts of the public health system, drawing on the Marmot review to address the wider determinants of health and complementing the role of the NHS to reduce inequalities in access to and outcome from health services.

A common focus on Outcomes

It is clear across all of its policy areas – Health, Social Care and Public Health – that the Department of Health envisages an integrated system to support people through all phases of their lives. The common focus across all areas of policy is on outcomes and to support the publication of the three outcomes frameworks - Adult Social Care, the NHS and Public Health - the Department has produced [guidance](#) explaining the principles behind the outcomes frameworks and setting out how they are intended to work together to improve outcomes across the system.

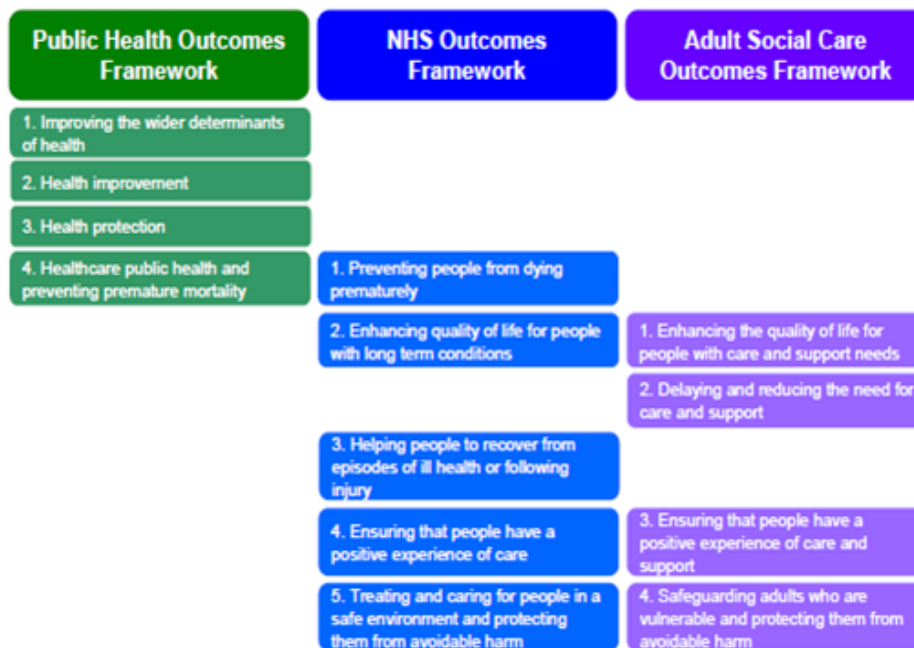


Figure 5: The DH Outcomes Frameworks

The Local Context – Aligning our strategic plans

The government legislation and policy guidelines described above are important considerations for every Local Authority in England. This section looks at how local strategic plans reflect both the national context and the community priorities that have been identified locally.

Telford & Wrekin Council sees decentralisation and community involvement as a crucial part of its strategic approach. As a [Co-operative Council](#) we are working together with residents, partners and local organisations to collectively deliver the best we can for Telford & Wrekin with the combined resources we have.

By being one of 17 Councils/opposition groups currently in the national Co-operative Councils Network (see www.Councils.coop/ for more information), we are working to:

- Bring more public services together so that people get what they need at the right place and the right time
- Involve local people and our staff more in planning and running services
- Support our communities better and encourage people to do more to help their own communities

Whilst we still face immediate, unprecedented Government funding cuts, we are making sure that local people are much more involved when it comes to reducing our costs and challenging what we spend.

We understand the need to involve others in developing our co-operative approach, and to achieve this, in September 2011 we set up a Co-operative Commission, made up of community and business leaders, Council officers and Councillors.

The Commission identified five themes to focus on and set up working groups to define the outcomes to be achieved and to develop recommendations for how we can work together more co-operatively to achieve them.

Themes	Outcomes
Co-operative values and communication	<ul style="list-style-type: none"> • Becoming a co-operative Council
Employment, skills and the economy (this is now called 'Employment and Skills')	<ul style="list-style-type: none"> • Attracting businesses into the Borough • Improving Employability
Commissioning and procurement	<ul style="list-style-type: none"> • Improving Voluntary Sector Engagement • Widening the pool of potential providers, maximising opportunities for local businesses and increasing local choice.
Volunteering (this is now called 'Civic Pride and Volunteering')	<ul style="list-style-type: none"> • Increasing volunteering • Developing the volunteer workforce
Image of Telford & Wrekin (this is now called 'Economy and Image')	<ul style="list-style-type: none"> • Increasing visitors to Telford & Wrekin (Business and Leisure Tourism). • Increasing business investment in Telford & Wrekin. • Improving Civic Pride for residents of Telford & Wrekin.

We are also working with our workforce through an Employee Commission which was established in October 2011. This Commission is employee-led, is open to all and gives employees a new way to get involved in shaping the organisation.

The recommendations made by both of the Commissions, [available to download here](#), were accepted by the Council's Cabinet in March 2012 and the Commission's working groups are now working together to implement these.

About the Place

Telford & Wrekin is situated at the heart of the UK, covering some 112 square miles of which 68% is classified as 'rural'.

The key settlements are:

- Telford – made up from 1960's new town estates and 'Borough Towns' including Oakengates, Wellington, Madeley and Dawley which existed before Telford was developed.
- Newport - to the north-west of the Borough and the location of Harper Adams University College.
- Ironbridge - a UNESCO World Heritage Site located on the northern banks of the River Severn the birthplace of the industrial revolution.

The Borough is well connected to the UK via the M54 and Telford International Railfreight Park, benefitting from a modern railway network.

Economy

There are some 4,500 registered businesses in the Borough employing around 81,000 people. Some 20% of these jobs are in foreign owned companies: 48 are US, 28 German, 16 French and 14 Japanese.

Jobs are mainly concentrated in the public sector (26% of all jobs), Retail, hotels and restaurants (23%), Banking and finance (21.7%) and Manufacturing (18%).

There is a strong bias in local economy towards automotive and advanced manufacturing, logistical and engineering related activities. The Borough is a favoured location for Tier 1 and Tier 2 automotive suppliers including Borgers, Denso, Cobra, Johnson Controls and Stadco.

Education

The Borough has excellent education and training providers: including local schools, New College, Telford College Arts & technology, Harper Adams University and the University of Wolverhampton.

Educational outcomes in the Borough are improving as measured by both GCSE (A* to C Grades) attainment and Foundation stage points. However, there are still significant differences in outcomes for children in receipt of free school meals, Pakistani heritage children and Children in Care.

Higher level workforce skills NVQ level 3 (15.6%) and NVQ level 4 (28.4%) qualifications are improving, although they both remain below national averages (16.2% and 35.6% respectively).

Deprivation

The Borough is ranked as the 96th most deprived Local Authority area in England (out of 326), based on a weighted average of deprivation indices.

Eight of the Borough's electoral wards have neighbourhoods that are in the 10% most deprived nationally: Brookside, College, Cuckoo Oak, Dawley Magna, Donnington, Hadley & Leegomery, Malinslee, and Woodside.

Around a quarter (24%) of the Borough's total population live in wards that are amongst the 20% most deprived parts of England.

Health

Although increasing, male life expectancy is worse than the national average (77.5 compared to 78.6 years). The female rate is broadly the same as the national rate.

The two key causes of early death in the Borough are cancer (217 per year) and cardiovascular disease (140 per year) and rates are worse than the national average.

Levels of breastfeeding and smoking in pregnancy are worse than the national average, particularly among young mothers.

Although improving, childhood obesity in 4-5 year olds remains above the national rate (24.9% and 22.6% respectively). However the rate for 10-11 year olds is below the national rate and falling.

Teenage pregnancy rates are falling (47.5/1000 pop 15-17 year olds) but remain above the national rate (35.4).

Population and demographics

The population profile and demography of Telford & Wrekin are analysed in greater depth in the section on 'Current and Future Demand' below.

Achieving Transformation

We are making progress with health service reforms through the establishment of new governance, monitoring and commissioning arrangements, including more integrated service planning and delivery arrangements.

The [Telford & Wrekin Health & Wellbeing Board](#) has identified 10 priorities for its work, based on local data about services and community needs in the Borough. These are to:

Reduce

- teenage pregnancies
- the number of overweight children and adults
- the numbers of smokers

Improve

- differences in life expectancy in the Borough particularly for people from deprived communities, black and minority ethnic groups, people with heart disease or cancer and among the male population
- emotional health and wellbeing of Borough residents
- people's experience of health and care services
- unpaid carers health and wellbeing

Support

- people with specific health needs to live independently for as long as possible
- people with dementia
- people with autism

Plans are progressing to develop the role of [Telford & Wrekin's Healthwatch](#) body as an influential and effective voice of the public, providing oversight of the system and informing health and well-being priorities. Local Healthwatch will:

- have a seat on the new statutory health and wellbeing boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA) and the authorisation of Clinical Commissioning Groups. This will ensure that local Healthwatch has a role in promoting public health, health improvements and in tackling health inequalities.
- Enable people to share their views and concerns about their local health and social care services and understand that their contribution will help build a picture of where services are doing well and where they can be improved.
- Be able to alert Healthwatch England to concerns about specific care providers.
- Provide people with information about their choices and what to do when things go wrong; this includes signposting people to the relevant provider when they want to complain about NHS services.
- Provide, or signpost people to, information about local health and care services and how to access them.
- Provide authoritative, evidence-based feedback to organisations responsible for commissioning or delivering local health and social care services.
- Help and support Clinical Commissioning Groups to make sure that services really are designed to meet citizens' needs.
- Be inclusive and reflect the diversity of the community it serves. There is an explicit requirement in the Health & Social Care Act that the way in which a local Healthwatch exercises its functions must be representative of local people and different users of services, including carers.

The Council has tendered for the provision of Healthwatch Telford & Wrekin, with the new provider starting service in April 2013.

The [Telford & Wrekin Clinical Commissioning Group](#) (CCG) has been set up and took over the commissioning of the majority of local NHS services from April 2013. Headed by local family doctors, the CCG will buy hospital, rehabilitation, mental health and community health services.

The CCG is committed to putting the patient at the heart of its commissioning decisions, for example through the new Telford Referral and Quality Service (TRAQS). TRAQS aims to support patients through their referral from GP to different NHS services – making the system more streamlined and accessible, improving the patient experience of the NHS and providing valuable information to the CCG themselves in looking at the future needs of the NHS locally.

CCG priorities will reflect and be informed by local Health & Wellbeing priorities and this is expected to impact on the commissioning of community-based services particularly in respect of the support for independent living required by people with long-term health needs, people with dementia and people with an autistic spectrum disorder.

Our vision for adult care and support in Telford & Wrekin

We are committed to making sure that care and support services are personalised and developed to allow people choice and control in their lives.

We want everyone in Telford & Wrekin to live as independently as they are able, and to enjoy the good health and well-being. We are committed to making plans and decisions based on our analysis of the evidence of what is needed so that we deliver the best possible outcomes for people who use care and support services.

Any one of us, or one of our relatives or friends, will access social care services now or in the future. The changes we are making will shape social care and make improvements for all of us. We wish to see services that are tailored around the person, not making people fit into what services are available or deemed fit for them by somebody else.

Our aim is to help people remain independent for as long as possible and give them control over any services they choose, including funding from the Council for their care or support, as well as better information and easy access to the services that suit them and their personal care requirements.

Service Delivery Model

We have developed a service delivery model around these principles, ensuring appropriate care and support at all stages of the ‘customer journey’:

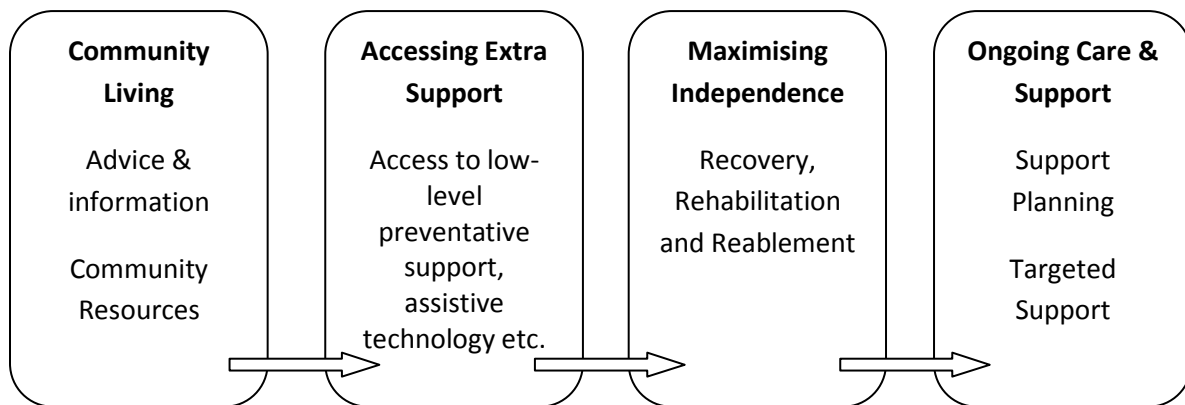


Figure 6: Service Delivery Model

The model assumes that as people live their lives, they will access the information, advice and other low-level community-based resources that they will need in order to live independently. Our primary focus in this area is on **Information and Advice** - developing an ‘information economy’ in which information is created, published and maintained so that people can understand more about their changing needs and the type of support that is available. For example, the My Life portal is being developed as a public information and service catalogue, providing local people with information and advice to enable them to help themselves and thereby reducing or delaying the need to access Community Care Services from Care and Support.

The model recognises that some people will require extra support. The **Access** service can provide a range of low-level preventative support and equipment and aims to help people undertake their own self-assessment and to source the solutions that they require.

Of course, many people require ongoing care and support and this is accommodated within the model in two ways. Firstly, the **Maximising Independence** service aims to reduce a person’s level of need through a more detailed assessment and introduction to short-term community and statutory ‘reablement’ services. The aim of reablement is to help people to recover from illness, injury or other life changes and to rehabilitate them so that they can adapt to their new circumstances whilst retaining their independence.

For those requiring longer-term or lifetime support, **Ongoing Services** are arranged in line with the principles of self-directed support, with a formal assessment of need leading to budget allocation, services being bought (either directly by the service user or commissioned on their behalf) and periodic reviews to ensure that satisfactory outcomes are being achieved. Those in receipt of ongoing support will be helped to access the most appropriate support by the Brokerage, or Personal Budget Support Teams; Commissioning staff will oversee and manage the market to ensure quality, choice and value.

Transparency, quality and outcomes

The Council publishes details of the performance of adult social care services, together with its analysis of what still needs to be done, within its annual [Adult Social Care Local Account](#). Performance is assessed in terms of the whole care and support system so that the outcomes delivered by a wide range of partners can be scrutinised.

The Local Account concludes that Adult Care and Support services in Telford & Wrekin continue to make significant improvements for vulnerable people, but recognises that there is more to be done in order to give people more choice and control over their lives and to make sure everyone has access to services that will help them to live as independently as possible.

The Council has adopted the outcomes proposed in the Adult Social Care Outcomes Framework (ASCOF) for 2013/14 to provide a focus for its improvement effort. The ASCOF describes outcomes and associated performance measures across four domains:

Enhancing the quality of life for people with care and support needs

- People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs.
- Carers can balance their caring roles and maintain their desired quality of life.
- People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

Delaying and reducing the need for care and support

- People have the opportunity to achieve the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.
- Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.
- When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

Ensuring that people have a positive experience of care and support

- People who use social care and their carers are satisfied with their experience of care and support services.
- Carers feel that they are respected as equal partners throughout the care process.
- People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.
- People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

Safeguarding adults whose circumstances make them vulnerable and protecting them from harm

- People enjoy physical safety and feel secure.
- People are free from physical and emotional abuse, harassment, neglect and self harm.
- People are protected as far as possible from avoidable harm, disease and injuries.
- People are supported to plan ahead and have the freedom to manage risks the way that they wish.

Telford & Wrekin Council has added a fifth priority – **Delivering Transformation and Managing Resources** – to recognise the financial and policy context within which these outcomes must be delivered.

Direction of Travel – Summary

We have made good progress in implementing and reflecting national policy in our local plans but remain sensitive to the local priorities that our communities are helping to identify: as a co-operative Council, we see this as a shared responsibility and are committed to working with all parts of the community to deliver our shared priorities.

The vision for adult social care is built around the principles of personalisation, prevention and early intervention; delivery of the vision is to be achieved through self-directed support, with choice and control being extended through personal budgets and access to a choice of personalised services.

This demands a more integrated system, with health, social care and public health partners working together to enable better health and well-being outcomes for people. It also demands a new, more productive relationship with service providers so that we design and co-produce solutions that meet the needs of our residents.

Our Market Position Statement, which accompanies this report, reflects our analysis of ‘what we know’ and whilst there are some gaps in our knowledge, we are confident that collectively we know enough to help us begin to define and plan for a better system – whilst striving to plug the gaps and refine our plans in light of the changing context.

Current & Future Demand

Demographic analysis of the Borough's current and future population is central to effective and efficient service planning and delivering the outcomes people aspire to. The Council uses demographic data to forecast need and identify priorities across all its communities, producing annual projections which are used as the basis for its service delivery plans. Locality based data is produced at a Council ward and co-operative learning community level to help identify local priorities and target resources by need.

Within Health and Social Care, demographic data is combined with deprivation data, socio-economic profiling, education and skills data, information about the local economy and employment and health and wellbeing intelligence to inform the [Joint Strategic Needs Assessment](#) (JSNA) process and to identify the local [health and well-being priorities](#) for the area.

The following data is relevant to the analysis of current and future demand for care and support services in Telford & Wrekin.

Population Forecasts

The analysis reflects a blend of population models:

Census data, maintained by the [Office for National Statistics](#) (ONS), which reflects the population 'count' at 10-yearly intervals (the most recent being 2011);

Population projections, also maintained by the ONS, provided a 'future view' of the population based on growth trends;

Prevalence and performance data applied to ONS population forecasts at 5-yearly intervals to give a more granular view of the needs of the population into the future (see [Projecting Older Peoples Population Information](#) and [Projecting Adult Needs and Service Information](#), both maintained by Oxford Brookes University Institute of Public Care);

The [Telford & Wrekin Population Model](#) (TWPM) makes adjustments for local factors including housing growth, migration, fertility and mortality rates in order to produce a more sensitive forecast. Official ONS census data is used retrospectively to check and refine the Telford & Wrekin population model. The 2011 update of the Telford & Wrekin Population Model uses the 2001 Census as the baseline, to produce annual estimates (2001 to 2026) of the Borough's population by single year of age, gender, specified areas of the Borough (e.g. wards and co-operative learning communities) and ethnic group. These projections are reflected in the graphic shown in Figure 5 below.

There is a need to update the baseline to reflect the 2011 census count and to validate the assumptions within the Telford & Wrekin Population Model in light of actual changes experienced over the period 2001 to 2011. For example, the 2011 census counted 166,641 people compared to the Telford & Wrekin Model projection of 170,300 in 2010, a variance of 2.2%. Whilst these adjustments may affect the numbers we have projected in Figure 5, the underlying message remains the same: that the needs of our population will continue to change.

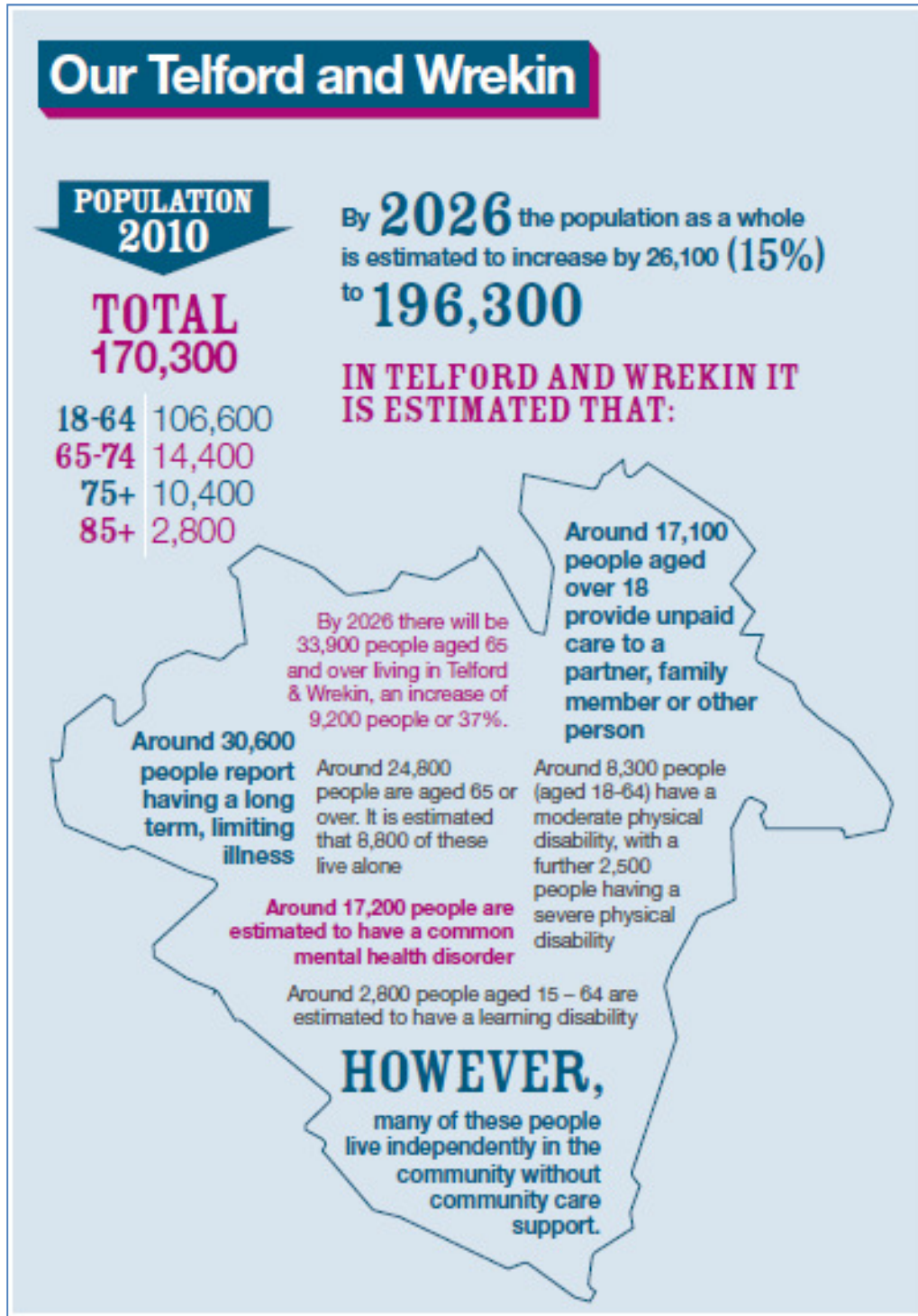


Figure 7: Telford & Wrekin Population Model 2011 - Key Projections

The Borough Population in 2011

The 2011 Census population of Telford & Wrekin was recorded as 166,641, an increase of 8,300 people or 5.2% from the 2001 figure of 158,325. This increase is considerably slower than that seen in the previous decade with growth of 11.9% between 1991 and 2001. Population growth has not been uniform across the ages with several age cohorts seeing a reduction since 2001. The 0-4 cohort has grown by 8%, faster than the overall population growth and reflecting the Borough’s increasing fertility rate. The cohorts showing fastest growth are the 85+ and the 65-84 as a result of improved life expectancy.

	T&W - 2001	T&W - 2011	% of Total - T&W	% of Total - England	Population Change 2001 to 2011 %
0 to 4	10,508	11,344	6.8%	6.3%	8.0%
5 to 9	11,054	10007	6.0%	5.6%	-9.5%
10 to 15	13749	12850	7.7%	7.0%	-6.5%
16 to 24	17552	20103	12.1%	11.9%	14.5%
24 to 44	47553	45217	27.1%	27.5%	-4.9%
45 to 64	38281	43031	25.8%	25.4%	12.4%
65 to 84	17523	21409	12.8%	14.1%	22.2%
85+	2105	2680	1.6%	2.2%	27.3%
Total	158,325	166,641	100%	100%	5.3%

Figure 8: Telford & Wrekin Population age cohorts - 2001 and 2011 (source: ONS Census)

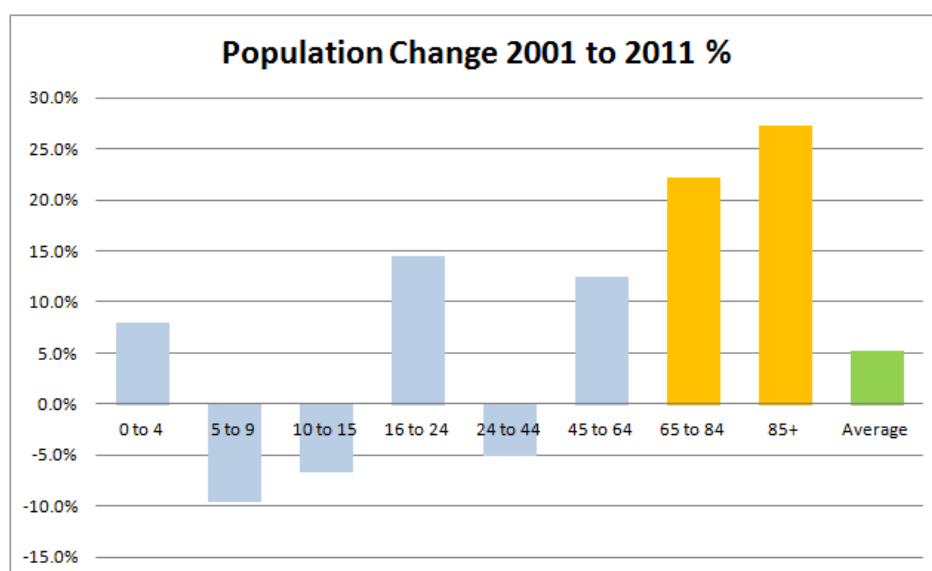


Figure 9: Population cohort change 2001 to 2011

The age structure of Telford & Wrekin's 2011 Census population is now fairly similar to the national picture, being just slightly younger, with a higher percentage of 0-15 year olds and smaller percentage of the population aged 65+ than nationally.

At the 2001 census Telford & Wrekin's population was more noticeably younger than the national picture meaning it has aged faster than the national population over the last 10 years. The implications of this change will be reflected in the next refresh of the Telford & Wrekin Population Model.

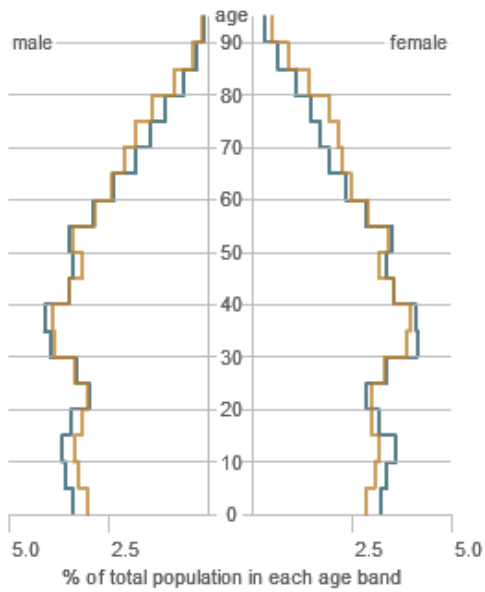


Figure 10: Population age band comparison: 2001 (T&W in blue, England in brown)

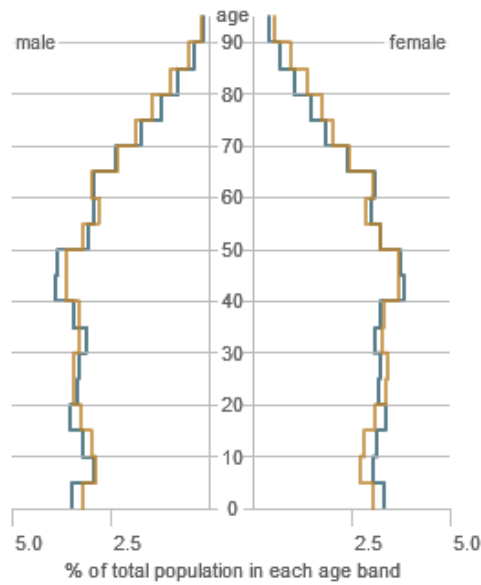


Figure 11: Population age band comparison 2011 (T&W in blue, England in brown)

Population projections show the total population of Telford & Wrekin continuing to grow, with the most significant increase projected in the over 65 age group:

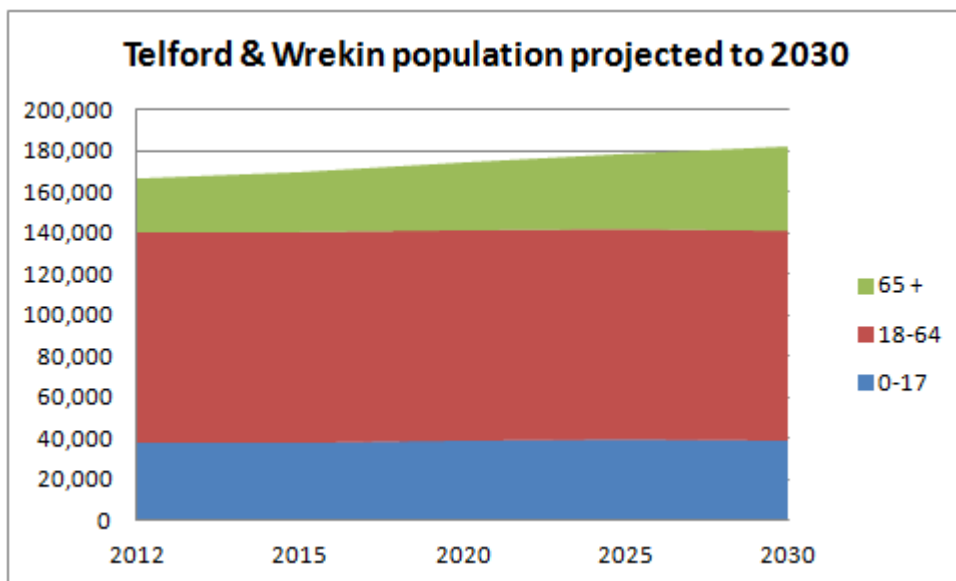


Figure 12: Population projection by age range to 2030 (ONS data)

The 65+ cohort currently accounts for 14.5% of the population (2001: 12.4%) compared to 16.4% nationally. The ratio of older people (65+) to young people (0-15) is 1:1.42 compared to 1:1.16 nationally. In 2001 this ratio was 1:1.8 in Telford & Wrekin.

ONS Population growth projections show that numbers in the younger (0 – 17 and 18 – 64) age groups will remain static while a further 14,800 people aged over 65 will be living in Telford & Wrekin in 2030, up 56% on the 2011 census. The Telford & Wrekin Population Model projects a smaller (37%) increase in the older age group and a 29% increase in young people, although the model has not yet been updated to reflect the new 2011 census baseline. In either case, this predicted growth is expected to lead to a significant increase in demand for older people’s services.

Ethnicity

Census results are published based on categorising the population into 18 ethnic groups (including any other ethnicity).

Ethnic group	Telford and Wrekin 2011		West Midlands 2011	England 2011
	Number	%	%	%
White: English/Welsh/Scottish/Northern Irish/British	149,096	89.5%	79.2%	79.8%
White: Irish	729	0.4%	1.0%	1.0%
White: Gypsy or Irish Traveller	166	0.1%	0.1%	0.1%
White: Other White	4,424	2.7%	2.5%	4.6%
Mixed/multiple ethnic group: White and Black Caribbean	1,423	0.9%	1.2%	0.8%
Mixed/multiple ethnic group: White and Black African	278	0.2%	0.2%	0.3%
Mixed/multiple ethnic group: White and Asian	799	0.5%	0.6%	0.6%
Mixed/multiple ethnic group: Other Mixed	483	0.3%	0.4%	0.5%
Asian/Asian British: Indian	3,076	1.8%	3.9%	2.6%
Asian/Asian British: Pakistani	2,243	1.3%	4.1%	2.1%
Asian/Asian British: Bangladeshi	162	0.1%	0.9%	0.8%
Asian/Asian British: Chinese	647	0.4%	0.6%	0.7%
Asian/Asian British: Other Asian	863	0.5%	1.3%	1.5%
Black/African/Caribbean/Black British: African	1,023	0.6%	1.1%	1.8%
Black/African/Caribbean/Black British: Caribbean	607	0.4%	1.5%	1.1%
Black/African/Caribbean/Black British: Other Black	149	0.1%	0.6%	0.5%
Other ethnic group: Arab	86	0.1%	0.3%	0.4%
Other ethnic group: Any other ethnic group	387	0.2%	0.6%	0.6%
<i>All usual residents</i>	<i>166,641</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>

Source: Office for National Statistics 2011 Census

Figure 13: Ethnic Groups 2011

Telford & Wrekin has a higher proportion of White British residents than regionally or nationally with resulting lower proportions of BME groups. The exception to this is the 'Other White' category where there is a higher proportion of residents in Telford & Wrekin than regionally, but still lower than the national picture. Around one in ten (10.5%) of Telford & Wrekin's population is from a non White British (English/Welsh/Scottish/Northern Irish/British) background with 7.3% of the population from a non White background.

TWPM population projections show some marginal change to this profile by 2026, with the White British majority falling slightly to 88.9% of the projected population (2011: 89.5%) and the Asian and Asian British Mixed minorities rising to a combined 5.9% (from 4.5% in 2011). These projections were made prior to the publication of 2011 Census data and may therefore be subject to change.

	2001		2010		2026	
	Count	%	Count	%	Count	%
White British	147,500	93.0%	155,100	91.1%	174,500	88.9%
White Irish	1,100	0.7%	1,200	0.7%	1,300	0.7%
White Other	1,600	1.0%	2,300	1.4%	2,900	1.5%
White & Black Caribbean	1,000	0.6%	1,200	0.7%	2,000	1.0%
White & Black African	100	0.1%	200	0.1%	400	0.2%
White & Asian	500	0.3%	600	0.3%	800	0.4%
Mixed other	200	0.1%	500	0.3%	900	0.5%
Indian	2,600	1.7%	3,600	2.1%	5,300	2.7%
Pakistani	1,600	1.0%	2,000	1.2%	2,900	1.5%
Bangladeshi	100	0.1%	300	0.2%	700	0.4%
Asian other	300	0.2%	500	0.3%	800	0.4%
Black Caribbean	600	0.4%	500	0.3%	400	0.2%
Black African	300	0.2%	700	0.4%	1,200	0.6%
Black other	100	0.1%	100	0.1%	300	0.1%
Chinese	500	0.3%	700	0.4%	900	0.5%
Other ethnicity	500	0.3%	800	0.4%	900	0.4%
Total BME	11,100	7.0%	15,200	8.9%	21,800	11.1%

All figures have been independently rounded to the nearest 100.

Source: Telford & Wrekin Population Model 2011, ETHPOP Database ESRC Follow on Fund

Figure 14: Telford & Wrekin population by ethnic group - 2001, 2010 and 2026

According to [research published by the Equality and Human Rights Commission](#)², different ethnic groups draw on different forms of care to different extents. Extracts from the research are quoted below:

- Research suggests that there is little difference between ethnic minority groups and others in accessing professional Domiciliary Care, but some literature suggests that there are cultural factors that mean services are not always appropriate. This could leave some individuals without appropriate help as well as potentially placing undue pressure on carers – Bangladeshi and Pakistani people are significantly more likely than other groups to provide informal care.
- Small-scale qualitative evidence in England indicates that not all formal support services respect, understand and accept different cultural expectations. This may be in relation to family life and obligations, use of space within the home or religious obligations including those relating to self-care and domestic tasks.
- Qualitative research conducted by the Joseph Rowntree Foundation with 28 disabled people in the Asian community found that many of those interviewed experienced long delays in fitting adaptations or aids even after they had been assessed. In many cases it was perceived that delays were due to inflexible approaches to meeting individual needs and preferences.
- There is little research evidence directly relating to social care services for older and disabled Gypsies and Travellers, although a small number of studies explore some of the cultural issues and barriers facing this group in relation to end of life care. One report finds that Gypsies and Travellers with health problems may find that their cultural needs, such as for the involvement of multiple family members in their care, are not always met by formal support services. There is evidence to indicate that in many cases older or disabled Gypsies and Travellers have had to wait considerable periods of time to obtain adaptations to their caravans on public sites. A number of GTAA interviewees have referred to the impact of

² How fair is Britain (Ch. 13 Care and Support), Equality & Human Rights Commission, 2011)

accommodation policies which may preclude older people having a carer to live with them on site through lack of space, or regulations on numbers of caravans at a location, forcing them to live alone, in contrast to their social and cultural expectations.

- Census data show that Bangladeshi men and women are more than twice as likely as other ethnic groups to provide care for adults. At the same time we know that employment rates for these groups are lower than for any other groups, and the likelihood of them being 'inactive, looking after family, home' (particularly for women) much higher.
- For some ethnic minority groups, dominant cultural norms mean that grandparents are often closely involved in their grandchildren's lives often due to the likelihood of co-residence. For example over 30% of Indian grandparents live in a multi-generational household.
- The generally young age at marriage, high birth rate and high rate of illness and disability among Gypsy and Traveller populations mean that many women will be involved in caring responsibilities throughout their active life. Gypsy and Traveller women have more children than other women (an average of between 3.5 and 5.9 children compared with 1.94 in the overall population) and, according to qualitative research and anecdotal information, seem more likely than other groups to report caring responsibilities for older and disabled family members.

Whilst the size of BME communities in Telford & Wrekin is relatively small, the Council and its partners will want to ensure that care and support services are both accessible and relevant to the needs of all its residents. This will mean developing a much greater sensitivity to the cultural needs of different ethnic communities and personalising services accordingly.

Health, care and support needs

ONS Census data, population projections and the Telford & Wrekin population model all provide rich information about the health, care and support needs of our residents.

		Telford and Wrekin		West Midlands	England	
		Count	%	%	%	
One person household	Aged 65 and over	7,113	10.7%	12.6%	12.4%	
	Other	9,680	14.5%	16.9%	17.9%	
One family only	All aged 65 and over		5,035	7.6%	8.6%	8.1%
	Married or same-sex civil partnership couple	No children	9,221	13.8%	12.1%	12.3%
		Dependent children	10,915	16.4%	15.4%	15.3%
		All children non-dependent	4,075	6.1%	6.2%	5.6%
	Cohabiting couple	No children	3,793	5.7%	4.8%	5.3%
		Dependent children	3,759	5.6%	4.3%	4.0%
		All children non-dependent	399	0.6%	0.5%	0.5%
	Lone parent	Dependent children	5,394	8.1%	7.5%	7.1%
All children non-dependent		2,416	3.6%	3.8%	3.5%	
Other household types	With dependent children		1,928	2.9%	2.9%	2.6%
	All full-time students		182	0.3%	0.5%	0.6%
	All aged 65 and over		165	0.2%	0.3%	0.3%
	Other		2,533	3.8%	3.6%	4.5%
All households		66,608	100.0%	100.0%	100.0%	

Source: Office for National Statistics 2011 Census

Figure 15: Analysis of Households

There are a total of 66,608 households in the Borough. Of these there are 12,313 households (18.5%) where all residents are aged 65 and over. This is lower than the regional (21.5%) and national (20.7%) figures. 7,113 people aged over 65 are living alone in Telford & Wrekin.

Whilst the majority of residents report a good standard of health and are not limited in their daily activities by a health problem or disability, some 30,995 people in Telford & Wrekin (18.6% of the population), reported a long term health problem or disability that limited their day-to-day activities in some way.

	Telford and Wrekin		West Midlands	England
	Count	%	%	%
Day-to-day activities limited a lot	15,060	9.0%	9.1%	8.3%
Day-to-day activities limited a little	15,935	9.6%	9.9%	9.3%
Day-to-day activities not limited	135,646	81.4%	81.0%	82.4%
<i>All usual residents</i>	<i>166,641</i>	<i>100.00%</i>	<i>100.0%</i>	<i>100.0%</i>

Source: Office for National Statistics 2011 Census

Figure 16: Long term health problems or disability that limits daily activities

This section considers the health, care and support needs of different service user groups based on population projections and UK prevalence and performance data.

Older People

At the 2011 census there were 24,089 people aged over 65 living in Telford & Wrekin (14.4% of the total population). This is projected to grow by between 37% (TWPM) and 56% (ONS) by 2030.

Key factors that may influence potential changes in demand for health and social care in people aged 65 and over living in Telford & Wrekin include dementia and other limiting long-term illness, both of which are likely to affect the ability of people to manage self-care and domestic care tasks and to cause an increase in the number of people aged 65 and over providing unpaid care and support.

	2012	2015	2020	2025	2030
People living with dementia	1726	1912	2301	2765	3326
People with a limiting long-term illness	13368	14804	16917	19057	21454
People unable to manage at least one self care task	8466	9349	10947	12521	14364
People unable to manage at least one domestic care task	10300	11380	13389	15330	17549
People aged 65 and over providing more than 50 hours care per week	2988	3295	3674	3920	4327

Figure 17: Factors affecting demand for care and support - people aged 65 and over

Dementia

The Prime Minister's Dementia Challenge states that one in three people over the age of 65 will develop dementia. In England in 2012, 670,000 people have dementia. This number will double in

the next 30 years. At an estimated £19 billion a year, the cost is estimated to be higher than the costs of cancer, heart disease or stroke.

The ambition set out in the Dementia Challenge is to create a society where everyone diagnosed with dementia, their families and carers receive high quality and timely care and support regardless of the care setting. This requires:

- More people to have an early diagnosis, with our diagnosis rates among the best in Europe
- High quality care in hospitals, at home and in care homes
- Helpful information given to people at the right time and effective signposting to local and national services
- Access for carers to support networks, information and respite care

The predicted growth in cases of dementia is expected to have a significant impact in Telford & Wrekin, as illustrated below:

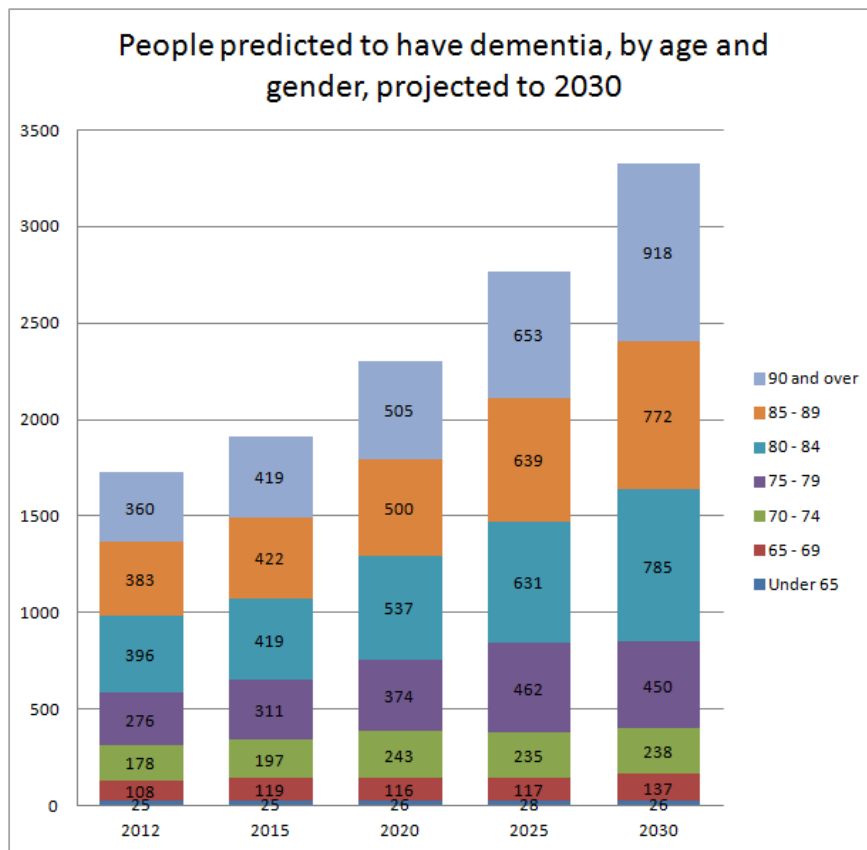


Figure 18: The growth in dementia

The aims of the National Dementia Strategy and the PM’s Dementia Challenge are reflected in “Living Well with Dementia in Telford & Wrekin”, a draft Joint Commissioning Strategy for NHS Telford & Wrekin and Telford & Wrekin Council. The strategy identifies 13 commissioning objectives for dementia services:

- Objective 1: Improving public and professional awareness and understanding of dementia.
- Objective 2: Good-quality early diagnosis and intervention for all
- Objective 3: Good-quality information for those with diagnosed dementia and their carers.

Objective 4: Enabling easy access to care, support and advice following diagnosis.

Objective 5: Development of structured peer support and learning networks.

Objective 6: Improved community personal support services.

Objective 7: Implementing the Carers' Strategy.

Objective 8: Improved quality of care for people with dementia in general hospitals.

Objective 9: Improved intermediate care for people with dementia.

Objective 10: Considering the potential for housing support, housing-related services and telecare to support people with dementia and their carers.

Objective 11: Living well with dementia in care homes.

Objective 12: Improved end of life care for people with dementia.

Objective 13: An informed and effective workforce for people with dementia.

National prevalence data is used to predict the number of people living with dementia in the UK and is overlaid with GP Quality & Outcomes Framework performance data to estimate the rate of diagnosis. The data is published in map form on the [Alzheimer's Society website](#).

Dementia diagnosis in Telford & Wrekin PCT area at 39.3% is lower than the average rates for the West Midlands SHA (43%) and England (44.2%).

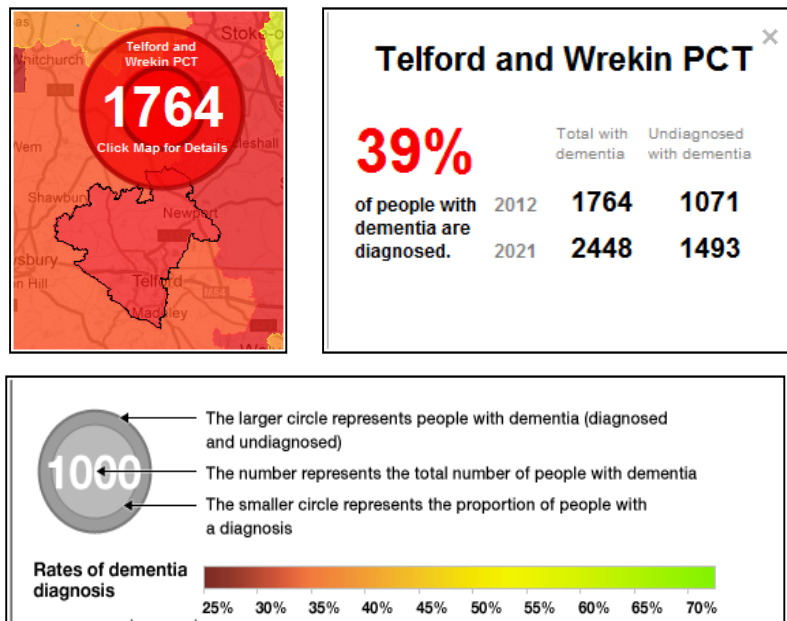


Figure 19: Dementia prevalence and diagnosis (source: Alzheimer's Society)

Early diagnosis is seen as an essential component of a modernised dementia service in Telford & Wrekin. Evidence cited in the National Dementia Strategy states that:

- Early support at home can decrease institutionalisation by 22 percent
- Even in complex cases, and where the control group is served by a highly skilled mental health team, case management can reduce admission to care homes by 6 percent
- Older people's mental health services can help with behavioural disturbance, hallucination and depression in dementia, reducing the need for institutional care

- Carer support and counselling at diagnosis can reduce care home placement by 28 percent
- Early diagnosis and intervention improves quality of life of people with dementia
- Early intervention has positive effects on the quality of life of family carers.

An increase in diagnosis rates to the regional average would immediately result in a further 65 people being diagnosed with dementia and potentially accessing early intervention care and support services. As more people are diagnosed early, it is essential that the remaining elements of the national strategy - high quality care in all settings, helpful information and effective signposting to local and national services, access for carers to support networks and much greater community understanding of dementia are in place to meet the growing demand for care and support.

Limiting Long Term Illness

The Census records whether people perceive that they have a long-term illness, health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age.

The Projecting Older People Population Information System (www.poppi.org.uk) uses ONS population projections and UK prevalence and performance data to project current and future demand for care and support and this projects a 60% increase in the number of people aged 65 and over living with a limiting long term illness by 2030:

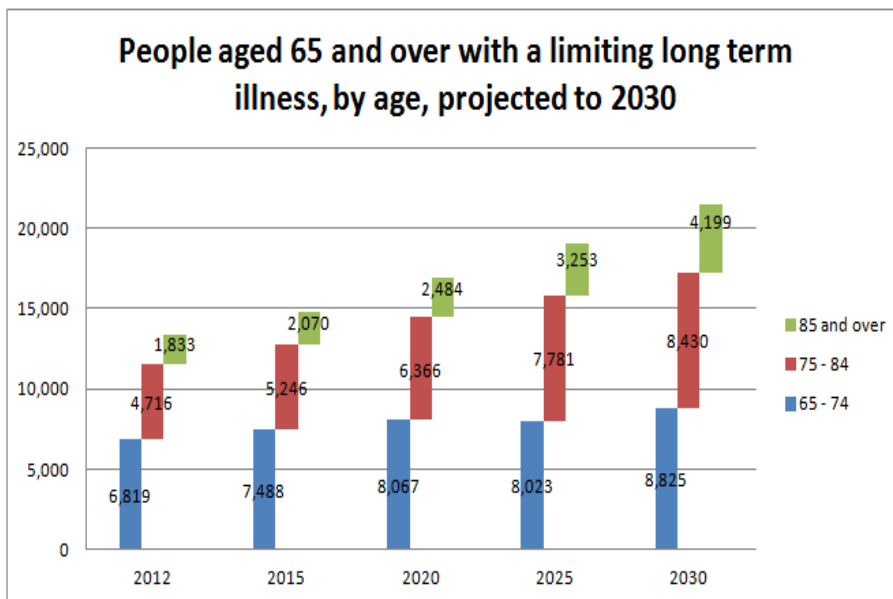


Figure 20: Projecting limiting long term illness

The increases will be most significant in the 75 – 84 (79%) and 85 and over (126%) cohorts.

Both dementia and limiting long term illnesses are likely to increase demand for care and support over time because of their impact on people’s ability to manage their own self-care and domestic tasks.

Self care tasks include bathing, showering or washing all over, dressing and undressing, washing face and hands, feeding, cutting toenails and taking medicines. The number of people aged 65 and over

in Telford & Wrekin currently unable to perform at least one self-care task is 8,466 and this is projected to rise by 70% to 14,363 by 2030. Of these, some 63% (9,118) will be women:

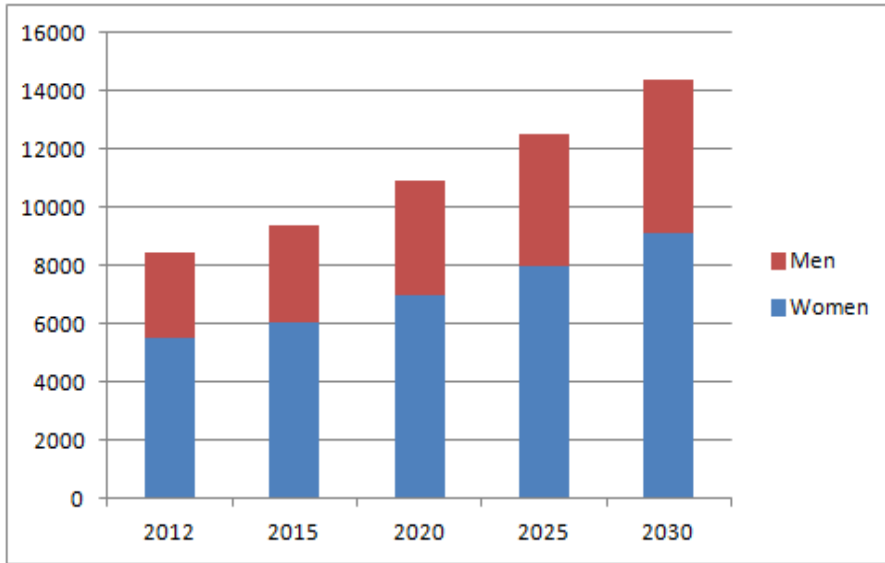


Figure 21: Managing self-care tasks

Domestic tasks include household shopping, washing and drying dishes, cleaning windows inside, jobs involving climbing, use of a vacuum cleaner to clean floors, washing clothing by hand, opening screw tops, dealing with personal affairs and doing practical activities. As with personal care, this cohort is projected to increase by 70% by 2030, with 65% of the 17,549 total being women:

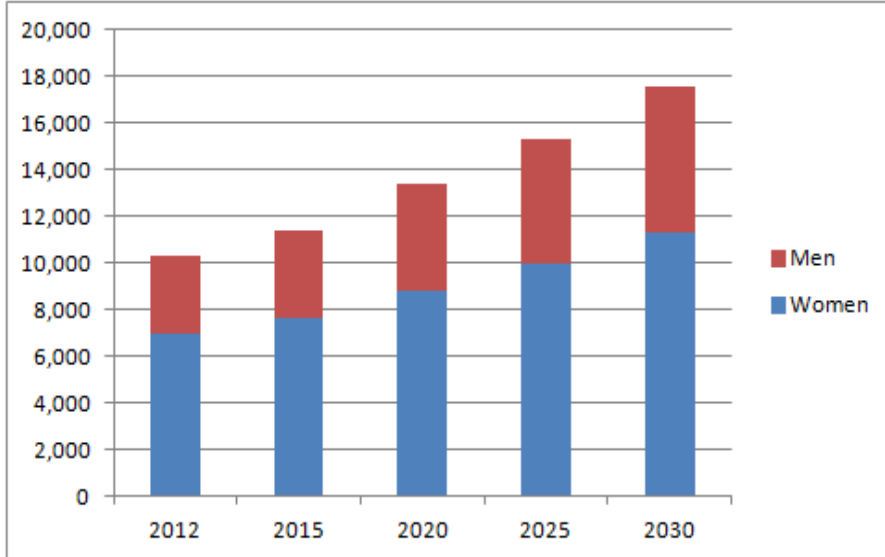


Figure 22: Managing domestic tasks

Both dementia and limiting long term illness are increasingly prevalent with age and as people live longer, so they can expect to be afflicted by such conditions in increasing numbers. Whilst there may be some discrepancies in the size of the over 65 cohort projected by ONS and TWPM models, it is clear that Telford & Wrekin will see a significant increase in demand for care and support services from people in this over 65 age range.

Adults aged 18 to 64 years

Whilst population projections and demographic change are most dramatic in the older age groups, a significant proportion of the demand for care and support comes from younger adults. According to the 2011 census around 8,100 of those reporting a limitation to their day-to-day activities (51% of the total) were aged 18-64.

Key factors that may influence potential changes in demand for care and support in this age group include physical disability, learning disability and mental health problems, all of which may be reflected in some form of personal care disability requiring support with one or more of the following: getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet.

	2011	2015	2020	2025	2030
People with a moderate or severe learning disability	560	563	566	574	582
People with a moderate or severe physical disability	10445	10491	10618	10733	10509
People with a moderate or severe personal care disability	4842	4861	4941	5011	4887
People with a common mental disorder	16472	16497	16470	16449	16382

Figure 23: Factors affecting demand for care & support - people aged 18 to 64 years

Each of these factors is explored below.

Learning Disabilities

Government policy is that people with learning disabilities should lead their lives like any other person, with the same opportunities and responsibilities, and be treated with the same dignity and respect. This means inclusion, particularly for those who are most often excluded, empowering those who receive services to make decisions and shape their own lives.

Projections for learning disability are based on national prevalence rates adjusted to take account of ethnicity (i.e. the increased prevalence of learning disabilities in South Asian communities) and of mortality (i.e. both increased survival rates of young people with severe and complex disabilities and reduced mortality among older adults with learning disabilities). Therefore, figures are based on an estimate of prevalence across the national population; locally this will produce an over-estimate in communities with a low South Asian community, and an under-estimate in communities with a high South Asian community.

Baseline ONS estimates show that there were around 2,500 people between the ages of 18 and 64 with a recognised learning disability in Telford & Wrekin. Of these, 560 people are estimated to have a moderate or severe learning disability and therefore be in need of care and support services.

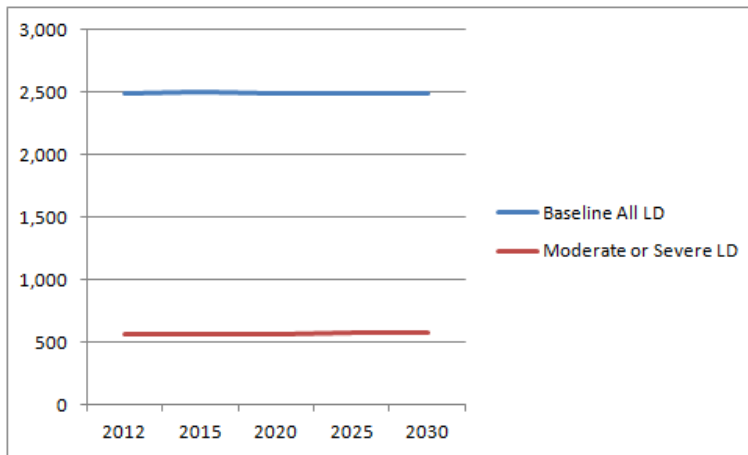


Figure 24: Estimated number of people aged 18 - 64 with a learning disability

The data projects static numbers of people with a learning disability between now and 2030, with only a modest (4%) increase in the number of people with moderate or severe learning disabilities by 2030. Whilst this suggests no change in demand, it must be recognised that people with learning disabilities may have significant complex needs which are often managed by family members acting as carers. This reinforces the need to support both carers and those with moderate and severe learning disabilities, whilst ensuring that people with learning disabilities can access a wide range of high quality personalised services.

ONS data also projects prevalence rates for specific conditions associated with learning disability, including Autistic Spectrum Disorder and Down's syndrome.

Autistic Spectrum Disorder

The autistic spectrum describes a range of conditions that are typically characterized by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases, cognitive delays.

The 2012 report "[Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007](#)" estimates that the prevalence of autism:

- Is 1 per cent in the general population.
- Is approximately 35 per cent among adults with severe learning disabilities living in private households.
- Is approximately 31 per cent among adults with mild or severe learning disabilities living in communal care establishments.

It is estimated that just over 1,000 people in Telford & Wrekin have Autistic Spectrum Disorders using the threshold of a score of 10 on the Autism Diagnostic Observation Schedule to indicate a positive case.

The National Autistic Society states that 'estimates of the proportion of people with autism spectrum disorders (ASD) who have a learning disability, (IQ less than 70) vary considerably, and it is not possible to give an accurate figure. Some very able people with ASD may never come to the attention of services as having special needs, because they have learned strategies to overcome any difficulties with communication and social interaction and found fulfilling employment that suits their particular talents. Other people with ASD may be able intellectually, but have need of support

from services, because the degree of impairment they have of social interaction hampers their chances of employment and achieving independence.'

For this reason, not all of those on the autistic spectrum will be included in the Learning Disability baseline, although those with more significant social, communication and cognitive difficulties are expected to be counted within the cohort with moderate or severe Learning Disabilities.

Down's Syndrome

There is a small cohort of 64 adults aged 18 – 64 years with Down's syndrome in Telford & Wrekin. It is estimated that 6 of these people also have dementia. The average life expectancy for people with Down's syndrome is approximately 59 years (Glasson et al, 2002).

Physical Disabilities

A recent large scale GB-wide research study for the Office for Disability Issues, [The Experiences and Expectations of Disabled People](#), reported on the care and support experiences of disabled people. As part of the research for the project, a survey of 7,000 disabled people was completed as well as qualitative work with 134 disabled individuals.

The degree to which support needs were met appears to be influenced by a number of characteristics:

- Those in single person households were more likely to report having unmet support needs (20%) than those in other households.
- Respondents in households with higher incomes were less likely than those with lower household incomes to say that they had an unmet support need: 12% of those with annual household incomes above £10,400 said this, compared with 19% of those with household incomes below this level. More than half of disabled people who have financial difficulties agreed that their financial situation had stopped them from getting the help or support they need.

The Health Survey for England gives prevalence rates for moderate and severe physical disability for the 18-64 population. Based on these rates it is estimated that in 2010 there were 8,000 people aged 18-64 in Telford & Wrekin with a moderate physical disability and a further 2,400 people in this age group with a severe physical disability.

These prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have a moderate or serious physical disability to 2030. This shows a largely static number of just over 10,000 people classed as having a moderate or serious physical disability, albeit with some rebalancing across the different age bands.

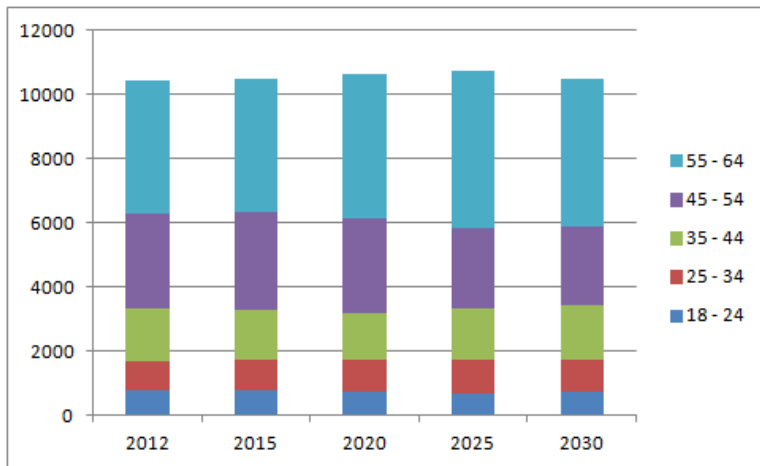


Figure 25: Estimates of people aged 18 to 64 with a moderate or severe physical disability

Of these, around 5,000 people are projected to require personal care, to 2030. This is based on the prevalence data for adults with physical disabilities requiring personal care by age and sex in the Health Survey for England, 2001, applied to ONS population projections of the 18 to 64 population. Types of care required include: getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet. A moderate personal care disability means the task can be performed with some difficulty; a severe personal care disability means that the task requires someone else to help.

Mental Health

The aims of the Government's mental health strategy are to:

- improve the mental health and wellbeing of the population and keep people well; and
- improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

The approach is based on the principles that the Government has laid down for its health reforms:

- putting people who use services at the heart of everything we do – 'No decision about me without me' is the governing principle. Care should be personalised to reflect people's needs, not those of the professional or the system. People should have access to the information and support they need to exercise choice of provider and treatment;
- focusing on measurable outcomes and the NICE Quality Standards that deliver them rather than top-down process targets; and
- empowering local organisations and practitioners to have the freedom to innovate and to drive improvements in services that deliver support of the highest quality for people of all ages, and all backgrounds and cultures.

ONS projections based on the report **Adult psychiatric morbidity in England, 2007: Results of a household survey**, published by the Health and Social Care Information Centre in 2009, estimate that in 2012 around 16,500 people in Telford & Wrekin suffered from a common mental disorder such as depression, anxiety and obsessive compulsive disorder, with around 61% of these estimated to be women. Much smaller numbers of people are estimated to suffer from personality disorders or psychotic disorders (including schizophrenia and bi-polar disorder).

Around 7,400 people are estimated to suffer from two or more psychiatric disorders.

People aged 18-64 predicted to have a mental health problem, by gender, projected to 2030					
	2012	2015	2020	2025	2030
Common mental disorder	16,472	16,497	16,470	16,449	16,382
Borderline personality disorder	460	461	460	459	457
Antisocial personality disorder	359	361	361	363	363
Psychotic disorder	409	410	409	409	407
Two or more psychotic disorders	7,372	7,385	7,377	7,376	7,352

Figure 26: Projections of people with mental health problems (ONS)

Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder.

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships. Antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are two types with particular public and mental health policy relevance.

ASPD is characterised by disregard for and violation of the rights of others. People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed.

BPD is characterised by high levels of personal and emotional instability associated with significant impairment. People with BPD have severe difficulties with sustaining relationships, and self-harm and suicidal behaviour is common.

Psychoses are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. The main types are schizophrenia and affective psychosis, such as bipolar disorder.

Psychiatric comorbidity - or meeting the diagnostic criteria for two or more psychiatric disorders - is known to be associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. Disorders included the most common mental disorders (namely anxiety and depressive disorders) as well as: psychotic disorder; antisocial and borderline personality disorders; eating disorder; posttraumatic stress disorder (PTSD); attention deficit hyperactivity disorder (ADHD); alcohol and drug dependency; and problem behaviours such as problem gambling and suicide attempts.

The [Community Mental Health Profile 2013](#) for Telford & Wrekin gives an overview of mental health risks, prevalence and services at a local, regional and national level using an interactive mapping tool and this provides further information to assist decision making and the improvement of mental health, and mental health services. The profile indicates a heightened risk of mental illness in Telford & Wrekin arising from some of the wider determinants of health, including high levels of deprivation and unemployment and, for younger people, high numbers not in employment, education or training (NEET). Around 10,000 people in Telford & Wrekin are predicted to have a drug or alcohol problem, with less than 10% of these undergoing drug treatment programmes.

The profile also identifies that the percentage of adults with depression is higher than regional and national averages, with Telford & Wrekin having the 10th highest (worst) rates nationally, whilst treatment and outcomes for people with mental health problems are also generally poorer than regional and national averages.

How to interpret the spine charts

Where perceived polarity:

England worst | England average | England best

25th percentile | 75th percentile

● Significantly worse ● Significantly better ● Not significant
 ◆ Regional average ○ Significance Not Tested

Where no perceived polarity:

England lowest | England average | England highest

25th percentile | 75th percentile

● Significantly lower ● Significantly higher ● Not significant
 ◆ Regional average ○ Significance Not Tested

* - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best".

Wider Determinants of Health

The wider determinants have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.

	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
1 Percentage of 16-18 year olds not in employment, education or training, 2011	8.5	6.2	11.9		1.9
2 Episodes of violent crime, rate per 1,000 population, 2010/11	12.8	14.6	34.5		6.3
3 Percentage of the relevant population living in the 20% most deprived areas in England, 2010	23.9	19.8	83.0		0.3
4 Working age adults who are unemployed, rate per 1,000 population, 2010/11	70.5	59.4	106.2		8.3
5 Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12	20.2	23.0	38.6		11.4
6 Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12	5.4	5.2	0.8		18.4

Risk Factors

A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease, injury or mental health problem. Some examples of the more important risk factors in mental health are under and over weight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness.

7 Statutory homeless households, rate per 1,000 households, all ages, 2010/11	1.61	2.03	10.36		0.13
8 Percentage of the population with a limiting long term illness, 2001	17.3	16.9	24.4		10.2
9 First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011	621	876	2,436		343
10 Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	12.3	11.2	5.7		17.3

Levels of Mental Health and illness

At any one time, roughly one in six of us is experiencing a mental health problem. mental health problems are also estimated to cost the economy £105 billion per year it's important to monitor and investigate the levels of mental health in order to target and improve mental health services at a local level.

11 Percentage of adults (18+) with dementia, 2011/12	0.40	0.53	0.95		0.21
12 Ratio of recorded to expected prevalence of dementia, 2010/11	0.38	0.42	0.27		0.69
13 Percentage of adults (18+) with depression, 2011/12	15.66	11.68	20.29		4.75
14 Percentage of adults (18+) with learning disabilities, 2011/12	0.40	0.45	0.21		0.77

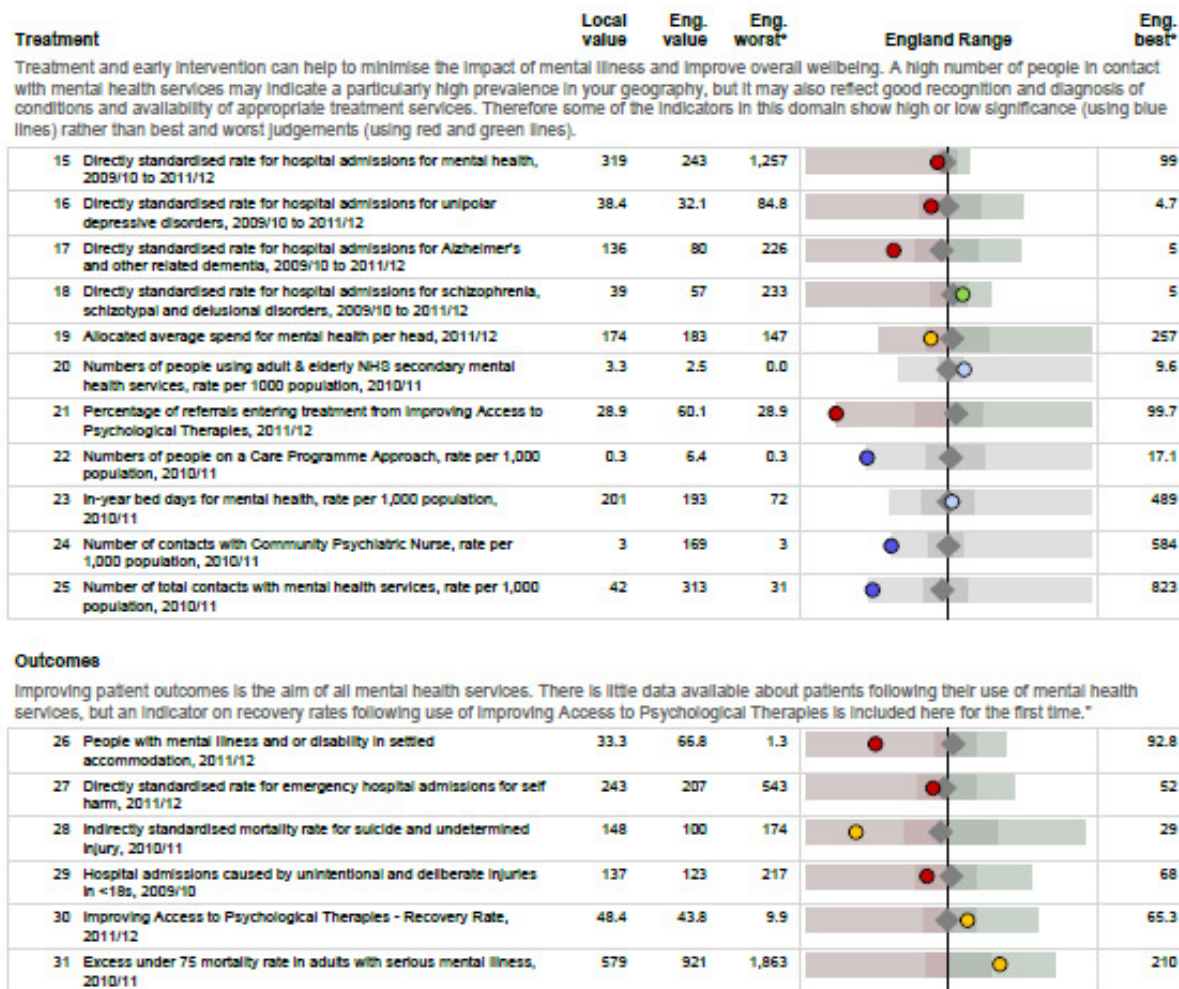


Figure 27: Community Mental Health Profile 2013

Overall the Profile suggests a need for better mental health provision in Telford & Wrekin, with more preventative support available to mitigate the wider determinants and risk factors and more community-based support in place to supplement clinical treatments.

As responsibility for commissioning community mental health services passes to the Clinical Commissioning Group in April 2013, there is an opportunity to consider the role that Domiciliary Care providers can play in offering preventative and early intervention supports.

Carers

The National Carer's Strategy seeks to support carers across four priority areas:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Personalised support both for carers and those they support, enabling them to have a family and community life.
- Supporting carers to remain mentally and physically well.

At the time of the 2011 Census, a total of 17,944 people in Telford & Wrekin (10.8% of the population) provided unpaid care to others, some 10.8% of the population. More than a quarter of these (4,978 people) were providing 50 or more hours of unpaid care a week.

	Telford and Wrekin			West Midlands	England
	2011		2001	2011	2011
	Count	%	%	%	%
Provides no unpaid care	148,697	89.2%	90.1%	89.0%	89.8%
Provides 1 to 19 hours unpaid care a week	10,313	6.2%	6.3%	6.8%	6.5%
Provides 20 to 49 hours unpaid care a week	2,653	1.6%	1.2%	1.5%	1.4%
Provides 50 or more hours unpaid care a week	4,978	3.0%	2.4%	2.7%	2.4%
Total providing unpaid care	17,944	10.8%	9.9%	11.0%	10.2%
All usual residents	166,641	100.0%	100.0%	100.0%	100.0%

Source: Office for National Statistics 2011 Census

Figure 28: Provision of unpaid care

ONS data suggests that in Telford & Wrekin there are currently just under 3,000 people aged 65 and above who provide more than 50 hours of care. As the population ages and people live for longer with increasing care and support needs, a 50% increase in the number of older carers is projected:

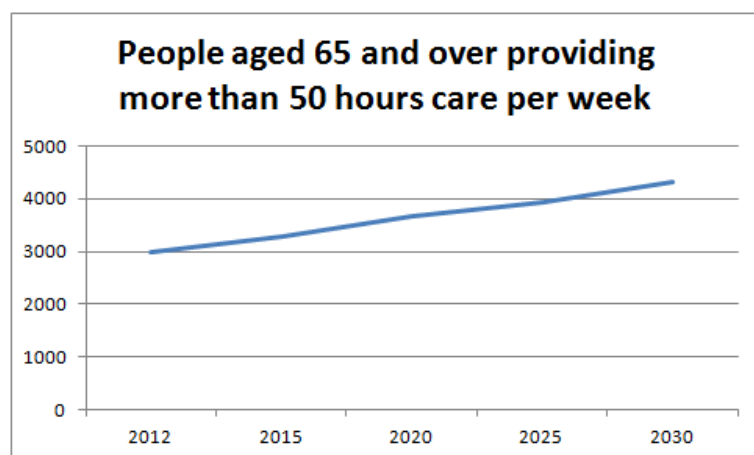


Figure 29: Older Carers

This cohort of carers is itself more susceptible to illness and whilst the Council and its partners will want to implement the National Carer’s Strategy for the benefit of all carers, it will be particularly important to ensure that older carers are appropriately supported. According to the 2001 Census over 225,000 people providing 50 or more hours of unpaid care per week stated that they were in ‘not good health’ themselves. More than half of the people providing this much care were over the age of 55, and it is at this age that the ‘not good health’ rate is highest. Carers often report specific injuries relating to their responsibilities, and a high level of stress-related illness is associated with the role.

Geographical Analysis

The data we have looked at so far relates to the whole of the Council area – however, community-level data is used to differentiate between localities and to identify pockets of demand. This is useful

because it can indicate the need to stimulate (or discourage) specific forms of provision within localities.

Co-operative Learning Communities

For the purpose of locality management and service delivery, the Council has developed ten co-operative learning communities based around school catchment areas.

The TWPM has been used to produce population estimates from 2001 to 2010 for each of these Co-operative Learning Communities (CLCs).

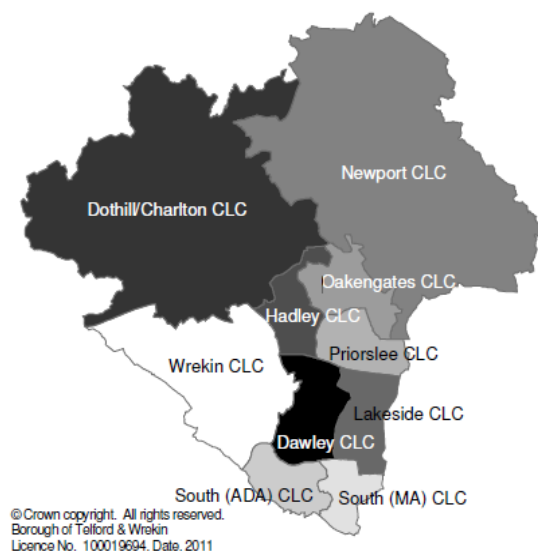


Figure 30: Co-operative Learning Communities

- All 10 CLC areas have seen an increase in population over the past 10 years
- Hadley CLC has grown the fastest in the past 10 years with a 10% increase in population since 2001.
- Newport CLC has seen the smallest percentage growth with an increase of just 4% since 2001.
- Dawley, Hadley, Lakeside and South ADA all have younger populations than the Borough average with South ADA the youngest, 23% of its population is aged 0-15 compared to 20% Borough wide.

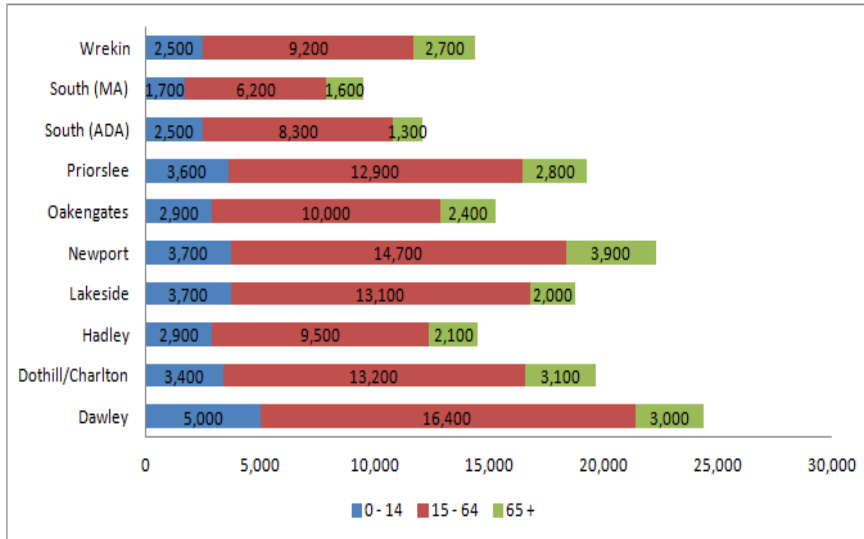


Figure 31: CLC Population Profile, (TWPM, 2010 estimates)

Wrekin CLC has the oldest population with 19% aged 65+ compared to 15% Borough wide. Three CLCs have more than 3,000 residents aged 65 and over with the highest concentration of older residents in the Newport CLC (3,900 people).

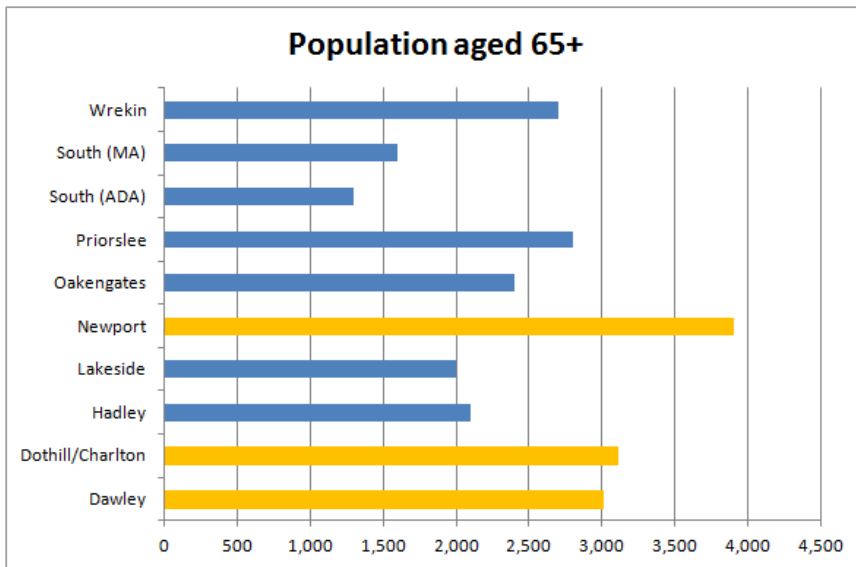


Figure 32: Population over age 65 by CLC (TWPM, 2010 estimates)

There is a need to update these projections to reflect 2011 Census data and to apply prevalence and performance data to provide an estimate of the future demographic profile.

Wards

The 2011 population model also includes a population breakdown by the 33 electoral wards within Telford & Wrekin. Wards vary in terms of population size, with 11,700 people living in the largest ward by population (Hadley and Leegomery) and 2,500 in the smallest (Ironbridge Gorge).

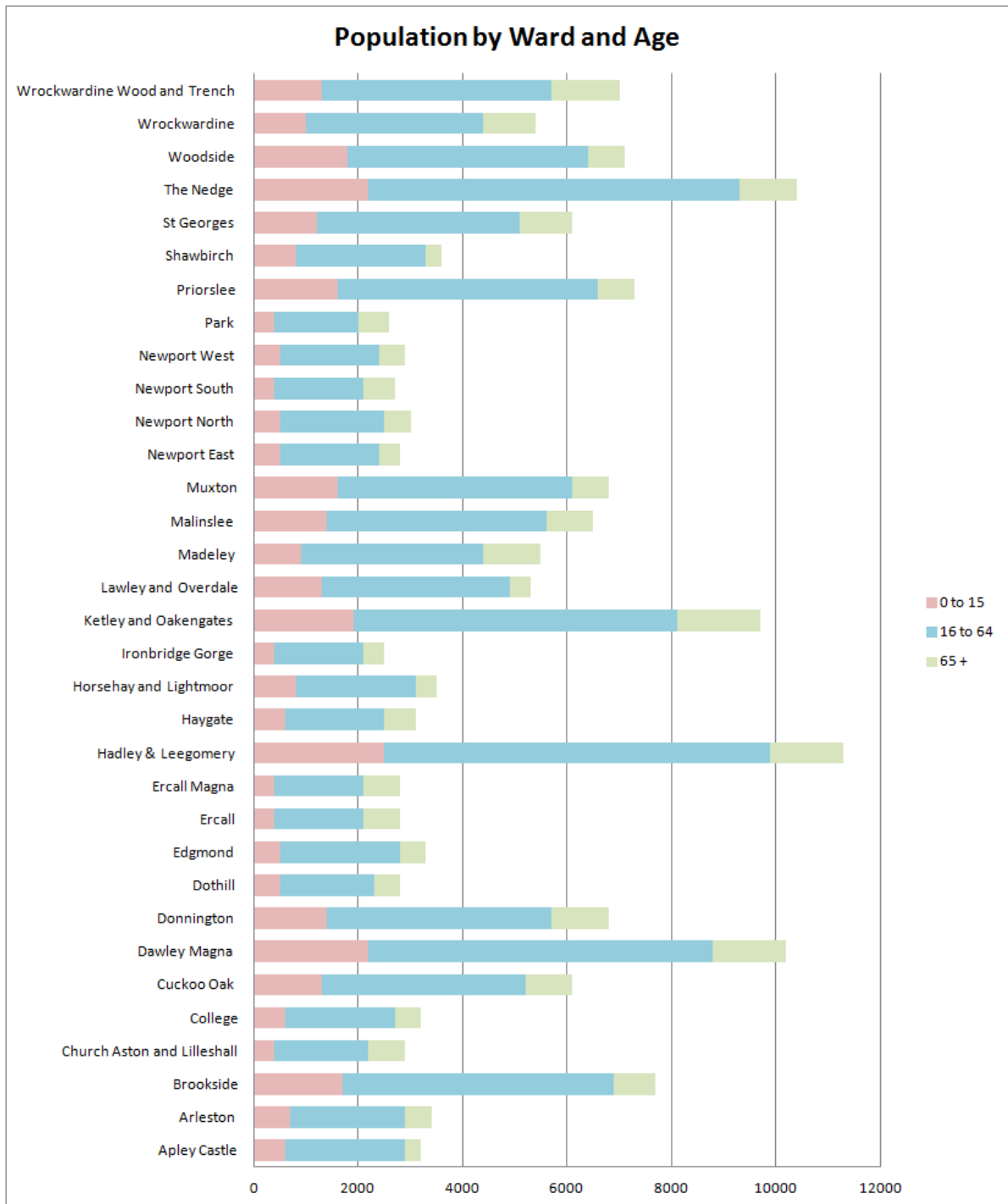


Figure 33: Population by Ward and Age

Age analysis of the ward profiles shows that the number of older people (aged 65 years and over) exceeds the number of young people (birth to 15 years) in 6 wards (Church Aston & Lilleshall, Ercall, Ercall Magna, Madeley, Newport South and Park, with the highest numbers of older people living in the Ketley & Oakengates, Hadley & Leegomery, Dawley Magna and Wrockwardine Wood & Trench wards.

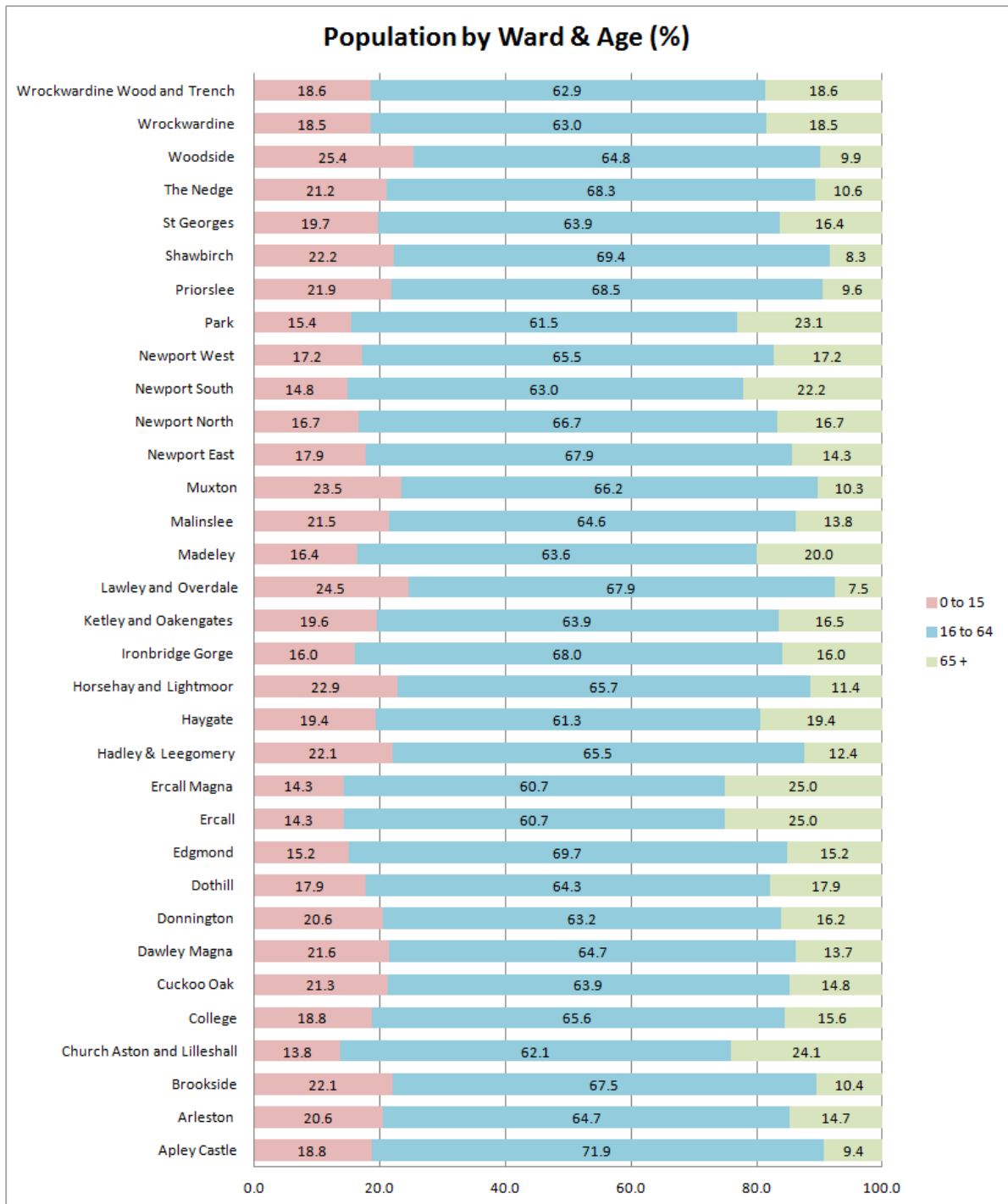


Figure 34: Ward Populations - Age Profile

Demand for older people’s services is likely to be most acute in those communities with the highest concentrations of older people.

Ward profiles also reflect local indices of multiple deprivations, with wards ranked according to their position relative to the national average. This analysis shows that a large number of Telford & Wrekin’s electoral wards experience high levels of deprivation across multiple domains, with eight wards within the 10% most deprived overall (Brookside, College, Cuckoo Oak, Dawley Magna, Donnington, Hadley & Leegomery, Malinslee and Woodside).

Telford & Wrekin Domiciliary Care Change Programme

Overall Deprivation Rank	10% least deprived	10 - 20% most deprived	10% most deprived		10% most deprived	10% most deprived	10% most deprived	10% most deprived		10% least deprived			10% most deprived				10 - 20% most deprived
Income	10% least deprived	10 - 20% most deprived	10% most deprived		10% most deprived	10% most deprived	10% most deprived	10% most deprived					10% most deprived	10 - 20% most deprived			10 - 20% most deprived
Employment		10 - 20% most deprived	10% most deprived		10% most deprived	10% most deprived	10% most deprived	10% most deprived	10% most deprived	10% least deprived			10 - 20% most deprived	10 - 20% most deprived			10 - 20% most deprived
Health deprivation & disability			10 - 20% most deprived		10 - 20% most deprived	10% most deprived	10 - 20% most deprived	10 - 20% most deprived	10% most deprived				10 - 20% most deprived	10 - 20% most deprived			10 - 20% most deprived
Education, skills & training			10% most deprived		10% most deprived	10% most deprived	10% most deprived	10% most deprived		10% least deprived			10% most deprived				10% most deprived
Barriers to housing & services				10 - 20% most deprived			10 - 20% most deprived	10% least deprived		10% most deprived		10% most deprived					
Crime & Disorder		10 - 20% most deprived	10 - 20% most deprived		10% most deprived	10% most deprived	10 - 20% most deprived			10% least deprived	10% least deprived	10% least deprived	10% most deprived				10% most deprived
Living Environment	10% least deprived							10% least deprived					10% least deprived			10% least deprived	
Income deprivation affecting children		10 - 20% most deprived	10% most deprived		10 - 20% most deprived	10% most deprived	10% most deprived	10% most deprived		10% least deprived	10% least deprived	10% most deprived	10% most deprived				10 - 20% most deprived
Income deprivation affecting older people		10 - 20% most deprived			10 - 20% most deprived	10 - 20% most deprived	10% most deprived	10% most deprived			10% least deprived	10% most deprived	10% most deprived	10 - 20% most deprived			10 - 20% most deprived
	Apley Castle	Arleston	Brookside	Church Aston and Illeshall	College	Cuckoo Oak	Dawley Magna	Donnington	Dothill	Edgmond	Ercall	Ercall Magna	Hadley & Leegomery	Haygate	Horseshay and Lightmoor	Ironbridge Gorge	Ketley and Oakengates

Overall Deprivation Rank		10 - 20% most deprived	10% most deprived			10% least deprived		10% least deprived		10% least deprived	10% least deprived	10 - 20% most deprived	10 - 20% most deprived	10% most deprived			
Income		10 - 20% most deprived	10% most deprived		10% least deprived	10% least deprived				10% least deprived	10% least deprived	10 - 20% most deprived	10 - 20% most deprived	10% most deprived			
Employment		10% most deprived	10% most deprived			10% least deprived				10% least deprived		10 - 20% most deprived	10 - 20% most deprived	10% most deprived		10 - 20% most deprived	
Health deprivation & disability		10 - 20% most deprived	10% most deprived							10% least deprived		10 - 20% most deprived	10 - 20% most deprived	10% most deprived			
Education, skills & training	10 - 20% most deprived		10% most deprived	10 - 20% most deprived		10% least deprived				10% least deprived		10 - 20% most deprived	10 - 20% most deprived	10% most deprived		10 - 20% most deprived	
Barriers to housing & services							10% least deprived		10% least deprived				10 - 20% most deprived	10% most deprived	10 - 20% most deprived		
Crime & Disorder		10% most deprived	10% most deprived		10% least deprived	10% least deprived		10% least deprived		10% least deprived			10% most deprived	10% most deprived	10% least deprived		
Living Environment	10% least deprived	10% least deprived	10% least deprived	10% least deprived	10% least deprived	10% least deprived		10% least deprived		10% least deprived	10% least deprived		10% least deprived	10% least deprived		10% least deprived	
Income deprivation affecting children	10 - 20% most deprived		10% most deprived	10 - 20% most deprived	10% least deprived	10% least deprived				10% least deprived			10 - 20% most deprived	10% most deprived			
Income deprivation affecting older people		10 - 20% most deprived	10% most deprived	10% least deprived						10% least deprived	10% least deprived	10% most deprived	10 - 20% most deprived	10% most deprived			
	Lawley and Overdale	Macleay	Malinslee	Muxton	Newport East	Newport North	Newport South	Newport West	Park	Priorslee	Shawbirch	St Georges	The Nedge	Woodside	Wrockwardine	Wrockwardine Wood and Trench	

Figure 35: Indices of Multiple Deprivations, by Ward – 2011

Health deprivation and disability is a clear influence on demand for care and support services, with 13 of the 33 wards featuring in the 20% most deprived nationally for this domain.

Income, Employment and Education deprivation present specific risks to both physical and mental health because of their potential impact on healthy lifestyles. High levels of income deprivation affecting older people are a feature in 13 wards, including 3 of the four wards with the highest numbers of elderly residents (Ketley & Oakengates, Hadley & Leegomery and Dawley Magna).

Service Demand

The data analysed thus far in this report has focused on population projections and demographic changes to give a predictive view of needs across the community. This section looks more closely at what we know about the services that are being purchased and is based on intelligence held within Council and other systems.

The National Minimum Data Set for Social Care (NMDS-SC) collects data on different types of adult care services:

Adult Residential	Definition
Care home services with nursing – CHN	<p>A care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it. Both the care that people receive and the premises are regulated.</p> <p>In addition, qualified nursing care is provided, to ensure that the full needs of the person using the service are met.</p> <p>Examples of services that fit under this category</p> <ul style="list-style-type: none"> Nursing home Convalescent home with nursing Respite care with nursing Mental health crisis house with nursing
Care home services without nursing – CHS	<p>A care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it. Both the care that people receive and the premises are regulated.</p> <p>Examples of services that fit under this category</p> <ul style="list-style-type: none"> Residential home Rest home Convalescent home Respite care Mental health crisis houses Therapeutic communities
Adult placement home	Short or long term accommodation, care or support provided by an approved adult placement carer, working with a maximum of 3 adults. (Even if the service is non-registerable)
Sheltered Housing	Sheltered housing is accommodation where a scheme manager or warden lives on the premises or nearby. They can be contacted through an alarm system if necessary. Some schemes are designed specifically for disabled people and may have specialised facilities and specially trained staff to provide support. They do not have to register with CQC as personal

	care is not provided. Sheltered housing schemes are usually run by local Councils or housing associations.
Extra care housing services – EXC	These services cover many different arrangements. Usually, they consist of purpose built accommodation in which varying amounts of care and support can be offered, and where some services and facilities are shared. The care the people receive is regulated by the Care Quality Commission, but the accommodation is not.
Supported living services – SLS CQC Regulated	These services involve a person living in their own home and receiving care and/or support in order to promote their independence. The care they receive is regulated by the Care Quality Commission, but the accommodation is not. The support that people receive is continuous, but is tailored to their individual needs. It aims to enable the person to be as autonomous and independent as possible, and usually involves social support rather than medical care.
Other adult residential	Other types of residential provision for older people and adults aged 18+ not described above. This category can include residential respite care if not part of a regulated service, and various types of hostels.

Adult Day	Definition
Day care or day services	Day care and day services for older people and adults aged 18+. Day services are where service users participate in activities, excursions etc not at one centre only. Note that ‘employment related’ services come under “Adult community care services”.
Other adult day care service	Any other types of day care provision not described above where service users are older people and adults aged 18+ e.g. Might be provision for Mental Health services

Adult Domiciliary	Definition
Domiciliary Care services (Adults) – DCC	<p>These services provide personal care for people living in their own homes. The needs of people using the services may vary greatly, but packages of care are designed to meet individual circumstances.</p> <p>The person is visited at various times of the day or, in some cases, care is provided over a full 24-hour period. Where care is provided intermittently throughout the day, the person may live independently of any continuous support or care between the visits.</p> <p>Examples of services that fit under this category</p> <p>Domiciliary Care agency</p>
Domestics services and home help	A service providing non-personal care services, such as cleaning, cooking, meal preparation, shopping, for older people and adults aged 18+

Meals on wheels	Meals on wheels for older people and adults aged 18+
Other adult Domiciliary Care service	Another type of Domiciliary Care provision not described above for older people and adults aged 18+ in their own home

Adult Community Care	Definition
Carers' support	This category includes a range of non-residential support services for carers, such as information, advice and guidance, networking and support groups, training and recruitment services.
Short breaks/respite care	Short breaks/respite care includes community respite care. Residential respite care is included under adult residential care services.
Community support and outreach	Any non-registered community service provided to adults and older people (but see above for services specifically for carers)
Social work and care management	Teams or individual social workers/care managers who provide a assessment or support service to adults
Shared lives – SHL	Shared Lives (formerly Adult Placement Scheme) is care and/or support provided by individuals, couples and families who have been approved and trained for that role by the service registered with Care Quality Commission. Care and/or support may also be provided either within or outside of the home of the carer as well as kinship support to people living in their own homes. It is the service that is regulated not the individual accommodation which is owned or rented by private residents.
Disability adaptations/assistive technology services	Provides a adaptations and or assistive technology service to adults or children
Occupational/employment related services	Provides a occupational/employment service to support adults
Information and advice services	Services which focus on providing information and advice to adults and older people (see above for services specifically for carers, and for wider-ranging services for adults and older people)
Other adult community care service	Another type of community provision not described above for older people and adults aged 18+

The Laing & Buisson, Care of Elderly People UK Market Survey 2011/12 reports that 51% of all residential care places are commissioned by local authorities, with 41% purchased by individual consumers and 8% by the NHS. The proportion of individuals funding their own residential care services is increasing, whilst the proportion of Local Authority funded residential care places is declining over time. NHS funded places are also increasing. However there are large geographical variations with 53% of residents in the South West of England paying for their care, compared to only 21% in the North of England.

Of all Domiciliary Care contact hours, 60% are purchased by Local Authorities, 21% by individual consumers, 10% by direct payment holders and 7% by the NHS. It is expected that the number of purchasers of Domiciliary Care choosing their services and purchasing them via a direct payment will increase over time, in line with Government policy. It is intended that this financial mechanism should encourage a vibrant market place in which a range of different services and different ways of meeting the needs and goals of the person, are available. Individual consumers will also have greater

access to information about local services, which should also support the development of services tailored to the needs of individuals.

The services available in the market will develop based on demand for services and over time, this may mean some services exit the market whilst at the same time new services become available.

In Telford & Wrekin the number of people receiving funding for care and support services has been falling since 2008/09. This reflects a change in funding eligibility criteria, with only those service users assessed as having substantial and critical needs receiving funding from the Council.

Demand comes from four service user groups: older people, adults with a learning disability, adults with a physical disability and adults with mental health problems. The table below shows how this demand is made up.

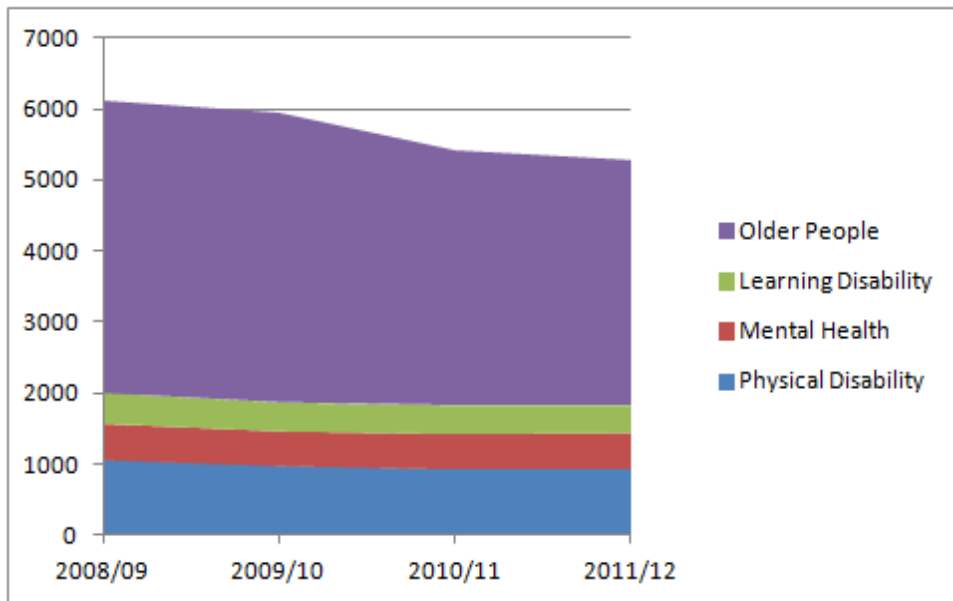


Figure 36: Care and support service users receiving services (source: RAP Return 2011/12)

Over the same period the number of home and day care service users has remained broadly static at around 1000 people (Source: RAP return):

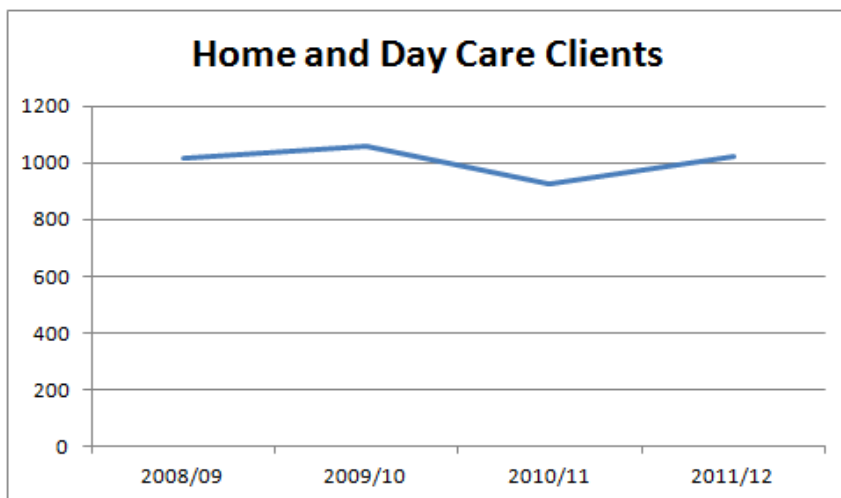


Figure 37: Home and Day Care - service user numbers 2009 - 2012

The majority of the demand for Domiciliary Care (69% of all service users) comes from older people and the number of service users in this group is increasing. Adults with physical disabilities account for 16% of the total Domiciliary Care service user base; learning disabled service users comprise 11% of the total and people with mental health problems account for just 4%.

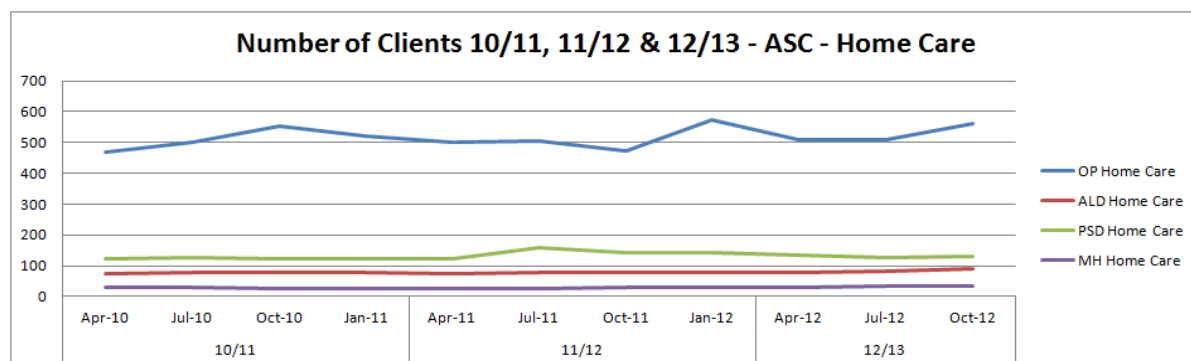


Figure 38: Home care numbers by service user group

As the older population group increases in size there is a need to manage demand by providing better information and encouraging more community-based support options to assist self-help, and by offering more preventative and re-ablement services so that people are able to remain as independent as possible, for as long as possible, without the need of long-term and costly care arrangements.

As 'new' people come into the care and support system as service users, they are likely to bring with them far greater expectations of involvement in – and control of – the services and support they will access. Generational barriers to the use of technology will decline and people will expect to use ever more intelligent systems to maximise their independence and will require far greater integration between human and technological supports. Providers who offer innovative and flexible arrangements combined with high order relationship skills will be increasingly sought out.

The planned changes in the funding of social care could also have an impact on demand. A £72,000 funding cap and £118,000 means test threshold will mean that more people qualify for state-funded care when they are introduced in April 2016 and this will have implications for both self-funded and LA-funded demand.

Summary: key points about current and future demand

The projected change in the demographic profile in Telford & Wrekin is the most significant factor affecting demand for care and support services. Significantly more older people, living longer, and many with limiting illnesses, all points to a significant increase in demand and a need for more services that are better attuned to the needs of older service users. This is particularly so for service users with dementia.

It also means that the Council will need to develop its approach to managing demand if it is to achieve savings of 30% of the adult social care budget by 2015.

The emphasis on maximising independence means that many older people will want to stay at home for as long as possible and this is likely to result in an increased demand for Domiciliary and community based services over residential care.

As the population ages, it is expected that more elderly people will assume more caring responsibilities. Maintaining the health and well-being of carers must therefore be seen as a priority.

There is also a need to ensure that Domiciliary Care services reflect and respect the cultural needs of minority communities. There is national evidence to suggest that this requires attention if people are not to be excluded from care and support.

Prevention and early intervention are well recognised to help people stay well, live independently and remain healthy for longer. It is important to ensure that a wide range of preventative services are available to support people across the spectrum of need, including those who do not approach the Council for support or meet its eligibility criteria. This will ensure that people do not go without the support which could prevent critical needs developing in the future.

Rising demand and expectations within the care and support market will require that commissioners and providers of Domiciliary Care services respond in ways they might traditionally not have thought of. People will expect better information and advice as well as a broad range of services and they will want to access these without approaching the Local Authority. There will be a growing need to offer people the right kind of information to help their buying decisions. There is a real need to involve people in the design of services that will help them remain well at home.

Providers will need to consider how to help people regain and maintain independence at home, remaining healthy and with a sense of wellbeing for longer. This means considering how to help people maintain good physical, mental, social, emotional and spiritual wellbeing in order to remain healthy, active citizens now and in the future.

People will fund their care in different ways, for example, insurance policies, savings, pensions and investments. Council funding is increasingly expected to be through direct payments and Individual Service Funds, placing the buying decision firmly in the hands of the person most likely to benefit.

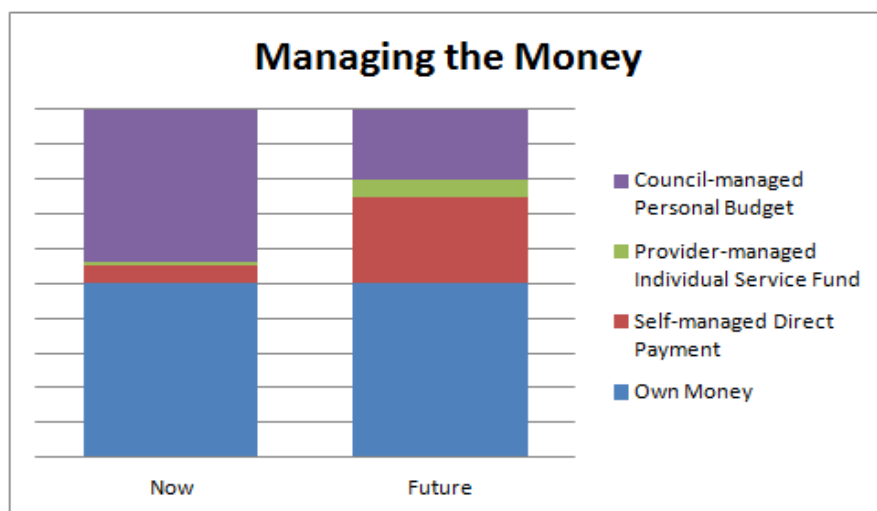


Figure 39: A shift in buying power (illustration only)

In the future the Council expects to commission proportionately less provision than it does now whilst individuals will increasingly take on the purchasing role. Providers will increasingly need to develop their service offer so that it attracts individual rather than statutory purchasers of services.

The State of Supply

National Overview

The Government spends £14.5 billion p.a. on adult social care in England, with just over half of this on services for older people.³

Nationally, the largest providers of both residential care and home care are corporate providers backed by a larger investment group, such as Saga (backed by Acromas) and Four Seasons (backed by Terra Firma).⁴

- the not-for profit sector provides a significant proportion of care, through a variety of different models of provision – including social enterprises, charitable provision, micro-enterprises, and mutuals. The Government is keen to encourage this diversity
- the vast majority of providers are small businesses; 43% of care home places are provided by operators with fewer than three homes whilst 60% of the 7,145 registered Domiciliary Care agencies are single agency businesses
- the majority of care provision is not from formal services but by unpaid carers, mainly spouses/partners, adult children and other close family. Around 5 million people in England provide such unpaid care, and
- the vast majority of paid care provision is from the private and voluntary sectors. The proportion of services supplied by Councils has fallen greatly over the last 15 to 20 years and they now provide less than 10% of residential care places for older people and around only 16% of home care.

There are also a range of models of care and retirement housing, such as extra-care housing. Specialised housing is a growing sector, however accurate data on size is hampered by multiple definitions and differing methodologies. The Elderly Accommodation Counsel (EAC) data suggests there are 821 extra care housing schemes in England although the Care Quality Commission reports there are 564 extra care locations.

In home care, there is a multiplicity of small providers, and fewer, larger providers with SAGA the biggest, following its purchase of Allied and Nestor Healthcare. There were 5,400 registered homecare businesses in England at mid-2011 (including 675 in the public sector). The estimated total market size in 2010-11 is £5.7bn (annual turnover) and the top 10 operators account for 16.5% of the market (by annual turnover). The CQC approves around 500 new Domiciliary Care agencies in England each year.

The Local Domiciliary Care Market

Domiciliary Care services in Telford & Wrekin are bought in two ways:

People who need care and support use their own money, or money they have been allocated by the state (Social Care, Health, Public Health) to buy services directly from providers offering Domiciliary Care services;

Commissioners from the statutory sector buy the required services on behalf of (and with input from) those service users in receipt of public money.

³ Fairer Care Funding: The report on the commission on funding of care and support, July 2011

⁴ Market Oversight in Adult Social Care consultation, DH, Dec 2012

The Council’s duties in respect of the local market extend to both state-funded and self-funded provision and are set out in the draft Care and Support Bill. This requires that the Council ensures the diversity, quality and sustainability of provision, within a severely constrained financial context.

This section of the analysis considers the current state of Domiciliary Care supply against each of these objectives. Whilst our analysis seeks to address the ‘whole market’ the evidence base is most robust in respect of commissioned services and reflects the need for more intelligence about and from those provides who contract directly with individuals paying for their own care.

Diversity

Diversity is important because it will ensure that people have more choice of providers and services to meet their needs, and because competition is important in order to stimulate innovation and manage costs.

The legislation envisages care and support being provided by a diverse range of organisations, including small businesses, voluntary organisations, social enterprises, user-led organisations, mutuals, and for-profit providers.

A diverse care and support market is characterised by:

- The number of providers in total
- The type of organisations providing care and support
- The types of service available
- The availability of services by location and access channel

Nationally there is a multiplicity of small Domiciliary Care providers and fewer larger providers with SAGA the biggest following its purchase of Allied and Nestor Healthcare. There were 5,400 registered homecare businesses in England at mid-2011 (including 675 in the public sector). The estimated total market size in 2010-11 is £5.7bn (annual turnover) and the top 10 operators account for 16.5% of the market (by annual turnover). The CQC approves around 500 new Domiciliary Care agencies in England each year.

Council commissioned services

In 2012/13 the Council commissioned Domiciliary Care services from 39 local, regional and national providers. These providers supported approximately 1,347 people.

16 of the providers under contract to the Council (41%) are expected to each serve less than 10 people in 2012/13 (54 people in total). 5 of these will support a single service user.

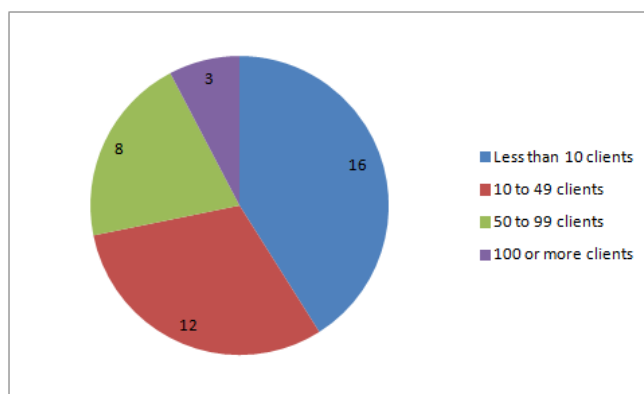


Figure 40: Domiciliary Care Providers by size of service user base

11 providers account for 75% of all Domiciliary Care service users funded by the Council, with the three largest providers serving 31% of all Council funded Domiciliary Care service users (415 people). The provider with the largest number of service users serves 167 people (12.3% of the total funded provision).

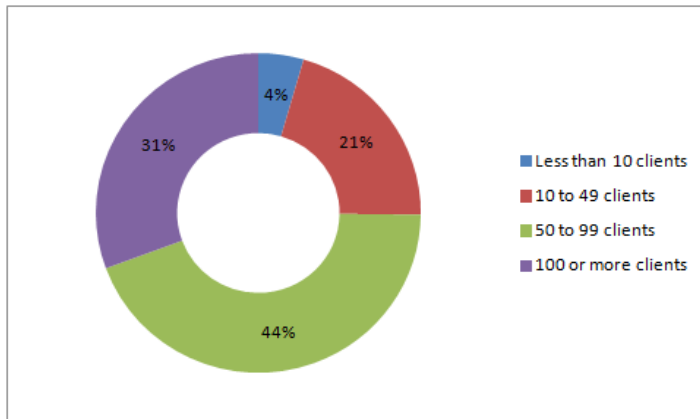


Figure 41: Domiciliary Care Providers - market share

33 of the 39 providers contracted to the Council are independent or private sector enterprises, supporting 92.3% of Local Authority funded service users and accounting for 98.5% of Local Authority spending on Domiciliary Care contracts. The 11 largest providers are all private limited companies. The largest community provider (by LA funded service user base) is a co-operative, supporting 46 service users.

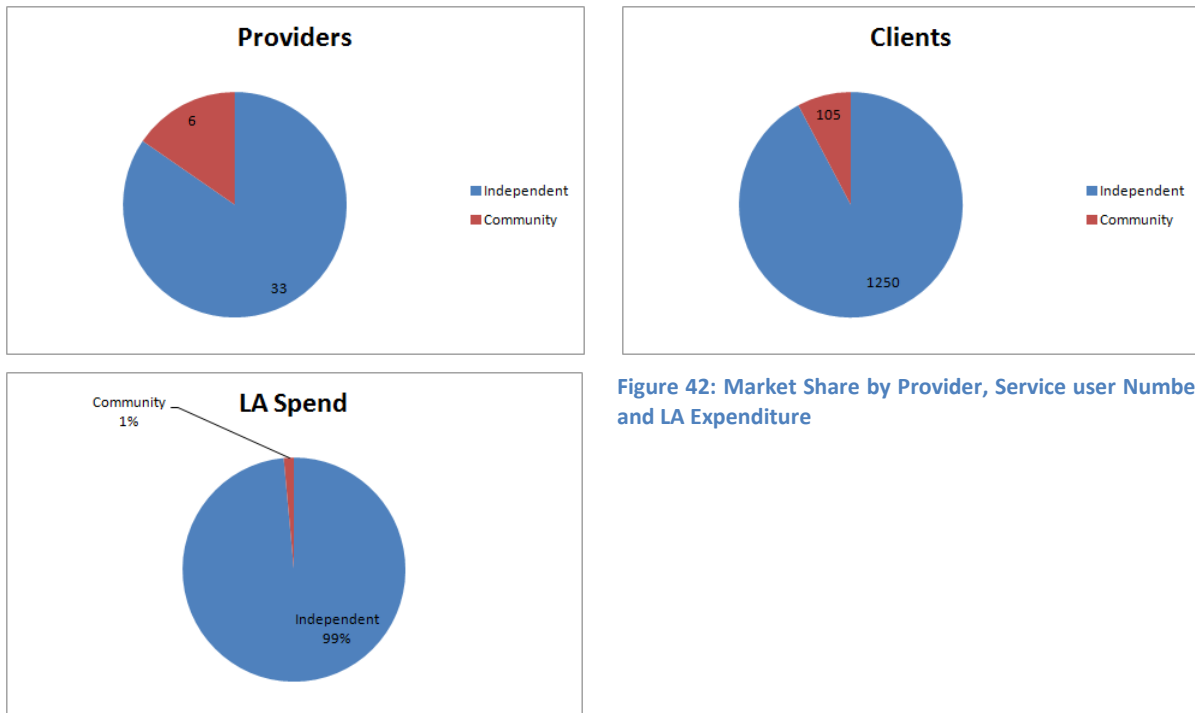


Figure 42: Market Share by Provider, Service user Number and LA Expenditure

All Domiciliary Care providers are required to be registered with the CQC. Registrations were confirmed for 37 providers contracted to the Council, whilst registrations had lapsed for the remaining 2 (neither of who is now trading nor under contract to the Council). One provider's registration relates to the operation of a Care Home rather than the provision of Domiciliary Care. This provider provides care to a small number of adults with learning disabilities: The provider is in

the process of changing their care model to supported living and adopting the relevant registration as a Domiciliary Care agency.

CQC registrations confirm the range of services being provided by those contracted to the Council, with specialisms reported against a number of categories.

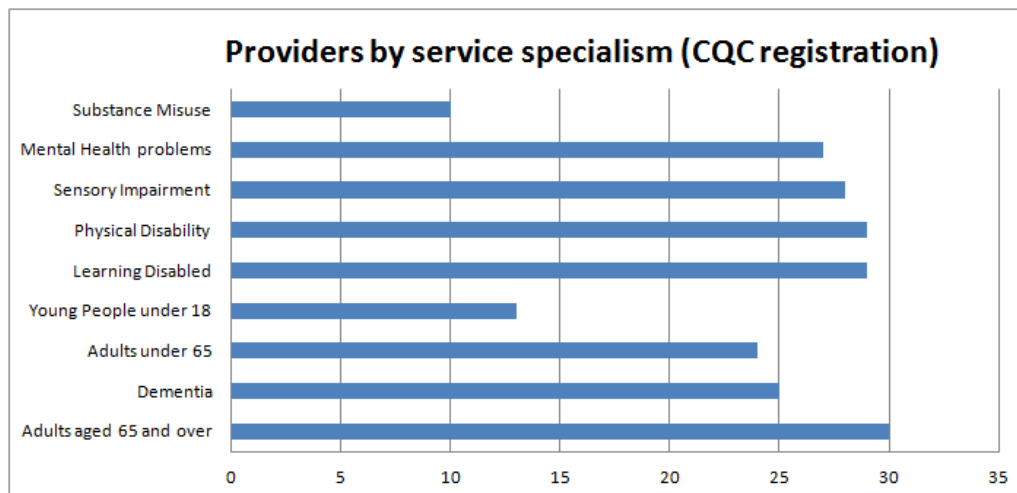


Figure 43: Provider Diversity by service specialism

This shows that whilst providers in Telford & Wrekin offer a broad range of specialisms, there is less choice of providers supporting people with problems of substance misuse and younger people with care and support needs.

The Wider Market

The Council publishes a hard copy directory of care service providers in Telford & Wrekin. This also identifies 39 Domiciliary Care providers, although not all are under contract to the Council with some assumed to be operating on the basis of privately generated revenue (e.g. from self-funders of care). The directory content is currently being reviewed and an updated version will be available later in the year.

Whilst information about the number of people buying Domiciliary Care services directly from the wider market is not known, the total number of CQC registrations provides the best available indication of the number of providers active in the local area.

According to the latest CQC data download, there are 263 providers registered to provide care and support services in the Telford & Shropshire areas. Of these, 84 offer home-based care.

These numbers increase significantly when providers based in neighbouring Local Authority areas are added in (for example, the total rises to 358, of which 127 offer home care, when including Wolverhampton based providers). The proximity of Telford & Wrekin to other Local Authority areas makes it difficult to estimate the actual number of providers active in the area although the numbers suggest that this could be many more than are contracted to the Council.

The National Minimum Data Set for Social Care (NMDS-SC) is another source of intelligence about the social care market. Maintained by Skills for Care, the data aims to provide key information about providers and their workforce. However, unlike with CQC there is no requirement for providers to submit their data to the NMDS-SC and as a consequence, the data is incomplete. For example, there

are 569 CQC-registered Domiciliary Care providers identified across the West Midlands but only 453 Domiciliary Care establishments included within NMDS-SC data. In seeking to enhance its understanding of the local market, the Council will want to encourage greater use of the NMDS-SC by providers.

Quality

The Care and Support White Paper makes it clear that primary responsibility for quality rests with providers, whilst Local Authorities are under a duty to promote quality across the whole of the market.

Quality in Care and Support services must be seen in the context of ‘personal outcomes’ and the shared expectations about how people view services. These are defined in the White Paper as:

A high-quality service means that people should say:

- I am supported to become as independent as possible.
- I am treated with compassion, dignity and respect.
- I am involved in decisions about my care.
- I am protected from avoidable harm, but also have my own freedom to take risks.
- I have a positive experience of care that meets my needs.
- I have a personalised service that lets me keep control over my own life.
- I feel that I am part of a community and participate actively in.
- The services I use represent excellent value for money.

CQC is responsible for monitoring all Domiciliary Care services in England and for making sure that they are meeting the required standards of care and welfare. Standards have been defined across five domains and are assessed through periodic inspection. Domiciliary Care service users can expect:

1. To be respected, involved and told what’s happening at every stage;
2. Care, treatment and support that meets their needs;
3. To be safe;
4. To be cared for by staff with the right skills to do their jobs properly; and
5. That the agency providing personal care routinely checks the quality of its services.

Performance in these areas is assessed against 16 ‘Essential Standards’ which relate to the 28 regulations contained in the legislation governing the work of CQC.

The Council purchases from 37 CQC registered providers: A review of CQC inspections showed that 32 had recently been inspected and the majority (24 out of 32) were meeting CQC requirements, leaving 8 with failings against CQC standards.

In relation to the CQC outcome areas described above; 3 providers had failings identified within 3 or more outcome areas; 4 providers had failings in just 1 outcome area.

Four of those where failings were identified were amongst the “top 11” providers by service user base, providing care to 391 people between them.

The most common failing (in 5 out of the 8 where shortcomings were identified) was in respect of the outcome around Staffing. For one provider the most significant failing, relating to the outcome on Quality & Sustainability of Management, required CQC enforcement action (this provider subsequently ceased trading).

All 4 providers with weaknesses in terms of the quality and sustainability of management failed to demonstrate that their services have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care (outcome 16).

	<i>CQC Outcome Areas</i>				
	Treating people with respect & involving them in their care	Providing care, treatment & support that meets people's	Caring for people safely & protecting them from harm	Staffing	Quality & sustainability of management
					16
		4	11		16
Top 11 providers				12	
		4	7		
		4	7	12	16
				12	
				13	
Remaining providers					
		4	9	14	16, 21

Figure 44: CQC Assessment Summary

A small number of providers are accredited to national and international quality standards (e.g. ISO9000, Investors in People) although this information is not centrally held.

The Council’s online care and support directory⁵ includes listings for Domiciliary Care providers but makes no reference to quality assessments. The planned introduction of the My Life portal will provide enhanced information care and support services available locally. The use of the system will be evaluated and the potential for further development of MyLife will be explored: Opportunities

⁵ http://www.telford.gov.uk/info/100010/health_and_social_care/1160/adult_care_and_support_directory

exist to enhance information about provider quality; allow users of services to rate their experiences, and support the development of an on-line market place.

The Council carries out quality monitoring visits in line with its contract management arrangements but does not currently assess or seek to influence quality with non-contracted providers (other than through its relationship with Shropshire Partners in Care and a “light touch” accreditation process). The Council monitors and responds to complaints that it becomes aware of, but there is currently no system for gathering and analysing complaints and compliments from across the market other than for contract management purposes.

The Annual Social Care Survey of people who use care and support services identifies general satisfaction levels with different types of services. In 2012, satisfaction with services and overall quality of life amongst Domiciliary Care service users was below that reported by users of residential care and day care services:

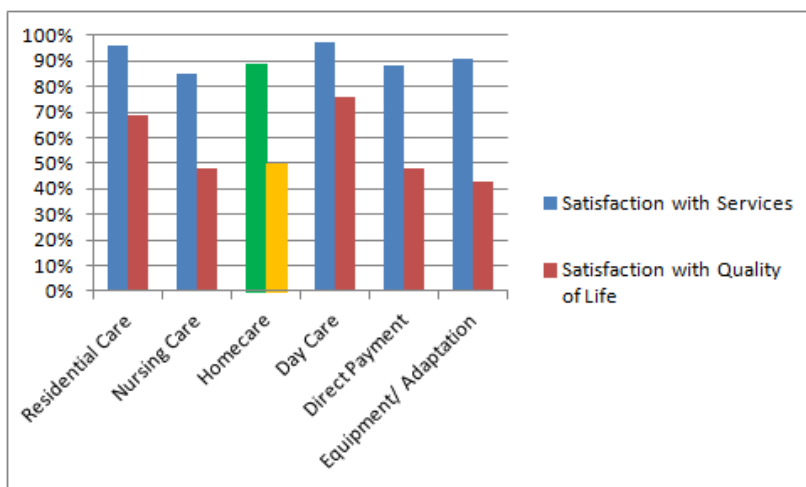


Figure 45: Adult Social Care Survey - Satisfaction Levels

Overall, opportunities for wider learning through an understanding of quality from a service user perspective are not yet fully developed.

Any Safeguarding concerns are promptly investigated and, where necessary, providers are either suspended or removed from new business under Council contracts whilst failings are addressed; however, there is currently no mechanism in place to inform people who fund or arrange their own care and support about serious quality or safeguarding concerns.

Sustainability

The Government believes that there is a need for greater reassurance to people receiving services which are likely to close or transfer to new ownership. The primary motivation for any change is to minimise the risk of a negative effect on the health and wellbeing of care users in the event of a provider failing financially and ceasing to provide services.

It is not acceptable for people with care and support needs not to receive the services that they need because a business fails or chooses to close. Should a provider exit the market, it is critical for the process to be well-managed to avoid undue stress and anxiety on individuals, their families and carers. This is particularly the case if a service has to stop completely (rather than be transferred to a new operator).

Councils are required to maintain oversight of the care and support market and this means identifying and mitigating the risks of market failure so that people who use services do not experience anxiety, disruption or negative outcomes as a result of changes in the market.

Market failure arises from the collapse of one or more essential parts of the market, causing the remainder of the market to be significantly hampered. This would have a negative effect on people who use services (for example, they may have to accept a change of provider or reduction in service, with very little time to prepare for the transition), for those seeking to purchase services (either for themselves or on behalf of someone else) by reducing the choice of provision, and of course for providers in the market who may either go out of business or be required to absorb an increase in their service user base at short notice.

Telford & Wrekin Council commissions support for 31% (415 people) of its funded Domiciliary Care service users from just three providers. There is a need to identify the individual risks of failure for each of these providers, given the potential disruption if any or all was to fail. It is not within the scope of this evidence base to develop a risk assessment – merely to reflect that such an assessment has not yet been made.

The government's proposed model of market oversight would require the development of local contingency plans, based on the risks assessed, so that any necessary transition can be smoothly managed with minimal disruption. This will require productive engagement with providers.

The number of active providers in the area provides a degree of market resilience although there is no record maintained of the capacity of providers to absorb a significant increase in service user numbers. This will be an important consideration for contingency planners.

50% of those providers contracted to the Council support less than 10 people, of which just under half (11 providers) have a single Council funded service user. The value of these one-on-one relationships should not be underplayed and it might be expected that as more people take on a greater role in the management of their care and support, there will be a need for more of this type of provision.

It is important that the Council engages with providers over the future direction for Domiciliary Care services in Telford & Wrekin and in particular over the policy agenda and its implications for providers. Providers who do not offer personalised services or who fail to deliver improved outcomes will be increasingly overlooked, especially by commissioners.

Affordability and Value for Money

The Council currently spends around £10m per annum on externally funded Domiciliary Care services and a further £1.7m through block contracts for extra care housing (2012/13 projections). In the face of planned savings of 30% across the adult social care budget by 2015, the Council is under pressure to contain its spending on Domiciliary Care services and to ensure that it maximises its return on this investment through better quality services and improved outcomes for people.

Around 61% of LA funded service users access "older people's" Domiciliary Care services, spending around 57% of the total bill.

117 Learning Disabled service users (9% of the total) use Domiciliary Care services at a cost of just under £2.5m (25% of the total spend).

Enablement services will account for 16% of all service users accessing Domiciliary Care, at a cost of just £340k (3% of the total).

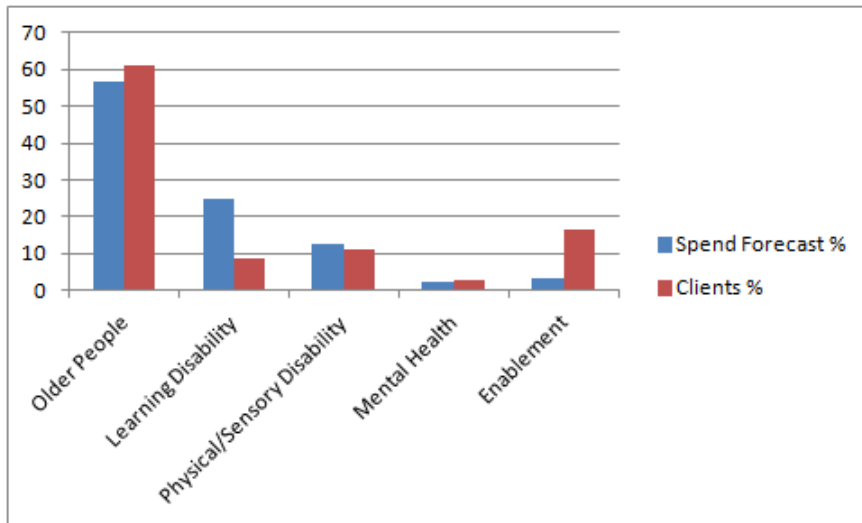


Figure 46: Spending by service user group

The ‘average cost per service user group’ shows that most money is spent per head on Learning Disability Domiciliary Care, with the lowest amount spent on Enablement.

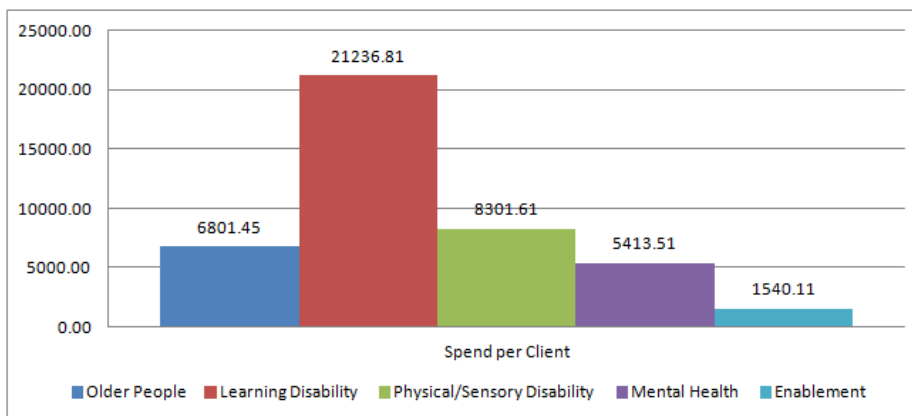


Figure 47: Average spend per service user

Average hourly rates vary somewhat between each service user group. Physical / Sensory and Learning disability provision is charged at less than the all-service average of £15.10 per hour, whilst Enablement, Older People’s and Mental Health services are all charged at above average rates.

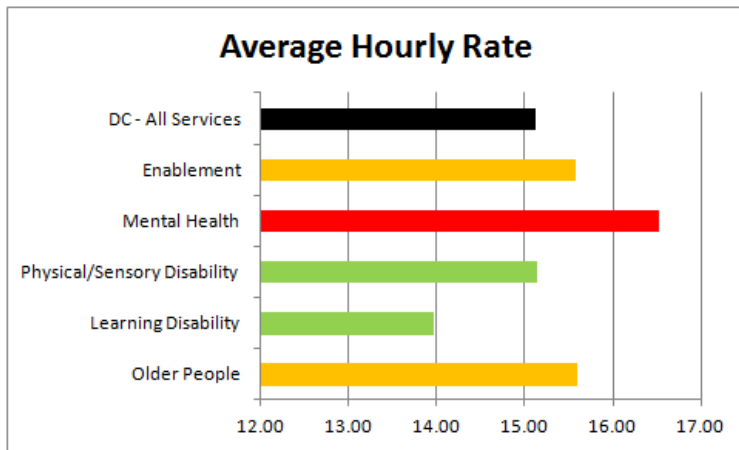


Figure 48: Average hourly rates - all service user groups

Older People’s Domiciliary Care costs between £11.52 and £28.43 per service user hour, with the average cost being £15.59 per hour. 13 providers charge less than the average hourly amount, with 6 providers charging less than £14 per hour on average.

Conversely, 15 providers charge more than the average hourly amount, of which 5 charge in excess of £18 per hour.

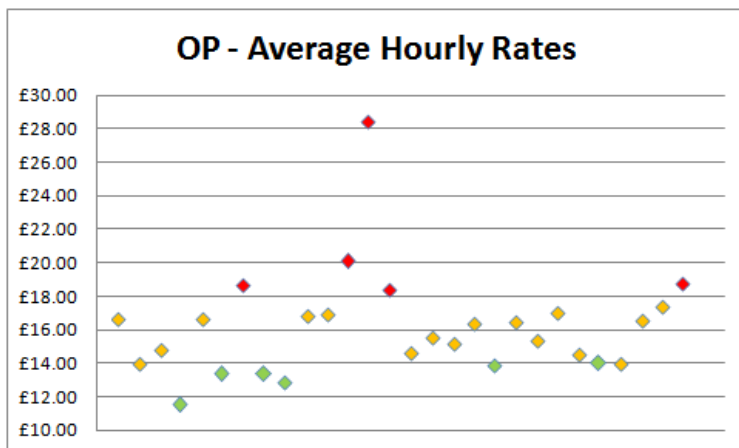


Figure 49: Average hourly rates for older people's Domiciliary Care

The Learning Disability service user group includes one payment of £211k in respect of a single service user and this somewhat distorts the average hourly rates paid for LD Domiciliary Care. Discounting this (and a number of other disproportionately high / low hourly rates reflecting one-off provision), payments for LD support fall into 3 bands, with 8 providers charging below £13 per hour, 10 providers charging between £13 and £16 per hour on average and 4 providers charging between £18 and £20 per hour.

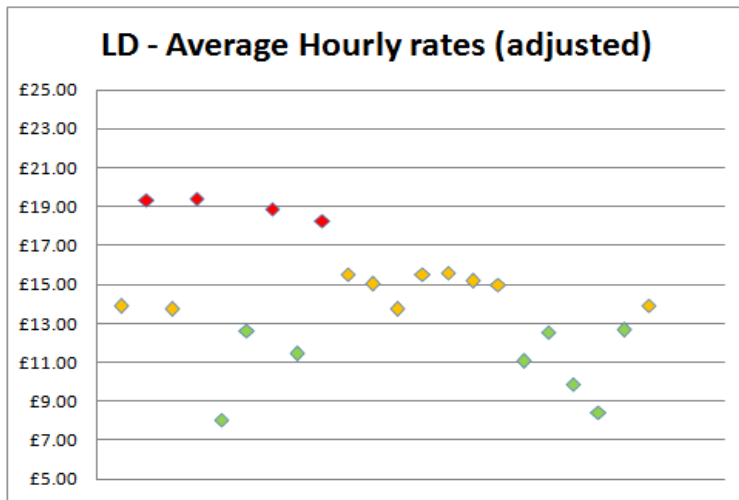


Figure 50: Average hourly rates for Learning Disability services

Domiciliary Care services for people with a physical or sensory disability are charged at between £12.10 and £17.05 per hour, with the average hourly rate being £15.12. 7 providers charge at below the average level.

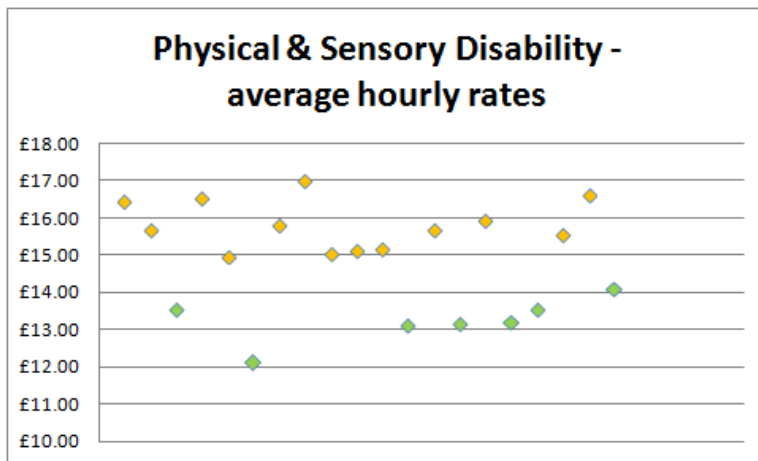


Figure 51: Average hourly rates for physical and sensory disability provision

Mental Health provision in the Domiciliary Care market ranges between £12.22 and £21.21 per hour on average. 5 providers charge average hourly rates below £14, with only 1 provider charging more than £18 per hour.

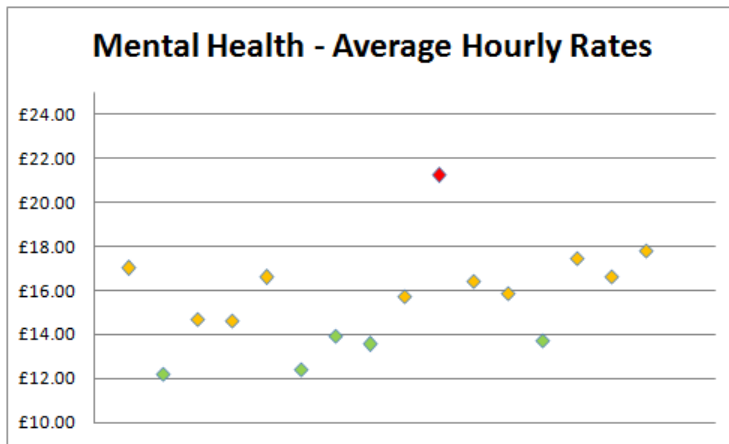


Figure 52: Average hourly rates for Mental Health service users

Enablement services range between £13.11 and £20.27 per hour on average. 8 providers charge hourly rates below the average of £15.55; 2 providers charge in excess of £18 per hour on average.

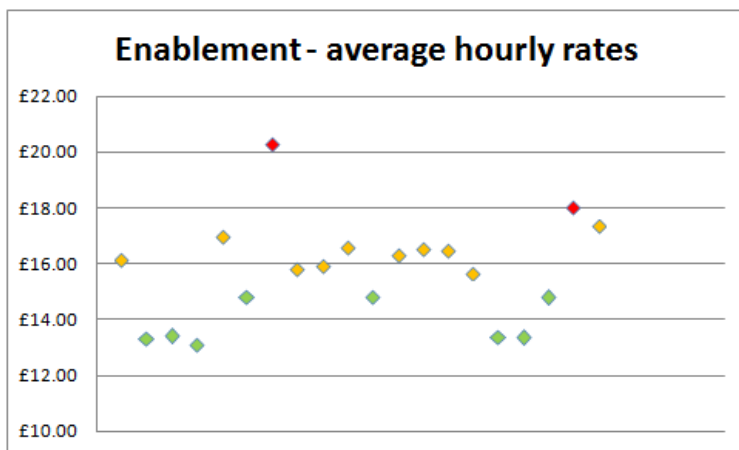


Figure 53: Average hourly rates for enablement

Whilst the hourly rates comparisons made here obviously ignore the care and support needs of individual service users, they do reveal some inequity in fee rates which warrants further investigation. In the context of achieving a sustainable market whilst operating within ever more constrained public sector funding settlements, average hourly rates will need to be controlled.

Whilst the Council is committed to an outcomes-based approach for care and support services, there is insufficient evidence currently available of the relationship between individual providers and the outcomes achieved. The Council will want to explore and extend its practice in defining and agreeing outcomes, monitoring performance and rewarding success (for example, building on its experience of monitoring Supporting People services). Outcomes will increasingly be used to provide a balanced view of performance, enabling those buying services to assess the relationship between price and outcomes in a far more transparent and useful way.

Summary – key points about supply

Overall, the evidence suggests that the Telford & Wrekin Domiciliary Care market is reasonably diverse, with a large number of providers operating in and around the area.

The market appears to be dominated by the independent sector, both in terms of provider numbers and share of the service user base. Third sector providers are under-represented, certainly in terms of the Council-commissioned part of the market.

25% of the provider base accounts for 75% (by service user number) of the market and there are 3 'dominant' providers who between them have more than a 30% share of Council-funded service users. The risks for the sustainability of the market should one or more of these providers fail or exit the market have not yet been assessed.

There are currently only limited indicators of quality within the local market and little has yet been achieved in terms of making this information accessible to people making decisions about their care and support. CQC assessments for those providers contracted to the Council are generally satisfactory, showing that in most cases the required standards are being met.

There is, however, a need to understand more about quality from a provider and a service user perspective and in particular to commence a dialogue aimed at driving up quality across both the state-funded and self-funded parts of the market.

The diversity and increased competition within the market does not yet appear to have had a dampening effect on prices. However the price schedules being submitted by Domiciliary Care providers for 2013/14 do indicate that some providers are realigning the cost elements in their schedules: This may be a response to an interim brokerage arrangement that was put in place late in 2012. Average hourly rates in some groups are significantly distorted by exceptional one-off cases. Overall, the Council will want to take action to contain prices whilst working with providers to demonstrate in increasing return (in terms of outcomes) on the money spent.

The new service delivery model does not yet appear to have materially changed the nature of supply. The implications of the model – more short-term preventative and reablement provision and fewer service users with long term needs – are expected to drive an increase in the need for shorter, recovery-based interventions aimed at maximising independence.

Glossary

The language and vocabulary used within adult social care can be complex and sometimes ambiguous. This glossary is intended to clarify and explain some of the terms used in this paper and elsewhere across the Council's adult social care function.

Advocacy – specialist independent support to help people understand their rights and the choices open to them, and help them express their views, preferences and decisions.

Assessment – A health and social care assessment is the assessment by a Local Authority of a person's need for community care services in order to maintain their life at a certain standard. Local authorities have a duty to assess any person in their area who appears to need such services (Section 47 NHS and Community Care Act 1990).

Assistive technology – an umbrella term that includes assistive, adaptive, and rehabilitative devices. AT promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing.

Brokerage – a team within Telford & Wrekin Council's Adult Social Care directorate which exists to facilitate access to care and support services. The Brokerage team attempts to match the needs of individual service users with the service offers made by providers, so that they can make informed choices.

Carers – Carers provide unpaid support to family or friends who couldn't manage without this help, whether they're caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

Carers assessments – Carers may be entitled to financial and other support. A carers assessment is an assessment of the help needed by a carer looking after a friend or relative to continue caring and to help maintain the carer's health and balance within their life, work and family commitments (Carers and Disabled Children Act 2000).

Choice and control – One of the pillars of social care and support policy, which recognises that people should be enabled to the maximum extent to choose the providers, services and funding arrangements that suit them and that puts them at the heart of service planning and delivery.

Commissioning – Commissioning is the process by which Local Authorities decide how to spend their money to get the best possible outcomes for individuals and communities, based on local needs. Local Authority commissioning of services involves a strategic overview of the needs of the local population, setting policies to decide how those needs will be met in the most effective and cost efficient way, procuring the services and monitoring them to ensure that they meet requirements.

Community-based support – the local community resources that people access in order to help them manage their own care. This includes information as well as physical resources.

Co-production – refers to active input by the people who use services, as well as those who provide them and those who have commissioned them. Councils are increasingly involving providers and service users in three-way co-production within adult social care.

Deployment Options – alternative ways that people in receipt of Local Authority funding for their care and support needs might choose to manage the money. A person can choose to receive their personal budget as a direct payment, a managed account, or a mix of the two options.

Direct Payments – one of the deployment options for people in receipt of a personal budget. The money is paid directly to a person (or to a third party acting on their behalf) who chooses to make their own care arrangements rather than receiving services provided by the Local Authority.

Domiciliary Care - services and support provided to people in their own homes, helping them to live as independently as possible, rather than using residential, long-term, or institution-based care. Also referred to as Homecare.

Flexible support – support arrangements developed with the service user and tailored to their individual needs.

Home care - See Domiciliary Care.

Individual Service Fund – one of the deployment options for people in receipt of a Direct Payment. The money is managed by a service provider on behalf of an individual. Spending is restricted for use on providing care and support services for that individual which meet the criteria set out in their support plan. It can include services purchased from other providers.

Information and advice – the means by which people can research and make decisions about their care and support provision. Local Authorities are under a duty to provide information and advice on a range of matters including the operation of the care and support system, the range and quality of services and how to access them.

Long term conditions – health related conditions that cannot be cured but can be managed through medication, therapy and support.

Making it Real – a set of "progress markers" - written by real people and families – that describe what people who use services and carers expect to see and experience if support services are truly personalised. The aim of Making it Real is for people to have more choice and control so they can live full and independent lives.

Managed Account – one of the deployment options for people in receipt of a personal budget. The money is managed by the Local Authority in line with the wishes of the person receiving home care, also known as a 'virtual budget'.

Market – in the context of adult social care, we use the term 'Market' to describe the environment in which care and support service requirements are defined and satisfied. The Domiciliary Care market will involve many 'actors' including people who use services, carers, advocates, commissioners, brokers and providers.

Market development / market shaping – a strategic activity aimed at achieving a change in the structure and/or operation of the market based on an analysis of market conditions. Councils should aim to co-produce market development plans based on their analysis.

Outcomes – the effects that services have on people. Outcomes are increasingly regarded as the best way to measure the value of services.

Peer support – initiatives where colleagues, members of professional networks and others meet as equals to give each other support on a reciprocal basis.

Personal budgets – A person can choose to receive their personal budget as a direct payment, a managed account, or a mix of the two options.

Personalisation – giving people more choice and control over deciding how their social care needs are met including through the use of personal budgets. Also known as self-directed support.

Prevention and preventative services – arrangements which prevent or delay the need for long-term care and support. Preventative services might include information, advice and advocacy, public health education and help to maintain independence.

Providers – organisations that provide care and support services to people who need them. Providers may come from the statutory, independent or community sectors.

Reablement – short term support to enable people to regain their independence, either fully or in part, following a period of illness or hospitalisation.

Resource Allocation Systems – IT-based system used by Councils to calculate how much money a person can reasonably expect to be made available through their personal budget (an indicative budget allocation). The RAS also specifies the outcomes that are to be achieved with that money.

Residential care – long-term care given to adults or children in a residential setting rather than in their own home.

Self directed support – see **Personalisation**.

Self funder - a person who pays entirely for their own care.

Service users – people who use care and support services. Service users can be state-funded or self-funders.

Support brokerage - support given to individuals to help them identify what support package will best meet their needs and preferences within available resources, and organise and manage this support. Brokerage services can include advocacy, organising a care package and managing a personal budget including staffing and pay-roll services.

Support planning – the process by which people with care and support needs identify and plan the services and support they will use.

Telecare – technology-based solutions that enable the remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes.

Transformation – fundamental change to the way that care and support services are specified, designed, organised and delivered so as to enable people to achieve better outcomes.

Disclaimer

This report has been prepared by Impact Change Solutions Ltd for the purpose of documenting the evidence that underpins the Telford & Wrekin Domiciliary Care Market Position Statement.

The contents of this report are based upon or derived from information publicly available and generally believed to be reliable although no representation is made that it is accurate or complete and Impact Change Solutions Ltd. accepts no liability with regard to the user's reliance on it.



Paul Johnston

Impact Change Solutions Ltd

March 2013

References, Resources & Citations

The following is a list of the resources researched and cited in this report:

Localism Act 2011, HM Government 2011

Building a Stronger Civil Society, Cabinet Office 2010

Health & Social Care Act 2012, HM Government 2012

Vision for Adult Social Care: Capable communities & active citizens, DH 2010

Think Local Act Personal Partnership Agreement, ADASS 2011

Living Well with Dementia, DH 2009

Prime Minister's Dementia Challenge, DH 2012

No Health Without Mental Health, HM Government 2011

Caring about Carers: a national strategy for carers, DH 1999

Recognised, Valued and Supported: next steps for the Carers Strategy, DH 2010

NHS Outcomes Framework, DH 2012

Adult Social Care Outcomes Framework, DH 2012

Public Health Outcomes Framework, DH 2012

Improving health and care: the role of the outcomes frameworks, DH 2012

Caring for our future: reforming care & support, DH 2012

Draft Care and Support Bill, HM Government, 2012

Fairer care funding, Commission on Funding of care and support 2011

Caring for our future: progress report on funding reform, HM Government 2012

Health Lives Healthy People: our strategy for public health in England, HM Government 2010

Telford & Wrekin Council website:

- Being a Co-operative Council
- Council Plan and Priorities
- Working in Partnership – Co-operative Commission
- Telford & Wrekin Population Estimates and Projections
- 2011 Census Updates
- Ward Profiles
- IMD (Indices of Multiple Deprivation) 2010 Analysis
- Health & Wellbeing Board
- Healthwatch
- Adult Social Care Local Account
- Joint Strategic Needs Assessment (JSNA)

NHS Telford & Wrekin Clinical Commissioning Group website

Office for National Statistics (ONS) website

Projecting Older People's Population Information (POPPI) website

Projecting Adult Needs and Service Information (PANSI) website

How Fair is Britain? Equality & Human Rights Commission 2011

Alzheimer's Society Dementia prevalence and diagnosis mapping tool (Alzheimer's Society website)

Health Survey for England, 2001

Adult Psychiatric Morbidity in England 2007, Health & Social Care Information Centre 2009

Telford & Wrekin Community Mental Health Profile 2013, North East Public Health Observatory (website)

National Minimum Dataset for Social Care (NMDS-SC) Local Authority Area Profile

Care of Elderly People UK Market Survey, Laing & Buisson 2011

Telford & Wrekin Council Performance Data:

- Service User Numbers 2010/11
- RAP Return Year End Summary 2011/12
- Homecare Analysis by Provider 2012/13

CQC Regulated Provider database extract

CQC Inspection data (CQC website)